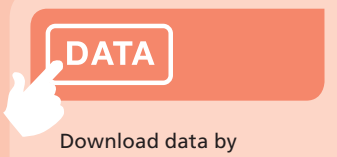
Chapter 7

Health

- In the UK in 2004, males could expect to live 62.3 years free from a limiting long-standing illness or a disability and females 63.9 years. (Table 7.2)
- In 2006 in Great Britain, 91 per cent of males and 89 per cent of females reported having good or fairly good health. (Table 7.3)
- Between 1971 and 2006, age-standardised death rates for circulatory diseases in the UK fell from 6,936 to 2,462 per million males and from 4,285 to 1,559 per million females. (Figure 7.4)
- Between 1994 and 2006 the proportion of men classified as obese in England increased from 14 per cent to 24 per cent, while the proportion for women rose from 17 per cent to 24 per cent. (Page 98)
- Between 1991 and 2006, death rates from alcohol-related causes in the UK rose from 9.1 to 18.3 per 100,000 men and from 5.0 to 8.8 per 100,000 for women. (Figure 7.12)
- In 2004 in Great Britain, the proportion of children aged 5 to 16 with a mental disorder was more than twice as high among those living in 'hard pressed' areas than those in areas populated by 'wealthy achievers'. (Figure 7.17)



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Over the past century there have been notable improvements in health in the UK. These can be attributed to improved nutrition, advances in medical science and technology, and the development of health services that are freely available to all. There are, however, some statistically significant health inequalities between different groups in society. Factors influencing these include income, and its effect on the quality of diet and housing that are affordable, and awareness of healthy lifestyles, which can impact on health problems linked to diet, levels of physical activity, smoking and drinking.

Key health indicators

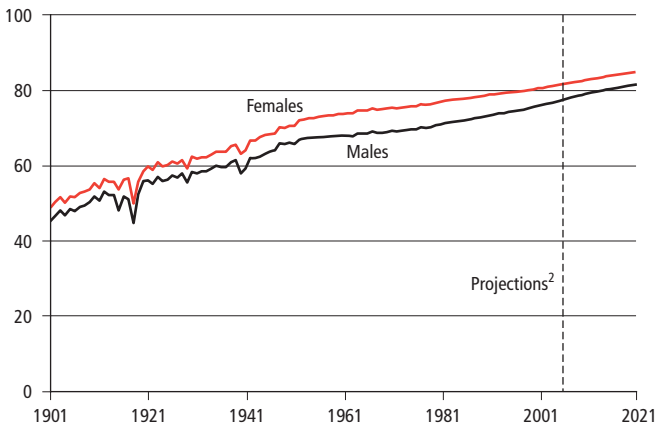
Life expectancy is a widely used indicator of the state of the nation's health. There have been large improvements in expectancy of life at birth over the past century for both males and females. In 1901 males born in the UK could expect to live around 45 years and females to around 49 years (Figure 7.1). By 2006 life expectancy at birth had risen to 77 years for males and to 82 years for females. Since before the beginning of the 20th century, female life expectancy at birth has been consistently higher than that of males. The disparity was at its greatest in 1969, when females could expect to live on average 6.3 years longer than males born in the same year. Since then the gap has steadily narrowed, with this trend projected to continue until around 2014, when the difference is expected to level off at around 3.5 years. Life expectancy at birth is projected to continue to rise for both sexes, to reach more than 81 years for males and more than 84 years for females by 2021.

Figure 7.1

Expectation of life[1] at birth: by sex

United Kingdom

Years



1 See Appendix, Part 7: Expectation of life. The average number of years a new-born baby would survive if he or she experienced age-specific mortality rates for that time period thoughout his or her life.
2 2006-based projections for 2007 to 2021.

Source: Government Actuary's Department, Office for National Statistics

Table 7.2

Life expectancy, healthy life expectancy and disability-free life expectancy:[1] by sex, 2004

United Kingdom Years

	Males		Females	
	At birth	At age 65	At birth	At age 65
Life expectancy	76.6	16.6	81.0	19.4
Healthy life expectancy	67.9	12.5	70.3	14.5
Years spent in poor health	8.7	4.1	10.7	4.9
Disability-free life expectancy	62.3	9.9	63.9	10.7
Years spent with disability	14.3	6.7	17.1	8.7

1 See Appendix, Part 7: Expectation of life, and Healthy life expectancy and disability-free life expectancy.

Source: Government Actuary's Department; Office for National Statistics

In contrast to the long-term improvements seen in life expectancy at birth, it was not until the latter part of the 20th century that life expectancy for adults in the UK showed a continuous improvement. Since the early 1970s the increase in life expectancy among older adults has been particularly notable. Between 1971 and 2006 life expectancy for men aged 65 increased by 4.9 years, compared with an increase of 1.7 years between 1901 and 1971. This improvement can be linked to a rapid decline in death rates among men at these older ages (see Chapter 1: Population, Table 1.9).

Despite its use as a general indicator of the population's health, life expectancy takes no account of the quality of life and whether it is lived in good health, with disability or dependency. Summary health measures such as healthy life expectancy and disability-free life expectancy focus on the population's health-related quality of life. In the UK in 2004, the healthy life expectancy of males was 67.9 years at birth and 12.5 years at age 65. For females, the equivalent figures were 70.3 years and 14.5 years respectively (Table 7.2).

Disability-free life expectancy, defined as the expected number of years lived free from a limiting long-standing illness, is calculated using life expectancy and self-reported limiting long-standing illness data. Such conditions include arthritis, back pain, heart disease and mental disorders. There were similar patterns for males and females in terms of the number of years they could expect to live free from a limiting long-standing illness or a disability. In the UK in 2004, on average males could expect to live 62.3 years free from a limiting long-standing illness or a disability, and 9.9 years at age 65. For females the equivalent figures were 63.9 years at birth, and 10.7 years at age 65.

Within the UK in 2004, England had the highest life expectancy at birth of 76.9 years for men and the highest disability-free life expectancy at birth of 62.6 years for men. England also had the highest life expectancy at birth of 81.2 years for women and the highest disability-free life expectancy for women, of 64.2 years. The lowest life expectancy was in Scotland at 74.2 years for men and 79.3 years for women. The lowest disability-free life expectancy for men was in Northern Ireland at 59.7 years and for women, 60.3 years.

The proportion of males and females reporting good health in Great Britain in 2006 was similar in all age groups but between the ages of 16 and 24 the figures for males were 5 percentage points higher than those for females (Table 7.3). In total 68 per cent of males and 66 per cent of females reported good health in contrast to 9 per cent of males and 11 per cent of females who reported their health as not good. In Northern Ireland 67 per cent of males and 64 per cent of females reported good health. In the 75 years and over age group 31 per cent of males and 28 per cent of females reported good health.

Since the early 1970s, circulatory diseases (which include heart disease and stroke) have remained the most common cause of death among both males and females in the UK. However, they have also shown by far the greatest decline of the main diseases that cause death, particularly among males (Figure 7.4). In 1971, age-standardised death rates for circulatory diseases were 6,936 per million males and

Table 7.3

Self-reported general health:[1] by sex and age, 2006[2]

Great Britain Percentages

	Good	Fairly good	Not good	All
Males				
0–15	85	12	2	100
16–24	83	14	3	100
25–44	74	20	6	100
45–64	58	28	14	100
65–74	44	36	19	100
75 and over	33	43	24	100
All ages	68	23	9	100
Females				
0–15	87	11	2	100
16–24	78	18	3	100
25–44	70	21	8	100
45–64	59	26	15	100
65–74	43	38	19	100
75 and over	33	39	28	100
All ages	66	23	11	100

1 See Appendix, Part 7: Self-reported illness.
2 See Appendix, Part 2: General Household Survey.

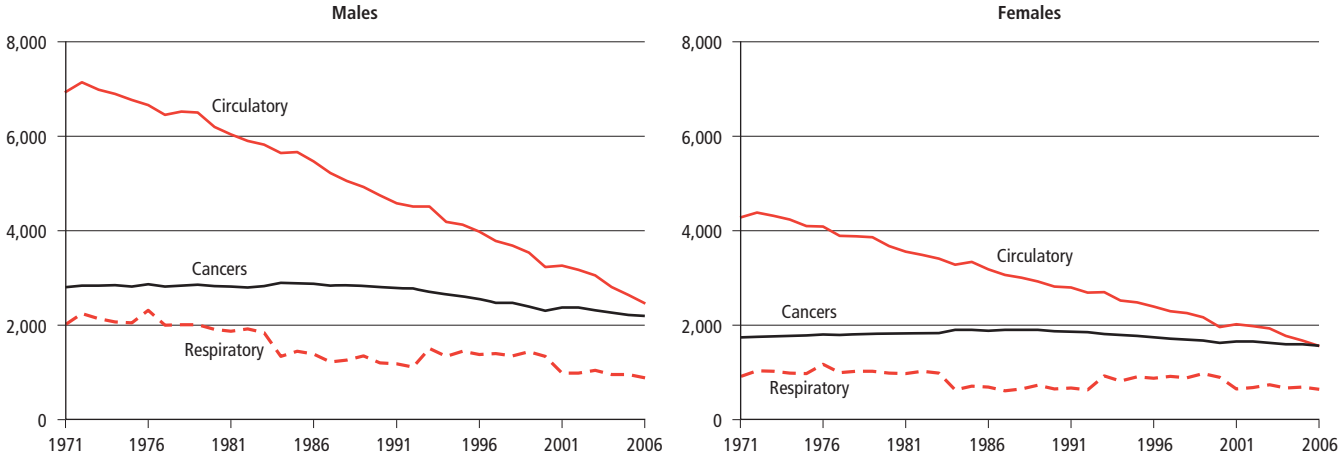
Source: General Household Survey (Longitudinal), Office for National Statistics

Figure 7.4

Mortality:[1] by sex and leading cause groups

United Kingdom[2]

Rates per million population



1 Data are for all ages and have been age-standardised using the European standard population. See Appendix, Part 7: Standardised rates, and International Classification of Diseases.
2 Data for 2000 are for England and Wales only.

Source: Office for National Statistics

4,285 per million females. By 2006 these rates had fallen to 2,462 per million for males and 1,559 per million for females, when the death rate for circulatory disease in females was lower than cancer for the first time.

Over the past 35 years cancers have been the second most common cause of death among men. The same was true for women until 2006 when cancers became the most common cause of death. Death rates from cancer peaked in 1984 for males at 2,899 per million, and by 2006 had fallen to 2,201 per million. Death rates from cancer for females are typically lower than those for males and peaked in 1989 at 1,905 per million, since when they have fallen gradually to 1,569 per million in 2006. These variations in mortality trends partly reflect differences in the types of cancer males and females are likely to experience, the risk factors associated with developing them and the relative survival rates for different cancers. The incidence and survival rates for the most common forms of cancer are examined later in this chapter.

The reduction in infant mortality (defined as deaths in the first year of life) was one of the factors contributing to an overall increase in life expectancy, particularly in the first half of the 20th century. In 1930, there were 60.0 deaths under the age of one, per 1,000 live births in England and Wales (Figure 7.5). In the years to the beginning of the Second World War, there was a gradual fall in the infant mortality rate to 50.6 in 1939. Although the rate fluctuated in the early 1940s, following the Second World War, there was a steady fall in the infant mortality rate from 46.0 per 1,000 live births in 1945 to half that at 23.1 per 1,000, 12 years later in 1957. This decline continued and in 2004, there were 5.0 deaths per 1,000 live births. The rate slightly increased to 5.1 in 2005, then declined to 5.0 deaths per 1,000 live births in 2006. The fall in infant mortality rates can be linked to improvements in diet and sanitation, better antenatal, postnatal and medical care, and the development of vaccines and immunisation programmes.

Neonatal mortality (defined as deaths in babies under 28 days) and perinatal mortality (defined as stillbirths and deaths to babies under seven days) rates followed similar historical trends to those for infant mortality. The neonatal mortality rate fell until 2001, when it levelled out at a rate of 3.6 deaths per 1,000. It fell again to 3.4 deaths per 1,000 births by 2005 before rising to 3.5 in 2006. Perinatal mortality fell until 2001 to a rate of 8.0 deaths per 1,000 and remained at this level until 2006 apart from a small rise in 2003 and 2004.

Despite the decline in infant mortality rates, notable socio-economic inequalities still exist. In England and Wales in 2005, the infant mortality rate among babies born inside marriage, whose fathers were in semi-routine occupations, was 6.1 per 1,000 live births. This was more than twice the infant mortality rate of 2.7 per 1,000 live births for those who were born inside marriage and whose fathers were in large employers and higher managerial occupations. For babies born outside marriage, where the birth was jointly registered by both parents, there was a similar pattern, with an infant mortality rate of 6.8 per 1,000 live births for babies whose fathers were in semi-routine occupations. This compared with a rate of 3.1 for those with fathers in large employers and higher managerial occupations.

Over the past 15 years there have been contrasting trends in the occurrence of the most commonly diagnosed childhood infections. A measles epidemic in 1994 in the UK had 23,500 notifications, almost twice the level of 1993. Since 1994, there has been a downward trend until 2005, when there were 2,330 notifications, before rising to 4,020 notifications in 2006 (Figure 7.6).

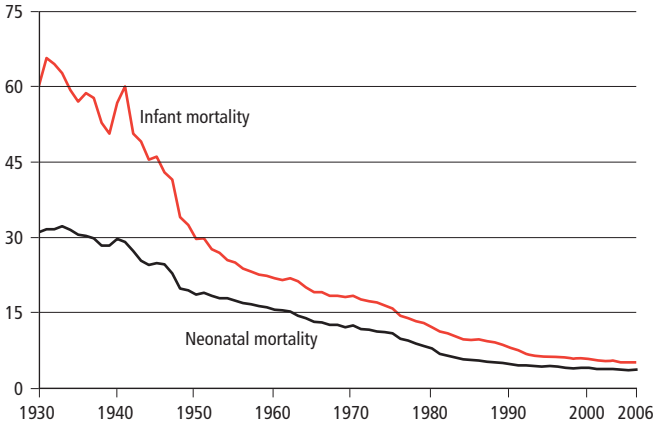
In 2005 there was a mumps epidemic, with 66,500 notifications in the UK. More than 80 per cent of notifications were in people aged 15 and over. The increase in this age group largely reflects lower immunity rates among older teenagers and young adults who were born before the introduction of the measles, mumps, rubella (MMR) triple vaccine in the UK in 1988. Coverage levels of 90 per cent for MMR were achieved by the early 1990s, but in recent years concerns over the safety of the vaccine have led to a fall in uptake. The uptake rate was particularly low in London with only 75 per cent of children immunised by their second birthday in 2006/07 compared to 89 per cent in the North East of England.

Figure 7.5

Infant[1] and neonatal[2] mortality

England & Wales

Rates per 1,000 live births



1 Deaths under age 1 per 1,000 live births.
2 Deaths under 28 days per 1,000 live births.

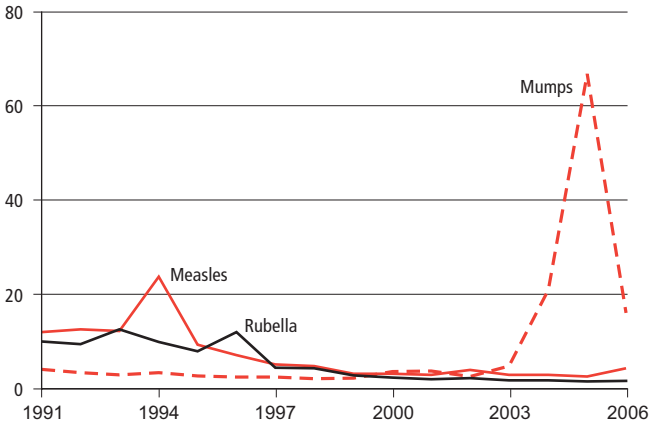
Source: Office for National Statistics

Figure 7.6

Notifications of measles, mumps and rubella

United Kingdom

Thousands



Source: Health Protection Agency; National Health Service in Scotland; Communicable Disease Surveillance Centre (Northern Ireland)

Rubella (also referred to as German measles), like measles, often occurs in epidemics in populations where vaccination has not been in use. The last epidemic occurred in 1996, when there were slightly less than 12,000 notifications in the UK. Since 2000 the annual number of notifications has been between 1,300 and 2,100. The disease is rarely serious except in pregnant women, where it may lead to abnormalities in unborn babies.

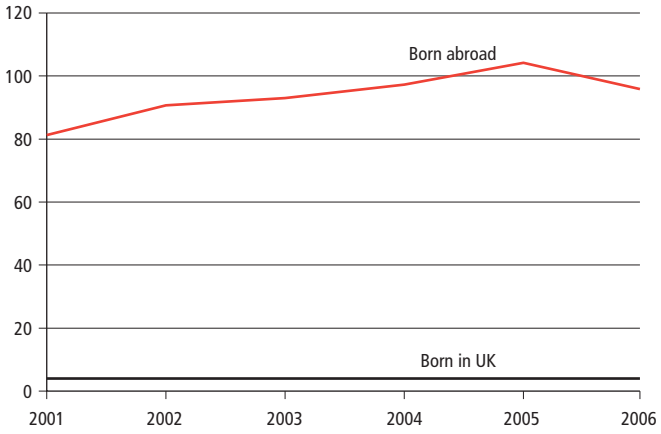
The number of reported cases of tuberculosis (TB) has been increasing steadily since the late 1980s. In 2006, more than 8,000 cases were reported in England and Wales, around 40 per cent more than in 1999 (Figure 7.7). Since 2001 the notification rate among people who were born in the UK remained very low, at around 4 per 100,000 population of England and Wales. The rate among those born abroad was much higher.

Figure 7.7

Tuberculosis rates: by place of birth

England & Wales

Rates per 100,000 population



Source: Health Protection Agency

Between 2001 and 2006 there was an overall increase in the TB rate among those born abroad, from 81 to 96 per 100,000 population in England and Wales. The increase over this period was largely in specific groups and areas. In 2006, 42 per cent of reported cases in England and Wales were in London. Overall, almost 40 per cent of cases were among people from an Indian, Pakistani or Bangladeshi ethnic group.

Diet and obesity

Diet has an important influence on weight and general health. The Department of Health recommends that a healthy diet should include at least five portions a day of a variety of fruit and vegetables (excluding potatoes). In 2006, 28 per cent of men and 32 per cent of women in England met this target (Table 7.8). Increased intake of fruit and vegetables is associated with decreasing the risk of developing various diseases and in

Table 7.8

Daily portions of fruit and vegetables consumed: by sex and age, 2006

England Percentages

	Number of portions per day				
	None	Above 0 but less than 5	5 or more	All	Average daily portions
Men					
16–24	*12*	*69*	*19*	*100*	3.0
25–34	*7*	*67*	*27*	*100*	3.7
35–44	*9*	*62*	*29*	*100*	3.5
45–54	*6*	*64*	*30*	*100*	3.7
55–64	*5*	*64*	*32*	*100*	3.9
65–74	*3*	*66*	*31*	*100*	4.0
75 and over	*3*	*67*	*29*	*100*	3.8
All aged 16 and over	*7*	*65*	*28*	*100*	3.6
Women					
16–24	*8*	*70*	*22*	*100*	3.3
25–34	*5*	*64*	*31*	*100*	3.9
35–44	*6*	*61*	*33*	*100*	4.0
45–54	*4*	*61*	*35*	*100*	4.2
55–64	*2*	*58*	*39*	*100*	4.5
65–74	*2*	*64*	*33*	*100*	4.1
75 and over	*3*	*73*	*25*	*100*	3.6
All aged 16 and over	*5*	*64*	*32*	*100*	3.9

Source: Health Survey for England, The Information Centre for health and social care

2006, the proportion of adults eating five or more portions a day generally increased with age up to the age of 64. Among men the proportion peaked at 32 per cent among those aged 55 to 64. Among women those aged 55 to 64 were the most likely to consume five or more portions, at 39 per cent. Young men and women aged 16 to 24 were by far the least likely group to consume the recommended daily portions of fruit and vegetables and were also the most likely to consume none at all. In 2006, 19 per cent of men and 22 per cent of women in this age group reported consuming five or more portions of fruit and vegetables on a daily basis, while 12 per cent of men and 8 per cent of women ate none at all.

In 2006, 19 per cent of boys and 22 per cent of girls aged 5 to 15 in England reported eating at least five portions of fruit and vegetables (excluding potatoes) on a daily basis. These proportions were notably higher than in 2004 (13 per cent of boys and 12 per cent of girls).

Access to a healthy diet is partly linked to affordability. In 2005/06 those living in UK households in the top one-fifth of the income distribution consumed more fresh fruit and vegetables (excluding potatoes) on a weekly basis than those in lower income groups (Figure 7.9). Households in the top quintile group (see Chapter 5: Income and wealth, analysing income distribution box) consumed an average of 857 grams of fresh vegetables and 943 grams of fresh fruit per person per week. In contrast, households in the bottom quintile group consumed 742 grams of fresh vegetables and 828 grams of fresh fruit per person per week. Those in the middle fifth quintile group, on average, consumed more processed potatoes and potato products, and processed vegetables than any other quintile group.

Diets that are high in fat and low in fresh fruit and vegetables can contribute to a person being overweight or obese. Obesity is linked to heart disease, diabetes and premature death. The body mass index (BMI) is a common measure for assessing an individual's weight relative to their height, and a BMI score of 30 kg/m^2 or more is taken as the definition of obesity (see Appendix, Part 7: Body mass index). In recent years the proportion of the adult population in England who are obese has increased. Between 1994 and 2006 the proportion of men aged 16 and over who were classified as obese increased from 14 per cent to 24 per cent, while among women the proportion rose from 17 per cent to 24 per cent. In addition, a further 43 per cent of men and 32 per cent of women were classified as overweight (BMI score of 25 kg/m^2 to less than 30 kg/m^2). In 2006, the proportion of the adult population classified as obese or overweight was 67 per cent and 56 per cent of men and women respectively (Figure 7.10).

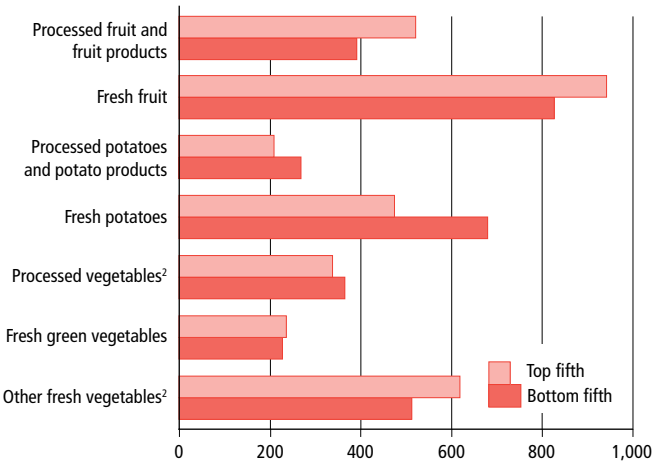
There is also concern over the increasing proportion of children who are obese or overweight. Based on the UK 1990 national BMI percentiles classification, between 1995 and 2006, the proportion of boys aged 2 to 15 in England who were

Figure 7.9

Consumption of fruit and vegetables in the home: by income grouping[1] of household, 2005/06

United Kingdom

Grams per person per week



1 Gross weekly income has been used to rank the households into quintile groups. See Chapter 5: Income and wealth, analysing income distribution box for more on quintiles.
2 Excluding potatoes.

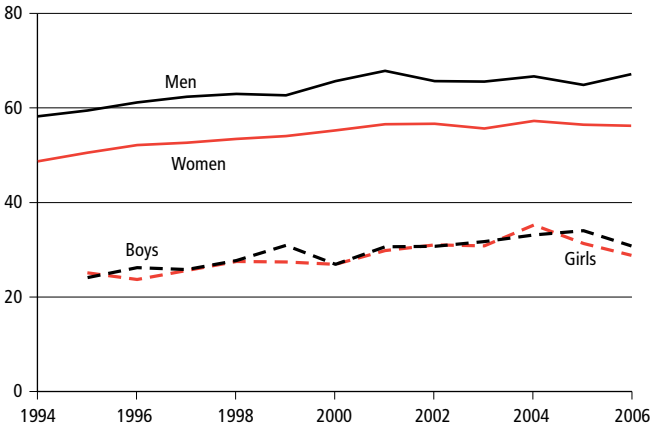
Source: Expenditure and Food Survey, Office for National Statistics; Department for Environment, Food and Rural Affairs

Figure 7.10

Proportion of adults and children[1] who are obese or overweight:[2] by sex

England

Percentages



1 Adults aged 16 years and over, children aged 2 to 15 years.
2 Using the body mass index (BMI) for people aged 16 and over and the 1990 UK national body mass index percentile classification for those aged 2 to 15. See Appendix, Part 7: Body mass index.

Source: Health Survey for England, The Information Centre for health and social care

classified as obese increased from 11 per cent to 17 per cent. Among girls in this age group the proportion rose from 12 per cent to 15 per cent, although there was some fluctuation between years. Among girls aged 2 to 15, the proportion who were obese decreased between 2005 and 2006, from 18 per cent to 15 per cent. Future years' data will show whether this is part of a downward trend. There was no significant change among boys over this period. In 2006, 13 per cent of boys and 14 per cent of girls aged 2 to 15 in England were classified as overweight.

Alcohol and smoking

Excessive alcohol consumption can lead to an increased likelihood of developing health problems such as high blood pressure, cancer and cirrhosis of the liver. The Department of Health advises that consumption of three to four units of alcohol a day for men and two to three units a day for women should not lead to significant health risks. Consistently drinking more than these levels is not advised because of the associated health risks. By the end of 2008 the Government expects all alcoholic drinks labels to include alcohol unit information.

In 2006, 40 per cent of men and 33 per cent of women in Great Britain reported exceeding the recommended amount of alcohol on at least one day during the week before interview (Table 7.11). People aged 25 to 44 were more likely (44 per cent) to exceed the recommended daily amount compared to people aged 65 and over who were least likely to exceed the recommended daily amount (17 per cent). Men aged 25 to 44 were the most likely of all to binge drink (defined as the consumption of twice the recommended daily amount). In 2006, 31 per cent had done so on at least one day in the previous week compared with 7 per cent of men aged 65 years and over.

In 2006 there was little variation by socio-economic group (see Appendix, Part 1: National Statistics Socio-economic Classification (NS-SEC)) of the household reference person (see Appendix, Part 7: Household reference persons) in the proportion of men who consumed more than the recommended levels of alcohol on at least one day in the week before interview. In contrast among women, those in large employer and higher managerial households were the most likely to exceed the recommended limits, with 47 per cent having done so on at least one day in the previous week. This compared with 24 per cent of women where the household reference person was in the routine socio-economic group.

In general, the higher the level of gross weekly household income, the more likely men and women were to drink alcohol in the previous week and to exceed the daily benchmarks.

Table 7.11

Adults' daily alcohol consumption:[1] by sex and age, 2006[2]

Great Britain — Percentages

	16–24	25–44	45–64	65 and over	All aged 16 and over
Men					
4 units or less[3]					
Drank nothing in previous week	40	27	24	33	29
Up to 4 units	18	25	33	46	31
More than 4 units[3]					
More than 4 units and up to 8 units	12	17	21	14	17
More than 8 units	30	31	21	7	23
	100	100	100	100	100
Women					
3 units or less[3]					
Drank nothing in previous week	47	40	40	56	44
Up to 3 units	14	20	25	30	23
More than 3 units[3]					
More than 3 units and up to 6 units	14	19	23	12	18
More than 6 units	25	21	12	2	15
	100	100	100	100	100

1 On at least one day in the previous week. See Appendix, Part 7: Alcohol consumption.
2 Figures obtained from converting volume of alcohol drunk to number of alcohol units drunk.
3 Department of Health guidelines recommend men should not regularly drink more than 3 to 4 units of alcohol per day, and women should not regularly drink more than 2 to 3 units of alcohol per day.

Source: General Household Survey (Longitudinal), Office for National Statistics

In 2006, 51 per cent of men in households with a gross weekly income of £1,000 or more drank more than four units on at least one day in the previous week, compared with 32 per cent of men in households with a gross weekly income of less than £200. There was a similar pattern for women, with 47 per cent of those with a gross weekly income of £1,000 or more per week and 20 per cent with a gross weekly income of less than £200 drinking more than three units on at least one day in the previous week.

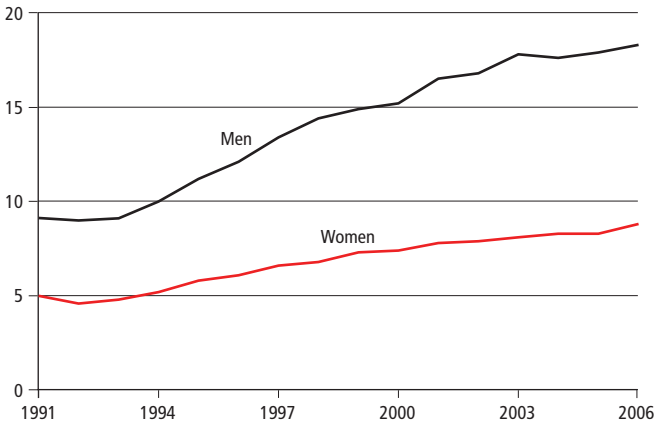
The number of alcohol-related deaths in the UK was 4,144 in 1991 and 8,758 in 2006. Death rates from alcohol-related causes were much higher among men than women and the

Figure 7.12

Death rates[1] from alcohol-related causes:[2] by sex

United Kingdom

Rates per 100,000 population



1 Age-standardised to the European standard population. See Appendix, Part 7: Standardised rates. Rates from 2001 are not directly comparable with those for earlier years because of the change from ICD-9 to ICD-10. See Appendix, Part 7: International Classification of Diseases.
2 See Appendix, Part 7: Alcohol-related causes of death.

Source: Office for National Statistics

gap between the sexes has widened in recent years (Figure 7.12). In 2006 the male death rate was 18.3 per 100,000, more than twice the rate of 8.8 per 100,000 for women. The alcohol-related death rates among men increased in all age groups between 1991 and 2006, and in 2006 were highest among those aged 55 to 74, at 44.6 per 100,000. There were similar patterns among women with the highest death rate in 2006 being among those aged 55 to 74, at 21.1 per 100,000.

There are large variations in alcohol-related death rates between countries and regions of the UK. Between 1991–93 and 2002–2004, Scotland had the highest rates for men and women in all age groups, while Yorkshire and the Humber and the East Midlands had the lowest rates for males and females. Alcohol-related death rates in the South East, South West and East of England were also low for females.

Across the UK during the period 1999–2003, alcohol-related death rates were highest among those living in the most deprived areas (wards ranked from least to most deprived using the Carstairs Index – see Appendix, Part 7: Area deprivation). Among women, alcohol-related death rates for those living in the most deprived areas were more than three times higher than for those living in the least deprived areas, rising from 3.7 deaths per 100,000 in the areas in which the 5 per cent least deprived areas fall to 11.3 per 100,000 in the areas in which the 5 per cent most deprived areas fall. For men the relationship was even stronger. The alcohol-related death rate for men living in the 5 per cent most deprived areas was more than five times higher than the rate for those living in the 5 per cent least deprived areas, 31.9 deaths per 100,000 compared with 6.2 deaths per 100,000.

Over the past 32 years there was a substantial decline in the proportion of adults aged 16 and over in Great Britain who smoked cigarettes. Smoking is related to a range of health problems, including lung cancer, heart disease, stroke, chronic bronchitis and emphysema. In 1974, 51 per cent of men aged 16 and over and 41 per cent of women were smokers. By 2006, 23 per cent of men and 21 per cent of women were smokers (Figure 7.13). Among both men and women much of the decline occurred in the 1970s and early 1980s, after which the rate of decline slowed. The reduction in the difference between the proportion of men and women who smoke partly reflects different cohort patterns for smoking, as smoking became common among men several decades before it did among women.

Since the early 1990s the prevalence of cigarette smoking has been higher among those aged 20 to 24 than among those in other age groups in Great Britain. In 2006, 33 per cent of men and 29 per cent of women in this age group were smokers compared to 13 per cent of men aged 60 and over and 12 per cent of women aged 60 and over who smoked.

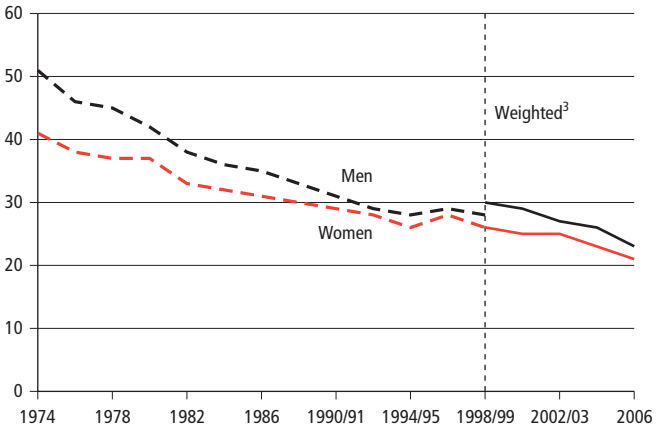
Smoking prevalence varies markedly by socio-economic group. In 2006, 31 per cent of men and 28 per cent women in routine

Figure 7.13

Prevalence of adult[1] cigarette smoking:[2] by sex

Great Britain

Percentages



1 People aged 16 and over.
2 From 1988 data are for financial years. Between 1974 and 2000/01 the surveys were run every two years. See Appendix, Part 2: General Household Survey.
3 From 1998/99 data are weighted to compensate for nonresponse and to match known population distributions. Weighted and unweighted data for 1998/99 are shown for comparison.

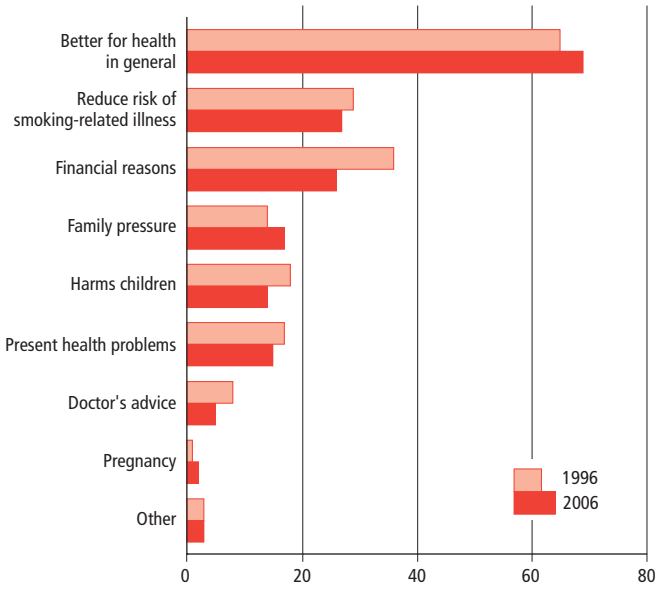
Source: General Household Survey (Longitudinal), Office for National Statistics

Figure 7.14

Main reasons for wanting to stop smoking[1]

Great Britain

Percentages[2]



1 Smokers who want to stop smoking.
2 Percentages do not add up to 100 per cent as respondents could give more than one answer.

Source: Omnibus Survey, Office for National Statistics

and manual occupation households in Great Britain were smokers, compared with 17 per cent of men and 14 per cent of women in managerial and professional households. The Government target, set out in the *NHS Cancer Plan* of 2000, is to reduce the proportion of smokers in manual occupation groups to 26 per cent by 2010.

To meet government targets for reducing the prevalence of cigarette smoking, people have to be discouraged from starting to smoke and people who smoke have to be encouraged to stop. A survey asking smokers their main reasons for wanting to quit smoking found the most common reason in Great Britain in 2006 was for better general health (69 per cent) (Figure 7.14). This compared with 65 per cent who gave this reason in 1996. The next most common reason for wanting to stop smoking in 2006 was to reduce the risk of smoking-related illness (27 per cent). This was, however, a lower proportion than in 1996 when 29 per cent gave this as a reason to quit. Financial reasons were the main reason for 36 per cent of smokers giving up in 1996; by 2006 this had fallen to 26 per cent.

Cancer

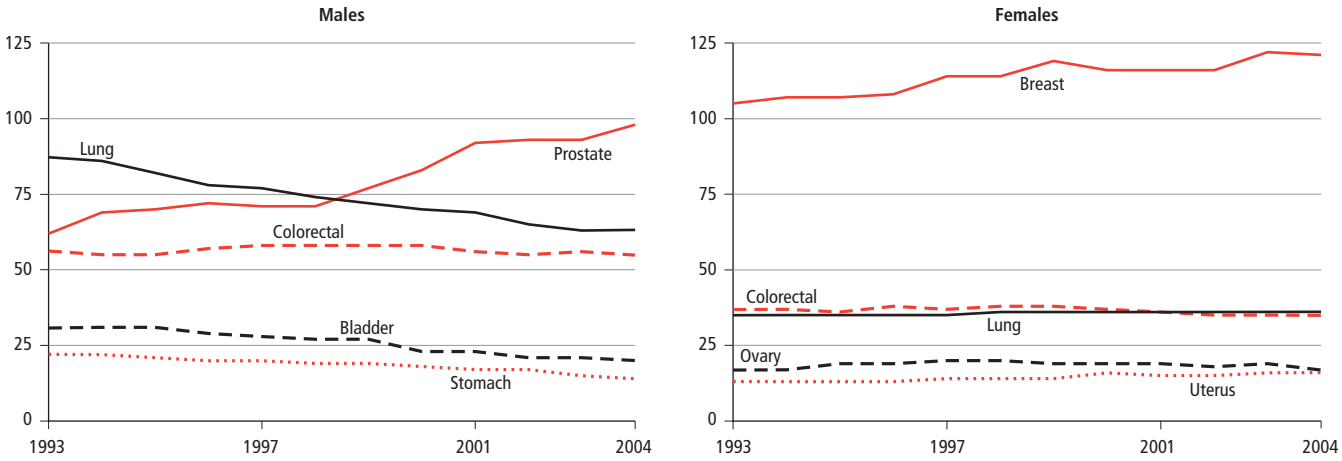
Around one-third of the population develop cancer at some time in their lives and in its various forms. Trends in lung cancer incidence are strongly linked to those for cigarette smoking, which is by far the greatest single risk factor for the disease. The incidence of lung cancer has fallen sharply in men since the early 1990s, mainly as a result of the decline in cigarette smoking (see Figure 7.13). In 1993 the age-standardised lung cancer incidence rate for men in the UK was 87 per 100,000 (Figure 7.15). By 2004, this had fallen by 28 per cent to 63 per 100,000. Lung cancer incidence rates among women are far

Figure 7.15

Standardised incidence rates[1] of major cancers: by sex

United Kingdom

Rates per 100,000 population



1 Age-standardised to the European standard population. See Appendix, Part 7: European standard population, Standardised rates, and International Classification of Diseases.

Source: Office for National Statistics

lower, largely as a consequence of a historically lower incidence of smoking among women.

The incidence of both prostate cancer among men and breast cancer among women has risen considerably over the past ten years and these are the most commonly diagnosed cancers for men and women respectively. The incidence rate for prostate cancer rose from 62 per 100,000 men in 1993 to 98 per 100,000 in 2004. In 1999 prostate cancer overtook lung cancer as the most commonly diagnosed cancer among men. Although there is no NHS screening programme for prostate cancer, the increase in incidence rates is mainly as a result of the large increase in the number of men presenting for individual screening using the PSA (prostate-specific antigen) test. This has increased the likelihood of early diagnosis.

Over the past ten years breast cancer has been the most commonly diagnosed form of cancer among women. In 1993 the incidence rate was 105 per 100,000 women. By 2004 this had risen to 121 per 100,000. The increase in the incidence of breast cancer is partly the result of the introduction of the NHS breast cancer screening programme between 1988 and 1994, which raised awareness of the condition and symptoms. This led to a large number of cases being diagnosed earlier than they may otherwise have been.

Cancer patient survival is a key indicator of the effectiveness of cancer control in the population. Survival rates from lung cancer are low compared with the other most common cancers. For those diagnosed with lung cancer in England in the period 1999–2003 the five-year survival rate (adjusted for overall levels of mortality from other causes in the general population) for men was 6.5 per cent and for women, 7.6 per cent (Table 7.16). In contrast, five-year survival rates for colon cancer were around 49.6 per cent for men and 50.8 per cent for women. Survival rates for types of cancer where some form of screening is available were even higher. The five-year survival rate was 74.4 per cent for prostate cancer and 81.0 per cent for female breast cancer.

Table 7.16

Five year relative survival rates for major cancers: by sex 1999–2003[1]

England

	Survival rate (percentages)	Number of cases
Males[2]		
Prostate	*74.4*	124,088
Bladder	*61.7*	31,755
Colon	*49.6*	42,247
Stomach	*13.3*	23,033
Oesophagus	*9.1*	18,279
Lung	*6.5*	82,787
Females[2]		
Breast	*81.0*	170,664
Cervix	*63.0*	12,024
Bladder	*53.2*	12,434
Colon	*50.8*	40,633
Stomach	*15.9*	12,308
Oesophagus	*12.0*	10,897
Lung	*7.6*[3]	53,399

1 Diagnosed during 1999-2003. See Appendix, Part 7: Relative survival rates.
2 Aged 15 to 99 years. Data have been age-standardised using the European standard population. See Appendix, Part 7: Standardised rates, and European standard population.
3 Not possible to produce an age-standardised five-year survival rate for lung cancer in women; this figure refers to the unstandardised survival estimate.

Source: Office for National Statistics

Mental health

In recent years there has been an increasing interest in the mental health problems experienced by children and young people. In 2004, 10 per cent of 5 to 16-year-olds living in private households in Great Britain had a clinically diagnosed mental disorder. These included: 4 per cent with an emotional disorder, 6 per cent with a conduct disorder, 2 per cent with a hyperkinetic disorder (characterised by hyperactive, impulsive or inattentive behaviour) and 1 per cent with a less common disorder (including autism, tics and eating disorders), however children can suffer multiple disorders. Boys in this age group were more likely to have some form of mental disorder (12 per cent) than girls (8 per cent).

The association between social disadvantage and mental disorder is well documented. Analysis by ACORN (see Appendix, Part 7: ACORN classification), which combines geographic and demographic characteristics to distinguish different types of people in different areas of Great Britain, showed that children living in areas classed as 'hard pressed' were the most likely to be assessed as having a mental disorder. In 2004, among children aged 5 to 16, 17 per cent of boys and 12 per cent of girls living in a hard pressed area had some type of mental disorder (Figure 7.17). Those living in 'wealthy achievers' areas were the least likely of all children to experience any type of mental disorder, at 7 per cent of boys and 5 per cent of girls. This trend was evident for the three main types of disorder among both boys and girls, and for both younger and older children.

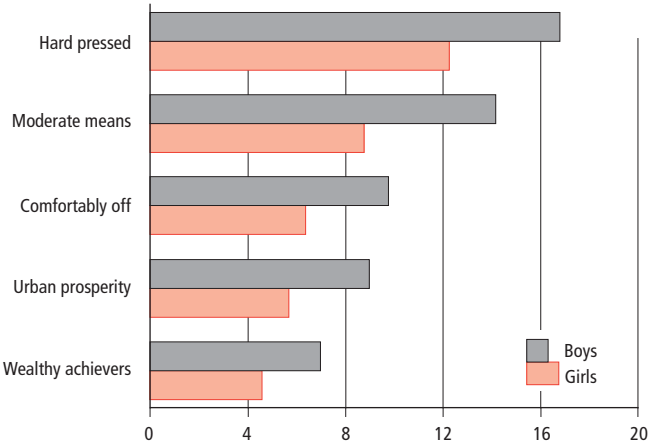
In 2000 (the latest year for which data are available), about one in six adults (164 cases per 1,000 adults) aged 16 to 74

Figure 7.17

Prevalence of mental disorders[1] among children:[2] by sex and ACORN classification,[3] 2004

Great Britain

Percentages



1 See Appendix, Part 7: Mental disorders.
2 Aged 5 to 16 years and living in private households.
3 See Appendix, Part 7: ACORN classification.

Source: Mental Health of Children and Young People Survey, Office for National Statistics

living in private households in Great Britain reported experiencing symptoms of a neurotic disorder ranging from the most common 'mixed anxiety and depressive disorder' to the less common 'phobia', in the seven days before interview for the Psychiatric Morbidity Survey. More women than men experienced neurotic disorder symptoms with the exception of panic disorder for which rates were the same for men and women at 7 cases per 1,000.

Mental illness is a risk factor for suicide. Trends in suicide rates have varied by age group and sex in the UK over the last 35 years (Figure 7.18). Until 1988, men aged 65 and over had the highest suicide rates. In 1986 the suicide rate among men aged 65 and over peaked at 26.3 per 100,000 population and then fell, to 13.0 per 100,000 in 2006. In contrast, suicide rates for younger men rose over the period, in particular for those aged 25 to 44, for whom the suicide rate almost doubled from 13.6 per 100,000 in 1971 to a peak of 26.9 per 100,000 in 1998. The suicide rate among men in this age group has since declined, but in 2006 remained the highest of all age groups and of both sexes, at 21.3 per 100,000.

There is a clear difference in suicide rates between men and women. In 2006 the age-standardised rate for all men aged 15 and over in the UK was 17.4 per 100,000, three times that of women, at 5.3 per 100,000. Among women aged 45 and over, suicide rates more than halved between 1981 and 2006. For younger women the rates have remained fairly stable since the mid-1980s.

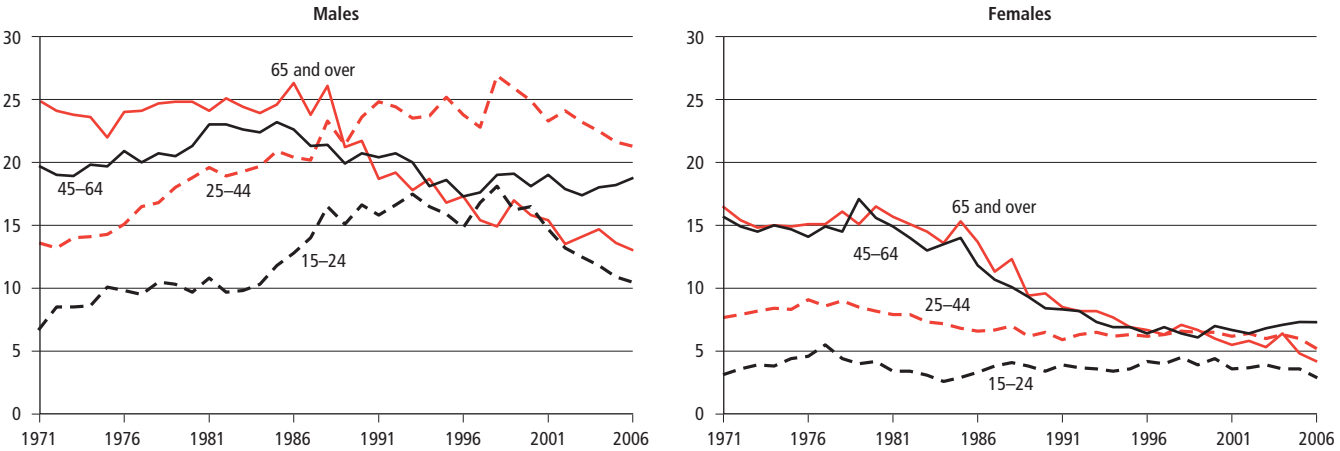
Analysis of data for England and Wales for the period 1999 to 2003 show suicide rates are highest in the most deprived areas (see Appendix, Part 7: Area deprivation). Among men aged 15 and over, the suicide rate for those living in the most deprived areas was 25.4 per 100,000, more than twice the rate of those in the least deprived areas (11.9 per 100,000).

Figure 7.18

Suicide rates:[1] by sex and age

United Kingdom

Rates per 100,000 population



1 Includes deaths with a verdict of undetermined intent (open verdicts). Rates from 2002 are coded to ICD-10. See Appendix, Part 7: International Classification of Diseases. Rates are age-standardised to the European standard population. See Appendix, Part 7: Standardised rates, and European standard population.

Source: Office for National Statistics; General Register Office for Scotland; Northern Ireland Statistics and Research Agency

Although suicide rates among women were much lower than rates among men in all areas, the rate for women in the most deprived areas was more than twice that of women in the least deprived areas, at 7.4 per 100,000 compared with 3.6 per 100,000.

Sexual health

Since the late 1990s the increase in notifications of sexually transmitted diseases, especially among young people, has become a major public health concern across the UK. People who have unprotected sex and multiple sexual partners are at the greatest risk of contracting a sexually transmitted infection. In Great Britain during 2006/07 men between the ages of 20 and 49 were more likely than women to have had more than one sexual partner in the previous year (Table 7.19). Among both sexes, multiple sexual partnerships were most common among those below the age of 25. Men aged 20 to 24 were the most likely of all men under 50 to report having had more than one sexual partner in the previous year and men aged 16 to 19 were the most likely to have had none. Women aged 16 to 19 were the most likely of all women under 50 to report having more than one sexual partner in the previous year and also most likely to have had none.

For both men and women, the number that have had only one partner increases with age up to 44 years in women and up to 49 years in men, though for men, numbers are similar in both the 35 to 44 and 45 to 49 age groups. In both men and women the number with no partner falls rapidly after the age of 19 years. This in part reflects marital status among the older age groups. In 2006/07, 94 per cent of married or cohabiting men aged 16 to 69 and 97 per cent of married or cohabiting women aged 16 to 49 reported having only one sexual partner in the previous year.

For people who have multiple sexual partnerships, condom use can help reduce the risk of contracting sexually transmitted diseases. In 2006/07 in Great Britain, 85 per cent of men aged 16 to 69 and 77 per cent of women aged 16 to 49 who had more than one sexual partner in the previous year used a condom. This compared with 36 per cent of men and 45 per cent of women who had one partner. People's reasons for using a condom vary by age and whether or not they have multiple partners. In 2006/07, 67 per cent of men and 63 per cent of women aged 16 to 24 reported using a condom both to prevent infection and for contraceptive purposes (Table 7.20). Most people aged 25 and over used condoms only as a form of contraceptive, which reflects the likelihood that older people are in a monogamous relationship (see Table 7.19).

Table 7.19

Number of sexual partners[1] in the previous year: by sex and age, 2006/07

Great Britain — Percentages

	16–19	20–24	25–34	35–44	45–49
Men					
No partners	44	7	7	9	12
1 partner	27	48	77	83	83
2 or 3 partners	22	30	12	5	4
4 or more partners	7	14	5	4	1
All aged 16–49	100	100	100	100	100
Women					
No partners	34	6	7	9	16
1 partner	35	74	83	86	83
2 or 3 partners	23	17	8	3	1
4 or more partners	8	3	2	1	-
All aged 16–49	100	100	100	100	100

1 Self-reported in the 12 months prior to interview.

Source: Omnibus Survey, Office for National Statistics

Table 7.20

Reasons for using a condom:[1] by sex and age, 2006/07

Great Britain — Percentages

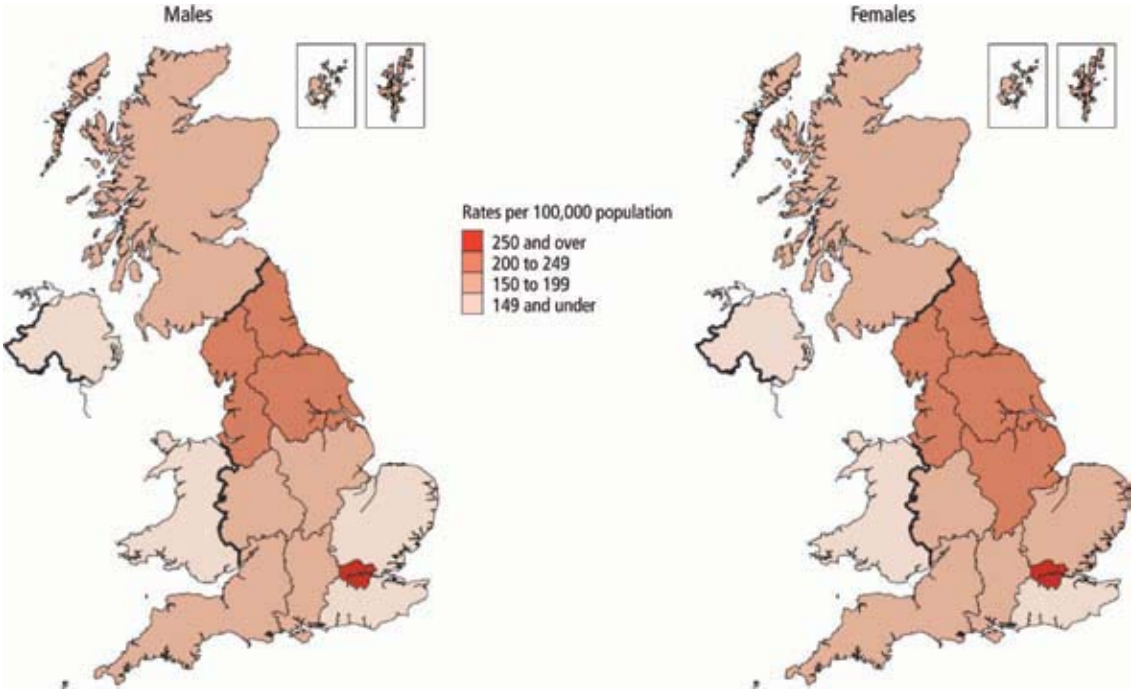
	16–24	25–34	35–49[2]
Men			
Prevent pregnancy	28	55	64
Prevent infection	4	4	8
Both reasons	67	38	27
Other reason	1	4	2
All aged 16–49	100	100	100
Women			
Prevent pregnancy	22	50	66
Prevent infection	11	6	7
Both reasons	63	41	23
Other reason	4	4	4
All aged 16–49	100	100	100

1 People currently in a sexual relationship or had one in last 12 months and had used a male condom in last 12 months.
2 Figures for 45 to 49 age group are merged with 35 to 44 age group due to inadequate sample size yielding unreliable figures.

Source: Omnibus Survey, Office for National Statistics

Map 7.21

Diagnoses of genital chlamydia: by sex and region,[1] 2006



1 Regions in England are divided into the 10 Strategic Health Authorities.

Source: Health Protection Agency

Sexually transmitted infections (STIs), including HIV infection, are the most prevalent infectious disease problem in the UK. In 2006 around 621,312 diagnoses were made in genito-urinary medicine (GUM) clinics in the UK. Genital chlamydia was the most common STI diagnosed at 113,585 diagnoses in 2006.

Rates of diagnoses varied across the UK. London had the highest rates of genital chlamydial infections for both men and women in 2006, at 285 per 100,000 for men and 265 per 100,000 for women (Map 7.21). In the East Midlands, East of England, South Central and Yorkshire and the Humber, rates were higher among women than men. Northern Ireland had the lowest rates in the UK for both men and women, at less than 120 per 100,000. Wales had a rate of 125 per 100,000 for men and 127 per 100,000 for women and Scotland had a rate of 177 per 100,000 for men and 163 per 100,000 for women.

In 2006 uncomplicated gonorrhoea was the second most common bacterial STI diagnosed in GUM clinics in the UK. In contrast to genital chlamydia there has been a gradual decline in the number of diagnoses since 2003, and between 2005 and 2006, there was a 1.3 per cent decrease to 19,000. The highest rates of diagnoses in 2006 were in men aged 20 to 24 (188 per 100,000) and in women aged 16 to 19 (128 per 100,000). Men accounted for 72 per cent of the overall diagnoses, with one-third of these occurring in men who have sex with men.

By the end of 2006, an estimated 73,000 people of all ages were living with HIV in the UK. Of these individuals approximately one-third remain undiagnosed. In 2006, 7,800 new HIV cases were diagnosed. The annual number of newly diagnosed persons has increased by 182 per cent between 1997 and 2006.

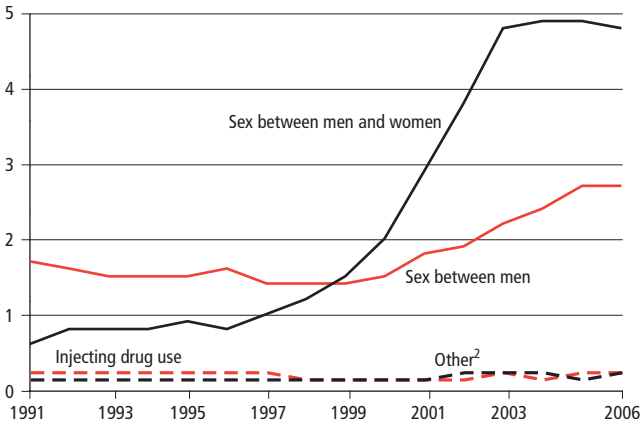
An estimated 4,700 men and 3,100 women were newly diagnosed with HIV in the UK in 2006 (see Appendix, Part 7: New HIV diagnoses database). HIV infections acquired heterosexually accounted for much of the rapid rise in the number of new HIV diagnoses in both men and women (4,750 in 2006 compared with 1,020 in 1997) although there was also an increase in the number of diagnoses among men who have sex with men, 2,700 in 2006 compared with 1,410 in 1997 (Figure 7.22 overleaf). Since 1999 the numbers of new HIV diagnoses among heterosexuals have outnumbered those among men who have sex with men. However, the 2,700 new diagnoses of HIV infection among men who have sex with men reported in 2006 was the highest ever, partly reflecting increased testing. Approximately three-fifths of newly diagnosed persons in 2006 who acquired their infection in the UK were heterosexual.

Figure 7.22

New HIV diagnoses[1] by year and route of transmission

United Kingdom

Thousands



1 Data for 2003 to 2006 have been adjusted to take into account delays between diagnoses and reporting. See Appendix, Part 7: New HIV diagnoses database.
2 Other routes of infection include children infected through mother to child transmission, those infected through the receipt of blood or blood products, and routes of transmission not yet ascertained.

Source: Health Protection Agency

Of the estimated total number of new diagnoses in the UK in 2006, 3,650 were Black African (most of who were infected abroad) and 3,250 were White. African born men and women accounted for 35 per cent of the total number of adults living with HIV in 2006, with 31 per cent of those unaware of their infection. Of all heterosexually acquired HIV infections African born men and women accounted for 68 per cent of the total, with 61 per cent of those unaware of their infection.

HIV can also be acquired through injecting drugs. The number of diagnoses with drug injection being the most likely source of infection has remained relatively low in recent years, with 190 diagnoses in 2006. A small number of infections acquired by other routes such as blood transfusions (all acquired abroad) have remained low and constant over the last decade.