Modern Studies

Homework Task

Case Study of Social Class and Health Inequalities

Duncraig Secondary School
Case Study of Social Class and Health Inequalities

This case study looks at:

- Evidence of Health Inequalities between different Social Classes
- Reasons for Health Inequalities
- Government strategies to tackle Health Inequalities
- Effectiveness of Government Policies in tackling Health Inequalities
- Other agencies involved in tackling Health Inequalities

“People die of molecular deaths, such as proteins coagulating in arteries and causing heart attacks and strokes. Yet we know that poor [social] conditions lead to poor health and premature deaths.”  
Sir Harry Burns Former Chief Medical Officer for Scotland (The Guardian, March 2014)

In attempts to explain health inequalities, there are two views we will refer to throughout this case study:

1. **Individualist Approach**: This is the belief that health inequalities exist due to the choices people make relating to their lifestyle.
2. **Collectivist Approach**: This is the belief that health inequalities are caused by social inequalities which exist in society; over which individuals have limited or no control.

![Life Expectancy Chart]

2010 Affluent Jordanhill area

Average life expectancy: 80

2010 Deprived East end area

Average life expectancy: 59

**OR**
Evidence of Health Inequalities (General)

- **Smoking rates**
  In Scotland’s most deprived areas, 40% of people smoke.
  In least deprived areas, just 11% smoke.

- **Alcohol**
  In Scotland’s most deprived areas, there were 1,621 alcohol-related hospital admissions per 100,000 population in 2011.
  In least deprived areas, there were 214 alcohol-related hospital admissions per 100,000 population in 2011.

- **Drug Misuse**
  More than half of drug-related deaths in 2010 were among people in the most deprived areas.

- **Mental Health (E.g. depression, anxiety)**
  In 2010/11, GPs in the most deprived areas had 62 consultations per 1,000 patients.
  In 2010/11, GPs in the least deprived areas had 28 consultations per 1,000 patients.

- **Cancer**
  In Scotland’s most deprived areas, (2007–11), the cancer mortality rate per 100,000 was 276 per 100,000 people.
  In the least deprived areas, (2007–11), the cancer mortality rate was 157 per 100,000 people.

- **Unintentional injuries**
  In Scotland’s most deprived areas, between 2006 and 2010, there were 1,502 adult deaths caused by unintentional injuries.
  In Scotland’s least deprived areas, between 2006 and 2010, there were 810 adult deaths caused by unintentional injuries.

- **Life Expectancy**
  Between 1999-2000 and 2009-10, the average life expectancy of men living in the least deprived areas remained around 11 years higher than in the most deprived areas.
  The example of Renfrewshire is quoted where men in the least deprived parts of the local authority live 9 years longer than men in the most deprived.
  The west of Scotland, especially Glasgow and its surrounding areas, has high levels of poverty.
  As a result, Glasgow and its surrounding areas accounts for a significant proportion of health inequalities in Scotland.
  The years 3-8 are critical in understanding health inequalities.

*Page 2*
These inequalities remain throughout life, and as Sir Harry Burns explains why poorer people suffer worse health and die earlier than richer people.

- **Low birth weight**
  
  In Scotland’s most deprived areas, 31% of babies were born with very low birth weight. In least deprived areas, 13% of babies were born with very low birth weight.

- **Breastfeeding**
  
  In Scotland’s most deprived areas, 15% of mothers in the most deprived areas in 2011-12 exclusively breastfed their child at 6-8 weeks.
  
  In least deprived areas, 40% of mothers in the least deprived areas exclusively breastfed their child at 6-8 weeks.

- **Dental health**
  
  In Scotland’s most deprived areas, 54% of children in the most deprived areas had no dental decay in 2011. In least deprived areas 81% of children in the least deprived areas had no dental decay in 2011.

- **Obesity/Overweight**
  
  In 2010/11, 25% of children in the most deprived areas were classified as overweight. In 2010/11, 18% of children in least deprived areas were classified as overweight.

- **Teenage Pregnancy**
  
  In 2010, 14 per 1,000 under 16s became mothers in the most deprived areas. In 2010, 3 per 1,000 under 16s became mothers in the most deprived areas.

### Activity 1

Read the following viewpoints.
Which do you agree with and why?

"The problem for these people is they are trapped in a negative cycle, children end up wasters and spineless, because their parents are. They get a taste for chips when young, are never taught to eat vegetables, and the health problems compound. People need the Welfare State to step in and help stop this vicious cycle, it is not really the fault of the individual but society as a whole.”

"The best way to solve poor health stats is for people to have a decent standard of life. Go to the Nordic countries and have a look. That requires employment of a type that will allow for a family to eat well, buy books for their kids and heat their homes”.

"By all means try to put the resources to where the problems are. But let us also emphasise personal responsibility. The poorer areas are not that poor that they starve their children ("one in four is obese") and no one forces anyone to smoke or drink to excess".
Reasons for Health Inequalities

1. Geographic inequalities
2. Social class inequalities
3. Lifestyle issues
4. Alcohol and drug abuse
5. Gender inequalities
6. Ethnicity and health

The link between socio-economic circumstances and health is well known, and there is an increasing evidence base supporting the hypothesis of a ‘Scottish Effect’, and more specifically a ‘Glasgow Effect’, the terminology used to identify higher levels of mortality and poor health found in Scotland and Glasgow beyond that explained by socio-economic circumstances. The overall aim of this case study is to investigate whether residence in Glasgow is independently associated with poorer health outcomes and worse health behaviours compared to the rest of Scotland, after controlling for socio-economic, behavioural, biological and other health-related risk factors.

This case study will focus on two Electoral Wards in Glasgow

Southside Central
Toryglen
Govanhill
Gorbals
Queenspark

Partick West
Partick
Jordanhill
Anniesland
Hyndland
Whiteinch
Broomhill
Activity 2

Your task is to complete profiles on both of the areas in Glasgow detailed above. Each profile must include reference to each of the causes of Health inequalities listed at the beginning of this section.

Once you have completed the profiles looking at the inequalities that exist and the causes of them, you must draw conclusions regarding the causes of Health inequalities, incorporating evidence you have provided in both profiles.

On page 6 you have been provided with information and statistics to help you get started.

Checklist

Your profiles must include reference to:

1. Income levels and Education (Social Class)
2. Households and Housing
3. Smoking
4. Diet
5. Unemployment levels
6. Alcohol consumption
7. Drug abuse
8. Ethnic background
9. Age/Gender
10. Welfare Benefits
11. Conclusion: How important is Social Class in determining the causes of Health Inequalities in Glasgow?

N.B. The checklist is in no particular order other than the conclusion which must come at the end, obviously!
## Ward 8 - Southside Central

### Population

<table>
<thead>
<tr>
<th>Category</th>
<th>2010 (1)</th>
<th>2008 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Males</td>
<td>16,139</td>
<td>1,900</td>
</tr>
<tr>
<td>Number of Females</td>
<td>15,085</td>
<td>1,800</td>
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### Population by Age (2010) (1)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0 to 4</th>
<th>5 to 11</th>
<th>12 to 15</th>
<th>16 to 29</th>
<th>30 to 44</th>
<th>45 to 64</th>
<th>65+</th>
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</thead>
<tbody>
<tr>
<td>Number</td>
<td>2,145</td>
<td>2,301</td>
<td>1,084</td>
<td>7,223</td>
<td>0,031</td>
<td>6,482</td>
<td>2,936</td>
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### Population by Ethnicity (2010) (2)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2010</th>
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</thead>
<tbody>
<tr>
<td>White Scottish, British, Irish</td>
<td>23,102</td>
</tr>
<tr>
<td>Other White</td>
<td>1,995</td>
</tr>
<tr>
<td>Indian</td>
<td>660</td>
</tr>
<tr>
<td>Pakistani</td>
<td>3,087</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>100</td>
</tr>
<tr>
<td>Other South Asian</td>
<td>247</td>
</tr>
<tr>
<td>Chinese</td>
<td>165</td>
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<tr>
<td>Caribbean</td>
<td>35</td>
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<td>African</td>
<td>434</td>
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<tr>
<td>Black Scottish or Other Black</td>
<td>20</td>
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<tr>
<td>Any Mixed Background</td>
<td>132</td>
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<tr>
<td>Other Ethnic Group</td>
<td>625</td>
</tr>
</tbody>
</table>

### Electorate (2012) (4)

- **23,020 Electors**

### Houses and Housing (2010) (2)

<table>
<thead>
<tr>
<th>Category</th>
<th>15,301</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households with Children</td>
<td>3,230</td>
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<tr>
<td>Single Parent Households</td>
<td>1,175</td>
</tr>
<tr>
<td>Other Households with Children</td>
<td>2,055</td>
</tr>
<tr>
<td>Single Person Households</td>
<td>7,151</td>
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<tr>
<td>Average Household Size</td>
<td>2.02</td>
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### Dwellings by Tenure (2011) (5)

<table>
<thead>
<tr>
<th>Tenure Type</th>
<th>16,104</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner Occupied</td>
<td>5,574</td>
</tr>
<tr>
<td>Private Rented</td>
<td>3,393</td>
</tr>
<tr>
<td>GHA</td>
<td>773</td>
</tr>
<tr>
<td>Other Social Rented</td>
<td>6,364</td>
</tr>
</tbody>
</table>

### Benefits Claimants Working Age by Client Group (2010) (8)

- **5,795 Benefit Claimants**
  - Job Seeker: 1,445
  - ESA and Incapacity Benefits: 3,210
  - Income Support/Other Benefits: 1,140

### Claimants of Unemployment Related Benefits (2011) (7)

- **1,450 Claimants**
  - Number of Males: 1,060
  - Number of Females: 450

### Claimants of Unemployment Related Benefits (2011) (7)

- **6.8 Claimants**
  - Number of Males: 8.6
  - Number of Females: 4.7

### Employee Jobs (2010) (9)

- **19,400 Jobs**
  - Full-time: 10,200
  - Part-time: 9,200

### Data Sources:

1. National Records of Scotland Estimates 2010
2. Glasgow City Council Estimates 2010
3. Glasgow City Council Estimates 2008
4. Glasgow City Assessor February 2012
5. Glasgow City Council Estimates 2011
6. Scottish Neighbourhood Statistics 2010 (including dwellings as part of communal establishment)
7. ONS/NOMIS Jobseeker Allowance Claims December 2011
8. The Department for Work and Pensions May 2011 **Employment Support Allowance**
9. ONS 2010 Business Register and Employment Survey

## Ward 12 - Partick West

### Population

<table>
<thead>
<tr>
<th>Category</th>
<th>2010 (1)</th>
<th>2008 (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Males</td>
<td>15,046</td>
<td>1,800</td>
</tr>
<tr>
<td>Number of Females</td>
<td>16,264</td>
<td></td>
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</tbody>
</table>

### Population by Age (2010) (1)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0 to 4</th>
<th>5 to 11</th>
<th>12 to 15</th>
<th>16 to 29</th>
<th>30 to 44</th>
<th>45 to 64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1,459</td>
<td>1,720</td>
<td>1,019</td>
<td>7,751</td>
<td>8,016</td>
<td>7,355</td>
<td>3,810</td>
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### Population by Ethnicity (2010) (2)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Scottish, British, Irish</td>
<td>27,920</td>
</tr>
<tr>
<td>Other White</td>
<td>1,589</td>
</tr>
<tr>
<td>Indian</td>
<td>468</td>
</tr>
<tr>
<td>Pakistani</td>
<td>422</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>27</td>
</tr>
<tr>
<td>Other South Asian</td>
<td>112</td>
</tr>
<tr>
<td>Chinese</td>
<td>231</td>
</tr>
<tr>
<td>Caribbean</td>
<td>20</td>
</tr>
<tr>
<td>African</td>
<td>139</td>
</tr>
<tr>
<td>Black Scottish or Other Black</td>
<td>14</td>
</tr>
<tr>
<td>Any Mixed Background</td>
<td>176</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>217</td>
</tr>
</tbody>
</table>

### Electorate (2012) (4)

- **25,874 Electors**

### Houses and Housing (2010) (2)

<table>
<thead>
<tr>
<th>Category</th>
<th>17,584</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households with Children</td>
<td>3,008</td>
</tr>
<tr>
<td>Single Parent Households</td>
<td>760</td>
</tr>
<tr>
<td>Other Households with Children</td>
<td>2,286</td>
</tr>
<tr>
<td>Average Household Size</td>
<td>3,088</td>
</tr>
<tr>
<td>Average Household Size</td>
<td>1.76</td>
</tr>
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</table>

### Dwellings by Tenure (2011) (5)

<table>
<thead>
<tr>
<th>Tenure Type</th>
<th>18,317</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner Occupied</td>
<td>9,849</td>
</tr>
<tr>
<td>Private Rented</td>
<td>1,076</td>
</tr>
<tr>
<td>GHA</td>
<td>828</td>
</tr>
<tr>
<td>Other Social Rented</td>
<td>3,282</td>
</tr>
</tbody>
</table>

### Benefits Claimants Working Age by Client Group (2010) (8)

- **3,540 Benefit Claimants**
  - Job Seeker: 885
  - ESA and Incapacity Benefits: 1,935
  - Income Support/Other Benefits: 720

### Claimants of Unemployment Related Benefits (2011) (7)

- **870 Claimants**
  - Number of Males: 610
  - Number of Females: 260

### Claimants of Unemployment Related Benefits (2011) (7)

- **3.8 Claimants**
  - Number of Males: 5.3
  - Number of Females: 2.3

### Employee Jobs (2010) (9)

- **10,700 Jobs**
  - Full-time: 7,100
  - Part-time: 3,600

### Data Sources:

1. National Records of Scotland Estimates 2010
2. Glasgow City Council Estimates 2010
3. Glasgow City Council Estimates 2008
4. Glasgow City Assessor February 2012
5. Glasgow City Council Estimates 2011
6. Scottish Neighbourhood Statistics 2010 (including dwellings as part of communal establishment)
7. ONS/NOMIS Jobseeker Allowance Claims December 2011
8. The Department for Work and Pensions May 2011 **Employment Support Allowance**
9. ONS 2010 Business Register and Employment Survey
Government Strategies to address Health Inequalities

Local Government Initiatives (Glasgow City Council)

Healthy Weight Action Plan 2009-2012

OBJECTIVE 1: To develop policy solutions that address health inequalities and work across policy areas with the aim of achieving a corrective population-wide shifting overweight/obesity trends.

OBJECTIVE 2: To both encourage and empower the population of Glasgow to make healthy lifestyle choices through awareness-raising activities, education, community engagement and knowledge and skills development.

OBJECTIVE 3: To improve the environment in order to make healthy choices easy choices; accepting that environmental interventions must coexist to support and facilitate behaviour change.

Scottish Government Initiatives (Scottish Executive/Parliament)

Strategies focused on addressing health inequalities

Free School Meals P1 to P3 January 2015

Free Prescriptions 2011

Child Poverty Strategy for Scotland (March 2011)
The main aims of this three-year strategy are to
- maximise household resources and
- improve children’s well-being and life chances

Government spending will move more to early intervention and prevention.
The Scottish Government plans to introduce a Children’s Services Bill and a Sustainable Procurement Bill, both of which may help to drive improvements in child well-being.

Progress towards targets is reported in the annual report for child poverty strategy in Scotland.
The first annual report was published in March 2012 but contained no evidence of impact to date.

Curriculum for Excellence: Health and Well-being 2010
Equally Well (June 2008)
Published evidence on health inequalities in Scotland and suggested how health and other public services might respond to factors that affect people’s health.
It set up a Ministerial Task Force.
The Ministerial Task Force reported in June 2010.
Equally Well does not expect to see health inequalities reduce in the short term.

Smoking Ban 2006
Scotland has taken radical action to stub out smoking-from the 2006 ban on smoking in public places to the end tobacco displays in shops and the ban sales from vending machines. (Effective as of 2013)

Hungry for Success 2002-2010
In 2003, the Scottish Executive’s Expert Panel on School Meals produced its report Hungry for Success: A Whole School Approach to School Meals in Scotland, initiating significant developments in the provision of school meals in Scotland.

Strategies aimed at improving health

There has been a fall in self-reported drug use, and higher levels of testing for blood-borne viruses among injecting drug users.
These improvements may or may not be linked to the actions in The Road to Recovery.

Cancer: Better Cancer Care: An Action Plan (October 2008)
Sets out actions to reduce the number of people who develop cancer and to support people with cancer.
The Scottish Cancer Taskforce was established to oversee the delivery of the plan.
The Scottish Government published a progress report in December 2010 which highlighted separate action plans to reduce smoking, alcohol misuse and obesity, as well as early detection through screening programmes.
However, it contained no information about the impact of the Cancer Plan to date.

Poverty: Achieving Our Potential (November 2008)
Sets out a “new” approach to tackling poverty in Scotland
The Scottish Government published a report in 2011 which included recommendations for future work, but contained no evidence about any impact Achieving Our Potential has had.
Poverty: Early Years Framework (December 2008)
Seeks to improve opportunities for children and address the needs of those children whose lives are constrained by poverty, poor health, poor attainment and unemployment.
The Scottish Government published a progress report in 2011 which outlined progress against a range of short- and medium-term indicators.
This described a range of processes and actions since the Early Years Framework was published but there was little information about outcomes.

Alcohol: Changing Scotland’s Relationship with Alcohol: A Framework for Action (February 2009)
Contains plans to use legislation to achieve shorter-term goals (such as bans on supermarket discounting) and to effect cultural change for longer-term goals.
In June 2012, a report found a small decline in off-trade sales in Scotland since the ban, but this reduction was also seen in England and Wales where there was no ban.

Mental Health: Towards a mentally flourishing Scotland (May 2009)
In August 2012, the Scottish Government published its mental health strategy for Scotland, which reported on progress towards meeting commitments in Towards a mentally flourishing Scotland: Policy and Action Plan 2009-12.
There have been achievements so far including a fall in the number of psychiatric readmissions and in the suicide rate.

Obesity: Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight (February 2010)
Outlines the various actions which central government, local councils and the NHS will take to prevent and manage obesity in Scotland.
The Scottish Government published an action plan in March 2011 (updated in September 2011) and a set of 16 indicators which it will use to monitor progress in tackling obesity.
The plan includes milestones for achieving specific aspects of the strategy, and the Government plans to update the indicators every year.
There is no evidence of impact to date.

Contains a wide variety of actions, including preventing diabetes, treatment and supporting people to help them to self-manage their condition.
The Scottish Government has yet to report on progress.
Activity 3: Questions

1. Based on all the information gathered so far, is Social Class a contributing factor to health inequalities in Glasgow?
2. To what extent do you believe the Individualist theory with regards to the causes of health inequalities is relevant when looking at Southside Central and Glasgow West?
3. Do any of the strategies discussed above target the health inequalities caused by Social Class?
4. From the strategies listed above, pick the four that you think target the link between social class and health inequalities.
   For each strategy chosen, assess the extent to which they have reduced health inequalities in Glasgow.

Other agencies involved in tackling health inequalities in Glasgow

As you are already aware, the Trussell Trust is a charity which provides Food banks all over the UK. In Glasgow alone, there are currently 4 active Food banks. Food banks such as this help to tackle health inequalities by providing food to people who cannot afford to buy their own. This again demonstrates the link between Social Class, Income and Health inequalities. If people do not have enough food to eat, their body begins to suffer; weight loss, lack of concentration, more susceptible to illness etc.

Barnardo’s Scotland has been working in Scotland for more than a century. Their purpose is to reach out to the most disadvantaged children, young people, families and communities to help ensure that every child has the best possible start in life. They aim to make sure that every young person is able to reach their full potential, whatever their circumstances in life. In this respect they help reduce health inequalities by providing emotional support for mental well-being, as well as financial support for physical well-being.
Calton Athletic Recovery Group has been helping individuals recover from drug and alcohol addiction through their unique abstinence based programme since 1985. Their main aim is to provide support through weekly recovery meetings, as well as various physical activities, both of which they believe are integral to achieve and sustain long term recovery.

Calton Athletic Recovery Group is a registered charity that is solely reliant on self-generated funds at present. They are currently providing a limited service on a voluntary capacity from rented premises in the East End of Glasgow.

They help tackle health inequalities caused by life in a deprived area where there are no facilities to encourage people to par-take in physical exercise. Calton Athletic runs a football team for recovering addicts as well as hillwalking and running. All of these activities improve individual health as well as the health benefits of being drug free.

Shettleston Harriers is a road and cross-country based running club. They are situated in Shettleston in the East End of Glasgow. This areas has the unenviable title of one of the poorest places in Europe! They are a charity and as such the cost to be a member is £1 per week. This covers their basic outlay only as it is a non-profit organisation. As a result of the low cost, health inequalities and income inequalities are tackled simultaneously. People can afford for their kids to attend, this ensures the kids are getting exercise on a regular basis. This reduces inequalities as many sports clubs have fairly pricey fees; anything from £20 to £60 per month. This would exclude many people in Shettleston from participating. Therefore, the low cost of the Shettleston Harriers (£4 per month) ensures the opportunity exists for structured exercise in a safe environment for many people from less well-off households.
Activity

1. For each of the four agencies discussed above, describe how they tackle health inequalities resulting from Social Class.
2. To what extent have these organisations been effective in addressing health inequalities?
Not everyone will live to the same age and not everyone will enjoy equally good health throughout their life.

It is not the existence of health inequalities that matters most but what is happening to the gap between the richest and poorest in society in terms of health and life expectancy.

In recent years, some of the most well-cited reports on health inequality include:
- Audit Scotland's Health Inequalities in Scotland of 2012
- the annual Scottish Health Survey (2008)

Health inequalities are most significant between the richest and poorest in society and the parts of Scotland (and the UK) in which these people live.

For example, between 2010-2012, a woman born in East Dunbartonshire (statistically one of Scotland’s wealthiest areas) can expect to live, on average, almost five years longer than a woman born in certain areas of Glasgow. For men, the life expectancy gap between these two parts of Scotland is even greater at 7.5 years.

A 2008 World Health Organization commission highlighted how wide the gulf in life expectancy can be, even in areas geographically close to each other.

For example, males living in the affluent Glasgow suburb of Lenzie can expect to live to the age of 82. Males in the city's Calton area (eight miles from Lenzie) have a life expectancy as low as 54.
Significant health inequalities also exist between men and women as well as between people from ethnic minority backgrounds and the population as a whole.

**Trends in inequality – Health**

There is evidence that overall life expectancy is rising in Scotland and the UK. Death rates from Scotland’s three most significant killers (heart disease, cancer and stroke) are falling nationally.

But not all groups across society are benefiting equally from increased life expectancy or improved health. In most but not all cases, the biggest improvement in health and life expectancy has been from the wealthiest groups in the wealthiest areas.

In general, there has been a widening of the life expectancy gap between the most affluent and least affluent people or between the most affluent areas and the most deprived areas.

Among the most deprived groups in society there has been little reduction in cancer rates. Most of the reductions in cancer rates in the last few years have been from the most affluent. This has resulted in a growing health gap.

On the other hand, the greatest falls in heart disease rates in Scotland have been among the poorest groups. Here the gap between most and least affluent has reduced. (Source: JRF Monitoring Poverty and Social Exclusion Scotland 2013)

Life expectancy is often recorded as HLE or years of Healthy Life Expectancy. HLE has been widely used from around 2009/10. This change was introduced to bring UK statistics in line with other EU countries.

HLE statistics may also be slowly rising for all groups. However, the wealthiest groups continue to enjoy a greater number of years of life before people claim ill health.
Gender and Race

Both men and women are living longer. However, statistics continue to show there is a life expectancy and morbidity gap.

Evidence from a range of reports shows that, on average, women live at least five years longer than men. For almost all causes of death the statistics are worse for men than women.

However men tend to have less limiting or non-limiting illness than women. There is some evidence that women are more likely to report illness than men - this may contribute to the higher figures.

In recent years, some evidence suggests that the life expectancy gap has begun to close. Statistics, e.g. from the Office for National Statistics (ONS), show male mortality rates have been higher than females for a number of years. But rates for males have fallen at a faster rate - the gap between male and female mortality has decreased.

There is some limited evidence that people from ethnic minority backgrounds often experience poorer health and have lower life expectancy than the majority population. However, the figures vary considerably within ethnic minority groups.

For example, within the UK’s ethnic minority groups, Bangladeshi men had a life expectancy of only 72.7 years compared to Chinese men at 78.1 years. (Source: Equality and Human Rights Commission (EHRC) Report 2010)

Health Inequalities

Health inequalities are explained in relation to several factors:

- poverty
- lifestyle choices
- hereditary factors
- gender
- race
Poverty

Numerous reports since the early 1980s have recognised the links between poverty and poor health. For example, people living on a low income are more likely to:

- have poorer diets
- live in poor quality housing
- have less money to heat or maintain their homes
- have less money to purchase appropriate winter clothing

These factors taken together increase the chances of an individual experiencing poor health.

Poverty can affect a person’s mental wellbeing. The stress of worrying about paying bills or surviving on a low income further reduces good health.

The surrounding physical environment may also have an effect on a person’s health. Areas that have fewer services (such as shops that sell affordable fresh fruit and vegetables), that lack health and leisure facilities or green space, that have more crime or have many buildings that have fallen into disrepair, create a living environment that is not good for health.

Access to and the quality of local health services may not always be as good in poorer areas. In deprived areas of Scotland, GPs are more likely to have more difficult caseloads.

Audit Scotland, 2012

Lifestyle choices

Lifestyle choices such as smoking, drinking alcohol, poor diet and lack of exercise impact on health and life expectancy.

Studies also show that often people in the poorest groups make the worst health choices. For example, smoking and alcohol consumption rates have been consistently higher among the poorest groups for a number of years. The stress of living on a low income is one reason to explain these poorer lifestyle choices.
Hereditary factors

Recent studies have concluded that there is a health link between individuals’ health and their family history. Although genes may increase a person’s likelihood of developing a certain condition, e.g. coronary heart disease, the risk of this happening is closely linked to other factors such as lifestyles choices and the environment.

Gender

Reasons to explain men’s lower life expectancy and higher rates of early death include:
- Men take part in more risk taking activities, e.g. high impact sports.
- Men are less likely to visit their GP to seek preventative care.
- Men, at least until recently, make poorer lifestyle choices, e.g. consuming more alcohol.

Reasons to explain women’s greater life expectancy but higher rates of ill health include:
- Women tend to be at increased risk of being poor and the links between poverty and ill health are strong.
- Women take on a greater role of caring for children and elderly family members which increases stress levels and affects health.
- Women visit their GP more regularly reporting greater levels of illness but also accessing services more quickly with better long-term health outcomes.
- Until recently, less women smoked than men although in Scotland there is little difference today.

Race

Ethnic minority groups generally have poorer health than the overall population although some minority groups fare much worse than others and patterns vary from one health condition to the next.

For example, ethnic minority groups tend to have higher rates of cardio-vascular disease than white people but lower rates of cancer (Source: UK Parliamentary Office Report 2007). This can be explained for a number of reasons including:
- ethnic minority groups as a whole are more likely to report ill health
- people from ethnic minority groups are more likely to be poorer
- hereditary factors and different lifestyle choices

Attempts to reduce inequalities in health

In Scotland, decisions on health are made by the Scottish Parliament. In 2008 the Scottish government’s Equally Well report (and a follow-up report in 2010) set out their approach to reducing health inequalities.

It states that in order to tackle health inequalities, national and local government, the NHS in Scotland and the voluntary sector must work together.

Linked to Equally Well are a number of other initiatives including:
- The Early Framework (2009) - aims to target government resources and promote partnership working to ensure children get the best start in life.
- NHS Healthcare Quality Strategy (Scotland) - aims to ensure equality of access to health care services regardless of a person’s background or location.

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Other important Scottish government attempts to improve health and reduce health inequalities include:

- Minimum pricing for alcohol and the Alcohol Scotland Act (2010) which banned multi-buy alcohol sales and some types of alcohol promotions and advertising.
- The ban on smoking in enclosed public places (2006)
- The introduction of plain package on cigarettes and the ban on cigarette displays.
- Additional support to schemes to help people to stop smoking.
- Greater drugs education (Know the Score) and a comprehensive drugs strategy (Road to Recovery).
- Various healthy living and eating campaigns including: Healthy Weight Route Map: A long term Obesity Strategy (2010), Healthy Eating Active Living (2008-2011), support for Take Life On and the Commonwealth Games legacy plan.