

**THE BASELINE SURVEY OF THE HEALTH
AND WELL-BEING OF THE POPULATION OF
GREATER GLASGOW HEALTH BOARD
1999**

**Summary version:
GLASGOW CITY POPULATION**

Greater Glasgow Health Board

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CHAPTER 1

INTRODUCTION

Background

Since the publication of the Black Report in the early 1980s¹, there has been a growing awareness that health is not only related to our lifestyle – what we eat or drink, whether we exercise regularly or smoke - important though that is, but is also related to components of our lives such as what job we do (or indeed whether we have a job), what we earn, where we live and whether we are supported by others in the home and community. The most recent Public Health White Paper², *Towards a Healthier Scotland*, emphasised the importance of addressing both sets of determinants of health –lifestyles and life circumstances - in order to reduce the inequalities in health that exist between those at different points on the socio-economic spectrum.

Underpinning current government policy is an emphasis on the need to develop initiatives to tackle such inequalities and reduce the underlying social exclusion. Fundamental to this are the Social Inclusion Partnerships (SIPs) which were designated to focus on the needs either of the population of a defined geographical area of multiple deprivation or of a particular client group. In Greater Glasgow, there are 11 geographical SIPs and three thematic ones (which address the needs of young people coming out of care, routes out of prostitution and anti-racism).

Two geographical SIPs West Dunbartonshire (Clydebank component) and Cambuslang lie within Greater Glasgow Health Board (GGHB) but outside the Glasgow City boundaries. Nine of the eleven geographical SIPs are within the City of Glasgow. Of these, three SIPs – Greater Easterhouse, the East End and North Glasgow - have been converted from Priority Partnership Area (PPA) status; four new ones have been funded – Greater Pollok, Gorbals, Govan and Drumchapel; and two small SIPs (Milton and Springburn/East Balornock) have been created and link with the North Glasgow SIP. In addition, Castlemilk continues as a Regeneration Partnership. Partnership working and full community participation are fundamental to the way in which the SIPs are to operate.

The Health Board recognised that if it was to assess the extent to which the health of those in SIP areas had improved relative to those living elsewhere over the period in which the SIP initiatives were to operate, it required a population survey to define the baseline position on health and well-being and to incorporate a set of core indicators on health that would effectively act as markers of progress when the surveys were repeated at regular intervals. If SIPs chose to adopt similar core indicators, the GGHB data could provide the relevant benchmarks by which SIPs could compare the health of their populations relative to GGHB or Glasgow City - a process fully endorsed by the Scottish Executive in *The Monitoring Framework for Social Inclusion Partnerships*³.

The survey would also provide an excellent source of data to tease out precisely what characteristics of the individual and his/her life circumstances were associated with health and quality of life. This seemed particularly important to inform SIP work which above all else is designed to enhance the quality of life of its residents.

The population survey

An Advisory Group was established (with experience in SIP working, research and information-service provision) :

- to develop the core indicators
- to devise the questionnaire to obtain the baseline data on these core indicators and other data to inform Health Board and SIP work

- to commission a research company to conduct personal interviews in the home situation with a sample of 2,000 of the Greater Glasgow population, and to ensure that the sample was both representative of the GGHB population as a whole in terms of age group, sex and geographical distribution and the Carstairs index of deprivation (DEPCAT) (see footnote¹); and replicable so that future surveys could track the indicators over time.
- to oversee the work at all stages and disseminate the findings.

The fieldwork was conducted between August and mid-December 1999. The response-rate for within-scope contacts was 70%, and the final achieved sample was 1693. An adjustment to the data representativeness was required so a weighting system was applied to the data to bring it into line as far as possible with the census population structure.

While a population sample of this size was robust enough to produce valid breakdowns of data according to whether respondents live in SIP or non-SIP areas, it was never intended and indeed was not large enough to support a breakdown of data by individual SIP or local authority area, with the exception of Glasgow City. The Glasgow City sub-sample comprised approximately two-thirds (67%, n=1134) of the total GGHB sample and was therefore large enough to justify the production of a separate report. **Therefore this report relates to the Glasgow City population only though a table showing the core indicators of health of the Greater Glasgow Health Board and Glasgow City populations is attached in Appendix 1 for comparative purposes.**

Analysis and Reporting

In the reporting of the survey findings, unless otherwise stated, differences between sub-groups are only quoted if that difference is statistically significant at the level of $p \leq 0.005$. Whenever significance levels are quoted in tables, they are highlighted if they are statistically significant. Percentages in tables have been corrected to the nearest whole number so occasionally totals are not always exactly 100%. For simplicity, confidence intervals are not quoted in the text. The reader is asked to bear in mind that all figures quoted in this report are sample *estimates* of the true value in the population and may vary from the true value (as defined by confidence intervals) despite the large sample size.

The findings for the Glasgow City sub-sample

In this summary report, the results of the study are presented in two parts. In Part I (chapters 2-5) the survey findings are described with a breakdown of the data into the two sub-groups: those who live in SIP and those who live in non-SIP areas. In respect of many of the measures of health and well-being, there is a substantial gap between the two groups. However, it is also important to recognise that not all deprived areas of Glasgow City fall into SIP areas, and the non-SIP population will contain some people whose health status is probably more akin to those who live in SIP areas. Thus the true inequalities in health may be greater than that suggested by the SIP/non-SIP breakdown.

In Part II of this summary report (chapters 6-9), the association between different measures of health and individual and situational characteristics is examined, to identify what components of people's lives seem to contribute to good or bad health.

¹ *Footnote:* The Carstairs Deprivation Scores are a method of quantifying relative deprivation or affluence in different localities and are usually applied to postcode sectors as here. They are derived from four variables from the Census, namely car ownership, male unemployment, overcrowding, and the proportion of all persons in private households with an economically active head in social class 4 and 5 (semi- and unskilled-manual workers). The scores have been translated into 7 categories or DEPCATS, from 1, the most affluent areas, to 6 and 7, the multiply-deprived ones⁴.

THE SURVEY FINDINGS: PART I

CHAPTER 2

PEOPLE'S PERCEPTION OF THEIR HEALTH AND ILLNESS

1. Overview

Substantial differences in health status were identified between SIP and non-SIP areas. These differences were apparent both in the self-perceived health measures and in those based on more objective measurement, such as the identification of depression.

2. Self-perceived health

The survey respondents were asked to assess different components of their health. Some measures were assessed using the 'faces' scale. On this, there were 7 faces representing different moods or perceptions from very gloomy to very happy, scored 1 to 7 respectively. Given that there were three faces in graduated negative moods, one neutral one and three in positive mood, the higher the score the more positive the perception. The self-perceived measures of health and well-being were as follows:

- *Health over the past year*
 - 66% of the total sample (62% of SIP sample; 69% of non-SIP sample) described their health over the past year as either excellent or good, rather than fair or poor.
 - *General physical well-being* (assessed on the faces scale)
 - *General mental or emotional well-being* (assessed on the faces scale)
 - *Overall quality of life* (assessed on the faces scale)
- The ratings and the mean score on each of these three measures is given in Table 1 below.

Table 1.
SELF RATED GENERAL PHYSICAL WELL-BEING, MENTAL OR EMOTIONAL WELL BEING
AND OVERALL QUALITY OF LIFE – GLASGOW CITY

MEASURE	RATING ON FACE SCALE(%)								MEAN SCORE ¹		
	A very +ve	B	C	D	E	F	G very -ve	TOTAL	Non-SIP (n=714)	SIP (n=398)	Glasgow City (n=1112)
Physical well-being	14	30	31	10	7	5	3	100 ²	5.2 ³	4.9 ³	5.1
Mental or emotional well being	23	33	26	6	5	3	3	100 ²	5.6⁴	5.2⁴	5.4
Overall quality of life	17	32	28	7	6	5	3	100 ²	5.5⁵	4.7⁵	5.2

¹ Face scale was scored from A=7 to G=1 i.e. the more positive the response the higher the score
² Percentages have been corrected to the nearest whole number so totals may not be exactly 100%
³ Independent samples t-test p=0.29
^{4,5} Independent samples t-test **p<0.001**

- the means for mental or emotional well-being and quality of life are significantly higher for the non-SIP populations, implying a more positive view of these measures of health. However, the differences in mean scores for physical well-being between SIP and non-SIP are not statistically significant.
- *Whether the respondent feels in control of decisions affecting his/her life (such as planning the budget, moving house or changing job)*
 - 92% of the non-SIP residents felt they had at least some control over those decisions compared with 84% in SIP areas (Glasgow City : 88%).
 - Respondents were asked if they felt they had adequate information on which to base those decisions. 90% of the non-SIP sample claimed they definitely or to some extent did, whereas only 78% did in SIP areas (Glasgow City : 86%).

3. Illness

- *A condition or illness that interferes with daily living*
 - 21% in non-SIP areas compared with the significantly higher proportion of 30% in SIP areas claimed they had a condition that interfered with their daily life (Glasgow City : 25%).
- *Specific illnesses*

People were asked if they had ever been diagnosed by a doctor as having specific conditions, whether they were currently being treated and by whom. Those conditions that proved to be the most commonly diagnosed are listed in Table 2 (see page 9).

 - The commonest conditions are not necessarily those that feature as government priorities, but are conditions such as arthritis and asthma that can, nevertheless, severely affect an individual's capacity to lead a normal, active, high quality life.
 - Over 80% of those reporting having been diagnosed with the more common conditions require ongoing treatment, with the treatment-provider being predominantly the GP.
- *Depression*

Few general population surveys use a validated measure of mental health. In this survey, the depression component of the well-validated Hospital Anxiety and Depression scale was incorporated into the questionnaire. The individual is scored on seven itemised questions (maximum score : 21). Those with a score of 11 or more are identified as 'cases' (suffering from clinical depression).

 - While 6% of the non-SIP population were categorised as 'cases' on this depression scale, the proportion was almost twice that at 11% in the SIP areas (Glasgow City : 8%).
 - Indicative of a similar trend, the mean depression score was only 3.8 in non-SIP areas compared with a mean score of 5.1 in the SIP areas (Glasgow City : 4.3).

Table 2.
PERCENTAGE OF THE SAMPLE EVER DIAGNOSED AND THEIR CURRENT TREATMENT PATTERN FOR SPECIFIC NAMED CONDITIONS - GLASGOW CITY (N=1134)

CONDITION ¹	DIAGNOSED	DIAGNOSED CURRENTLY BEING TREATED	TREATMENT PROVIDER %			
	%	%	GP	Hospital	Other	Total
Arthritis/rheumatism or painful joints	20.7	82	80	18	2	100
Asthma/bronchitis or persistent cough	13.2	83	80	18	2	100
Stress related conditions e.g. difficulty sleeping etc	9.1	65	81	14	5	100
High blood pressure	8.9	89	83	16	1	100
Gastrointestinal problems e.g. peptic ulcer, IBS	7.4	88	66	33	1	100
Coronary heart disease	7.3	86	60	39	1	100
Clinical depression	6.8	85	81	18	1	100
Diabetes	4.7	86	67	31	2	100
Accidental injury	3.5	24	44	56	0	100
Severe eyesight problems	3.3	66	38	60	2	100
Drug or alcohol related conditions	3.2	77	64	15	21	100
Severe hearing problems	2.9	63	51	47	2	100
Stroke	2.3	64	48	52	0	100
Cancer	2.2	57	17	83	0	100
Epilepsy	2.2	81	71	29	0	100

¹ Crosstabulation by SIP status applying a chi-square test, only reveals a statistically significant difference for clinical depression ($p<0.001$) which is more likely to occur in SIP areas and accidental injury ($p=0.002$) in Non-SIP areas.

4. Oral health

Dental decay is a particular problem in deprived areas and there is also a lower proportion of the population in these areas who are registered with a dentist. This was reflected in the survey findings where the indicator of dental decay that was used was the proportion of teeth that were one's own.

- 16% of those living in non-SIP areas had no teeth of their own whereas for those in SIP areas it was found to be 19% (Glasgow City : 17%).
- Registration with a dentist was reported at 80% in non-SIP areas, but only 73% in SIP areas (Glasgow City : 78%). The commonest reason for not registering was "having dentures".
- Those who were registered with a dentist were asked whether it was with an NHS or private one. 4% were registered with a private dentist in SIP areas, 10% in non-SIP ones (Glasgow City : 8%)

CHAPTER 3

THE USE OF HEALTH SERVICES

1. Overview

A higher proportion of people in the SIP areas than in other areas had used GP services in the past year. However, the reverse was the case with out-patient services. Some difficulty was reported by about a fifth of the sample in obtaining an appointment to see a GP and in getting an out-patient appointment. Respondents from SIP areas were more likely to experience difficulty in getting to their GP surgery or health centre, arranging a home visit, getting to the hospital and arranging physiotherapy or chiropody services than those from non-SIP areas. The survey suggests that there would be substantial scope for involving more of the public in discussions and decisions affecting their health or treatment.

2. The use of specific health services

- A significantly higher proportion of the SIP sample (93%) had used GP services in the past year compared to the non-SIP sample (86%) (Glasgow City : 89%). However, the mean number of visits made to the GP was not significantly higher in the SIP group (SIP 6.3 and non-SIP 6.2).
- A significantly higher proportion of the non-SIP sample had used hospital out-patient departments (non-SIP: 35%; SIP: 26%; Glasgow City : 31%) in the previous year.
- The proportions making use of other health services (such as accident and emergency, in-patient services, dentist, physiotherapy, chiropody etc) in the SIP and non-SIP groups, showed no significant differences.

3. Involvement in decisions affecting health service delivery

Survey respondents were asked about their attitudes to their recent use and experience of health services such as the GP, Dentist and Hospital. Some felt they could not comment because of their scant recent use of health services but Table 3 reports the replies of the sample by SIP status.

ATTITUDES TO RECENT USE AND EXPERIENCE OF HEALTH SERVICES
(e.g. GP, Dentist, Hospital) – GLASGOW CITY (n=1134) (%)

	ATTITUDE (%)					SIGNIFICANCE (Chi-square test by SIP status) <i>p</i>
	Definitely	To some extent	No	Cannot comment	Total	
i) Had adequate access to the necessary information	25	37	21	16	100	<0.001
ii) Been encouraged to participate in decisions affecting own health/treatment	15	42	25	17	100	0.11
iii) Feel had a say in how services were delivered	10	28	44	18	100	0.009
iv) Feels views and circumstances are understood and valued	13	36	31	20	100	0.009

- 44% of the survey sample felt they had no say in the way that health services were delivered.
- About a third believe that their views and circumstances are not understood and valued in the treatment process, and a quarter feel that they are not encouraged to participate in decisions affecting their health or treatment.
- 21% feel that they do not have adequate access to the necessary information.
- People in SIP areas are significantly less likely to feel that they have adequate access to the necessary information.

4. Accessing health services

In the survey, people were asked how difficult they found it to access specific health services. The responses appear in Table 4. For some services, for example physiotherapy and chiropody, about half of the sample could not comment because they had no experience of trying to access that particular service. However, for the other services, a high proportion of the sample was in a position to comment.

DEGREE OF DIFFICULTY EXPERIENCED BY SERVICE-USERS IN ACCESSING SPECIFIC HEALTH SERVICES (%)

	n	DEGREE OF DIFFICULTY (%)			Total	SIGNIFICANCE (Chi-square test by SIP status)
		Great difficulty	Some difficulty	No difficulty		p
i) Arranging a home visit	940	5	12	83	100	0.001
ii) Making an appointment to see GP	1103	4	22	74	100	<0.001
iii) Getting to GP surgery/health centre	1101	3	11	86	100	0.005
iv) Getting to GP emergency service	809	4	12	84	100	0.006
v) Obtaining hospital appointment	762	5	16	79	100	0.085
vi) Reaching hospital for appointment	956	3	15	82	100	<0.001
vii) Making a dentist appointment	1002	1	3	96	100	0.064
viii) Getting a prescription filled	1048	1	4	95	100	0.090
ix) Obtaining physiotherapy/chiropody	505	3	8	89	100	0.001
x) Obtaining other health services	740	2	5	93	100	<0.001

- More than 20% of the service-users experienced at least some difficulty in:
 - Making an appointment to see a GP
 - Obtaining a hospital appointment
- Particular difficulty was experienced in SIPs compared with non-SIPs in:
 - Making an appointment to see a GP
 - Getting to GP surgery/health centre

- Arranging a home visit
- Reaching hospital for an appointment
- Obtaining physiotherapy or chiropody or other health services

Respondents were also asked whether they ever experience personal difficulty in making use of health services, and, for those experiencing difficulty, what the barriers were.

- 5% of the sample experienced difficulty. (There was no significant difference in the proportion between SIPs and non-SIPs.)
- For this relatively small group, the most common difficulties were:
 - Practical problems such as location of their home, lack of necessary public transport, living too far away (48%)
 - Disability, old age or illness (31%)
 - Shortage of money (27%)
 - They could not understand the system (13%)

CHAPTER 4

HEALTH BEHAVIOURS

1. Overview

High proportions of the population of Glasgow City, particularly in SIP areas, display health-damaging behaviours: smoking, binge drinking, taking inadequate vigorous exercise, eating too little of the foods that contribute to a healthy diet, and not brushing their teeth regularly.

2. Smoking

- *Passive smoking*

It is now widely acknowledged that exposure to someone else's cigarette smoke represents a risk to health. Table 5 shows the degree to which members of the survey sample are exposed to other's smoke.

**FREQUENCY OF PASSIVE SMOKING
BY SIP STATUS (%)**

FREQUENCY IN PLACES WHERE PEOPLE ARE SMOKING	PERCENTAGE OF RESPONDENTS		
	NON-SIP ¹ (n=727)	SIP ¹ (n=402)	GLASGOW CITY (n=1129)
Spend most of the day in places where others smoke	27	27	27
Spend some of the day in places where others smoke	31	44	36
Seldom in places where others smoke	42	29	37
TOTAL	100	100	100

¹Chi-square test : **p<0.001**

- 63% of the Glasgow City sample spend most or some of their day in places where others smoke.
- Amongst the non-SIP population, 58% do so, whereas in the SIP sample, 71% spend at least some of their day exposed to others' smoke.
- *Active smoking*
 - In the Glasgow City sample as a whole, 41% of the respondents smoke
 - 43% of the males and 39% of the females smoke. In both men and women prevalence is highest amongst the 45-64 year olds (52% and 50% respectively).

- The discrepancy in smoking prevalence between non-SIP and SIP areas is large: in the non-SIP sample, 36% smoke while in the SIP one, 50% do so.
- The mean number of cigarettes smoked by those who do smoke is 101 per week.

3. Drinking

It is notoriously difficult to assess weekly alcohol intake. The diary method used in this survey (by which the respondent identifies the drinks and quantity taken each day in the preceding week) is regarded as a valid estimate. However, it is important to recognise that in the context of a personal interview that focuses on health, there is likely to be under-reporting, so the levels reported here should be taken as minimum figures.

The findings can be summarised as follows:

- The recommended maximum weekly intake of alcohol is 21 units for men and 14 units for women. This limit was exceeded by 20% of the Glasgow City sample as a whole (aged 16 and over), by 30% of the men, and 10% of the women.
- Amongst those who took any alcoholic drink in the past week, 43% exceeded this limit in the Glasgow City sample, (men: 52%; women : 30%).
- Of those who took any alcoholic drink in the past week, 41% in non-SIP and 46% in SIP areas exceeded the recommended maximum intake.
- The mean unit intake for the week is similar in SIP and non-SIP areas (14 units compared with 13). However, in the light of the official advice that alcoholic intake should be spread rather than taken in 'binges', it is worrying that binge drinking is particularly common on Friday and Saturday nights. This is especially the case in SIP areas where the mean intake on those days is 4.2 and 4.7 units respectively, significantly higher than the comparable means of 3.1 and 3.8 units in non -SIP areas.

4. Exercise

The recommended levels of exercise distinguish between moderate exercise accumulated over the day and vigorous exercise for concentrated periods.

- 43% of the Glasgow City sample met the recommended level of moderate exercise of at least 30 minutes accumulated over the day on at least 5 days per week. The difference between the SIP and non-SIP sub-samples was not significant.
- However, people in the SIP areas were significantly less likely than others to meet the vigorous exercise target of at least 20 minutes on at least 3 days per week – 8% meeting it in SIP areas, compared with 19% in non-SIP (Glasgow City : 15%).
- There is no significant difference between the proportion in SIP and non-SIP areas who meet either one or the other of the recommended levels, vigorous or cumulative moderate.

5. Diet

The Scottish Diet Action Plan⁵ targets for the consumption of the different food groups, can be translated into an approximate number of portions per day (or week). The extent

to which these targets are being met in the population survey sample is shown in Table 6.

**PERCENTAGE CONSUMING FOOD AT THE RECOMMENDED FREQUENCY
BY SIP STATUS**

FOOD GROUP	RECOMMENDED LEVEL	% CONSUMING AT RECOMMENDED LEVELS			SIGNIFICANCE (Chi-square test) <i>p</i>
		NON-SIP (n=728)	SIP (n=403)	GLASGOW CITY (n=1131)	
Fruit & vegetables	5 portions per day	25	18	23	0.004
Bread	5 slices/rolls per day	17	17	17	0.787
Breakfast cereal	5 portions per week	46	36	42	0.001
Oily Fish	2 portions per week	32	17	27	<0.001

- A relatively low proportion of the Glasgow City sample is meeting these dietary targets.
- With the exception of the bread target, significantly fewer reach the targets in SIP compared with non-SIP areas.
- *Body build*
 - 39% of the Glasgow City sample were defined as overweight given that their body mass index was 25 or higher (body mass index is calculated from self-reported height and weight).
 - 27% of the sample respondents had a waist measurement indicating that they were at risk of coronary heart disease (i.e. their self-reported waist measurement was 37 inches or more if male or 32 inches if female).

6. Oral health behaviour

- In non-SIPs, only 66% were brushing their teeth the recommended twice or more a day while in SIPs, this was as low as 60% (Glasgow City : 64%).
- 11% of the SIP and 7% of the non-SIP sample were brushing their teeth less than once a day.

CHAPTER 5

SOCIAL HEALTH

1. Overview

Large differences are revealed between the proportions of the sample in SIP compared with non-SIP areas who feel isolated from friends and family, who fail to belong to the sort of organisations that could link them to others socially, and who do not feel that they belong to the local community or feel valued by it. In both SIP and non-SIP areas, there were concerns expressed about the inadequate provision of activities for young people and of sports and leisure facilities.

2. Social connectedness

- *Isolation from friends and family*
 - Feeling isolated from friends and family seems to be a problem affecting proportionately more people in the SIP (26%) than the non-SIP areas (18%) (Glasgow City : 21%).
 - The location of their home, tensions and problems with the family and the respondent's way of life were cited as reasons for feeling isolated by both groups, but particularly by those in SIP areas. Living too far away was considered to be more of a barrier in non-SIP than SIP areas (59% and 32% respectively). Interestingly, the proportions citing shortage of money as a barrier were virtually the same in each area (23% non-SIP, 24% SIP). The disability, ill-health or addiction of the respondent or his/her partner were other quite common reasons.
- *Establishing social links*
 - Only 19% of the SIP compared with 32% of the non-SIP sample (Glasgow City : 27%) belong to a club, association or social group where they might meet others to socialise.
 - Volunteering represents another mechanism for meeting others. Relatively low proportions act as volunteers. While 7% do so in non-SIP areas, the figure is much lower at 3% in SIP areas (Glasgow City : 6%).
- *Having a role in decision making processes*
 - About a third of the people interviewed in SIP areas claimed that they had some say in decisions which affect their local area with about a quarter in non-SIP areas claiming so (Glasgow City : 26%).
 - About a quarter would like to be more involved in decisions which affect it.
 - A significantly higher proportion in non-SIP (70%) compared with SIP areas (60%) would like more information on decisions which affect that local area (Glasgow City : 66%).
- *A feeling of belonging to the local area*
 - About a quarter (24%) of the SIP population felt they did not belong to their local area compared to 17% in the non-SIP group (Glasgow City : 19%).
 - 17% in SIP areas compared with only 9% in non-SIP ones felt that friendships and associations with other people in the local area do not mean a lot to them (Glasgow City : 12%)

- While 21% of people in non-SIP areas feel they are not valued as members of their community, this figure rises to 31% in SIP areas (Glasgow City : 21%).

3. The social and physical environment

- *Feelings about the area as a place to live*
Respondents were asked to rate their area as a place to live (and to bring up children) using the 'faces' scale.
 - While 82% rated their area positively as a place to live in non-SIP areas, only 52% did so in SIP areas (Glasgow City : 72%).
 - 66% in non-SIP areas rated their area positively as a place in which to bring up children, whereas in SIP areas the percentage is dramatically lower at 29% (Glasgow City : 53%).
- *Perception of the area as improving or deteriorating*
 - Within the total Glasgow City sample, 16% claimed their local area had improved over the past 5 years, 55% that it had stayed the same and 29% that it had deteriorated.
 - Those living in SIP areas were more likely to say it had deteriorated; those in non-SIP areas, to say that it had stayed the same.
- *Whether people feel safe in their local area*
 - 33% in non-SIP areas did not feel safe walking round their local area alone even after dark, but this figure was much higher at 48% in SIP areas (Glasgow City : 38%).
- *Perception of the problems of the area*
Survey respondents were offered a list of problems that might affect their local area and were asked: (a) how common a problem each was, and (b) which was the most serious problem. Table 7 represents their replies.

Table 7.
PERCENTAGE REGARDING EACH PROBLEM AS FAIRLY COMMON (OR VERY COMMON) RATHER THAN NOT VERY/NOT AT ALL COMMON IN THEIR AREA AND THE PERCENTAGE WHO REGARD IT AS THE MOST SERIOUS PROBLEM BY SIP STATUS

PROBLEM	PERCENTAGE REGARDING PROBLEM AS COMMON				PERCENTAGE REGARDING PROBLEM AS MOST SERIOUS ONE		
	NON-SIP (n=729)	SIP (n=405)	GLASGOW CITY (n=1134)	SIGNIFICANCE (Chi-square crosstab by SIP status) <i>p</i>	NON-SIP ¹	SIP ¹	GLASGOW CITY
Unemployment	63	93	73	<0.001	28	34	30
Domestic violence	19	34	25	<0.001	*	2	1
Burglaries	39	41	40	0.27	10	1	7
Vandalism	45	64	52	<0.001	11	5	9
Assaults & mugging	22	33	26	<0.001	3	1	2
Bullying in schools	20	19	19	0.01	2	0	1
Drug activity	51	82	62	<0.001	18	35	24
Excessive drinking	55	84	65	<0.001	9	11	10
Rubbish lying about	46	62	52	<0.001	6	4	6
Noise and disturbance	30	45	35	<0.001	3	2	2
Poor street lighting	17	16	17	0.90	2	1	1
TOTAL					100 ²	100 ²	100 ²

¹ Chi-square $p < 0.001$

² Because percentages have been corrected to the nearest whole number totals may not be exactly 100

* Percentage $< 0.5\%$

- Unemployment, domestic violence, vandalism, assaults, drug activity, excessive drinking, rubbish lying about and noise and disturbance were perceived to be far more common in SIP compared with non-SIP areas. Bullying in schools was perceived to be an issue that was slightly more common in non-SIP areas but the difference was not significantly different.
- The SIP sample unambiguously viewed unemployment and drug activity as the most serious problems (about one third for each) with excessive drinking identified by 11%. While unemployment and drug activity were also highest on the ranking in the non-SIP areas, a lower proportion of respondents there viewed each as the most serious problems.
- *Quality of the provision of local services*
 Respondents were asked their views on the provision of specific services in their area. For most services, fewer than a quarter of the sample regarded them as very poor, poor or adequate (rather than good or excellent). However:
 - Over half the SIP respondents felt that activities for the young and the provision of sports and leisure facilities were at best adequate; the percentage feeling this in SIP areas in relation to activities for the young

- (62%), and the provision of sports and leisure facilities (57%), was significantly higher than in non-SIP ones (49% and 46% respectively).
- The provision of food shops and of childcare was regarded as substantially worse in SIP areas. In the SIP areas, 46% regarded food shop provision as at best adequate compared with 30% in non-SIP areas; the corresponding figures for childcare provision were 25% in SIP and 16% in non-SIP areas.

4. Individual circumstances

A series of questions were included in the questionnaire to identify personal circumstances that might lead to social exclusion or impact on health. Table 8 shows the levels of specific circumstances in the general sample and where there are significant differences between the SIP and non-SIP populations. The highlighted significance levels indicate a significant difference between the two groups.

RESPONDENT CHARACTERISTICS THAT COULD LEAD TO SOCIAL EXCLUSION
BY SIP STATUS

RESPONDENT CHARACTERISTIC	PERCENTAGE IN CATEGORY			SIGNIFICANCE (Chi-square by SIP status) <i>p</i>
	NON-SIP	SIP	GLASGOW CITY	
Has children under 17	26	35	29	0.007
Is a lone parent	8	13	10	0.006
Lives in a household where no-one is employed (as % of total sample)	50	63	54	<0.001
Lives in a household where no-one is employed (as % of those of working age)	36	56	43	<0.001
Comes from an ethnic minority	3	4	3	0.119
Is separated or divorced	9	14	10	0.007
Lives in a household without a telephone	10	23	15	<0.001
Lives in a household without access to a car	43	63	50	<0.001
Lives in a house with no central heating	11	15	12	0.036
Cares for someone on a day to day basis for 8 hours or more (outwith work & ordinary childcare)	5	8	6	0.045
In need of home support service and does not receive it	5	6	5	*
Is of working age but has no formal qualifications	31	48	37	<0.001
Lives in a house which is perceived to be very/slightly overcrowded	13	10	12	0.288
All the household income comes from state benefits (as a % of total sample)	23	46	31	<0.001
All the household income comes from state benefits (as a % of working age)	21	43	29	<0.001
Income is under £100 per week (as % of those divulging income)	23	33	27	<0.001

* Numbers too small to produce valid chi-square test

THE SURVEY FINDINGS: PART II

In Part I of this report, there was a description of the health and life status of the people of Glasgow City as we enter the new Millennium. The contrast was shown between those living in the areas recently designated as Social Inclusion Partnership areas and those living elsewhere in the City. This represents the baseline position and defines the extent of the inequalities in health that are to be addressed through national and local social inclusion policies. However, in order to develop appropriate strategies and interventions to reduce inequalities in health, it is important to understand more fully what individual and situational characteristics are associated with poorer health status.

Part II of this report examines the relationship in the population survey data between each of a set of health measures (representing differing dimensions of health) and different components of life.

These life components are:

- *financial well-being and poverty (chapter 6)*
- *employment and training (chapter 7)*
- *domestic and social relationships or 'connectedness' (chapter 8)*
- *the social and physical environment in which people live (chapter 9)*

The standard set of health and well-being measures that were tested were the core indicators of:

- *health over the past year* - self-assessed as poor or fair (defined as negative) or good or excellent (defined as positive)
- *long-term illness* – whether or not the individual has any condition or illness that interferes with daily living
- *depression* – whether or not the individual is identified as clinically depressed on the depression component of the Hospital Anxiety and Depression Scale
- *quality of life* – self-assessed on the 7-point faces scale with responses grouped as negative or neutral, or positive
- *in control of decisions that affect life (such as planning the budget, moving house or changing job)* – those who definitely or to some extent feel in control being contrasted with those who claim to have no control

and two lifestyle behaviours:

- *smoking* – comparing smokers and non-smokers
- *fruit and vegetable consumption* – comparing those who fail to meet the Scottish Diet Action Plan target of 5 portions of fruit and/or vegetables per week with those who meet it

A summary table showing the significance levels of the chi-square testing of these health variables against the life components, can be found in Appendix 2.

CHAPTER 6

HEALTH AND FINANCIAL WELL-BEING

The standard set of health measures will be considered in relation to:

- household income
- two measures of poverty:
 - whether the respondent or any member of his/her household is in receipt of income support
 - the proportion of the household income that comes from state benefits
- two measures that focus more on the spending capacity of the household budget:
 - the perceived adequacy of the household income
 - the degree of difficulty in meeting an unexpected expense of £100

1. Overview

All the health measures showed a highly significant relationship with each of the measures of financial well-being listed above. i.e. Health status appears to be directly related to financial well-being, whether one is considering general health, mental health or quality of life.

2. Health and household income

- There is a strong tendency for better health status to be associated with higher income.
- Over half (57%) of those in the lowest income group (under £75) described their health as only poor or fair. This proportion fell with an increase in income such that only 18% of those with a weekly income of over £350 described their health as fair or poor (rather than good or excellent).
- The proportion of those with a condition/illness affecting their daily life rose six-fold from those in the higher income group of over £350 (7%) to those in the low income group of £50-£75 (42%).
- Clinical depression affected about a quarter (26%) of the lowest income group. This proportion reduced markedly to only 1% in the highest income group.
- About a fifth of those in the lowest income groups felt they had no control over decisions affecting their lives compared to 2% in the highest one.
- The highest smoking prevalence (56%) is in the lowest income group, reducing to 30% in the highest.
- Likewise, not consuming the recommended 5 portions per day of fruit and vegetables shows an income gradient – 90% of those in the lowest income group not meeting the target compared with 69% in the highest.
- Quality of life might be expected to embrace a wide range of components of life and indeed this proves to be the case as subsequent sections of this report show, but it, like the other aspects of health, is strongly related to income. 40% of those in the lowest income group had a negative perception of their quality of life; this reduced to 2% in the highest income group.

3. Health and poverty

- If poverty is assessed as the proportion of household income that comes from *state* benefits, this too is strongly related to health status. As the proportion reduces, health status tends to improve.
- Of those respondents who drew no benefits only 6% reported having an illness which affects their daily lives compared to 41% of those whose total income came from state benefits. Moreover, 11% of those who drew no benefits described their health over the past year as merely poor or fair compared with 55% of those whose total income came from state benefits. 3% of respondents who drew no state benefits had a negative perception of their quality of life, the comparative figure for those entirely dependant on state benefits was 41%. Similar differentials, though not as wide, are apparent in the other health measures.
- It is worth noting that clinical depression and a feeling of not being in control of decisions that affect life are particularly common among those whose total income comes from benefits (18% and 23% respectively compared with only 8% and 11% in the whole Glasgow City sample).
- Being in receipt of Income Support is likewise related to lower health status. Approximately double the percentage of those on income support compared to those not on it have a negative perception of their quality of life, a longstanding illness which interferes with their daily living, are clinically depressed or feel they are not in control of life decisions.

4. Health and spending capacity

- Adequacy of the household income was self-assessed using the 7-point faces scale. There was a marked reduction in health status from those assessing their income as very adequate to those assessing it as very inadequate. At the extremes:
 - Not one of the respondents with the 'very adequate' income described their quality of life negatively compared with 67% with the 'very *inadequate*' income; 28% smoked in the 'very adequate' group compared with 77% in the 'very *inadequate*' income group.
 - 10% of those assessing income as very adequate described their health as poor or fair compared with 49% in those assessing their income as very *inadequate*.
 - A third of those assessing their income as *inadequate* were suffering from clinical depression and/or described themselves as having no control over life decisions compared with 8% and 11% in the total Glasgow City sample.
- It would appear that living in a situation in which it is impossible to meet an unexpected expense is also associated with poorer health status and the greater the difficulty, the worse the health.
 - Only 25% of those who would have *no* problem meeting an unexpected expense of £100 described their health over the past year as poor or fair compared with 57% of those who would find it *impossible* to find that sum.
 - The differential is greater in relation to quality of life – only 5% of those experiencing *no* problem described their quality of life negatively compared with 56% of those who would find it *impossible* to meet an unexpected expense of £100.
 - Again, clinical depression, feeling of having no control over life decisions and having a longstanding illness which affects daily life were especially common amongst those who found it *impossible* to find £100 for an unexpected expense (27%, 36% and 44% respectively).

CHAPTER 7

HEALTH AND EMPLOYMENT

The relationship between health status and the following components of the employment picture will be reported in this chapter:

- Employment status of the respondent
- Whether (s)he lives in a household in which no one is in gainful employment
- The occupation of the respondent (or of the main wage earner in the household if not the respondent and if that occupation is of higher occupational status)
- Whether the respondent has any qualifications

1. Overview

As might perhaps be expected from the findings reported in the previous chapter on income and health, there is a clear relationship between health status and the type of work the individual does and whether s/he has any qualifications. However, the relationship with employment status is rather more complex but is most revealing.

2. Health and occupation

- The health measures show an unambiguous decline in status as one moves from the professional and senior management occupations (A), through middle management (B), junior management and routine non-manual (C1), skilled manual and manual supervisory (C2) to the semi- and un-skilled manual occupations(D) with those entirely dependent on the state or in casual work (E) most likely to experience poor health status. Thus:
 - Only 24% in occupational group A describe their health over the past year as poor or fair compared with 56% in group E.
 - 10% in group A assess their quality of life negatively while 42% in group E do so.
 - 11% in group A have an illness or condition affecting their daily life compared with 35% in group E.
 - None of the respondents in group A have clinical depression whereas about one fifth do so in group E.
 - All of the respondents in group A feel in control of life decisions compared to three quarters of those in group E.

The health behaviours too show comparable gradients:

- 5% in occupational group A smoke whereas the prevalence is 55% in group E.
- 59% do not meet the fruit and vegetable target of 5 portions a day in group A compared with 87% in group E.

3. Health and employment status

- Employment status impacts on all the health measures, in some cases to a dramatic extent. For example:
 - Only 7% of the employed define their quality of life in negative terms while 29% of the unemployed who are seeking work do so. However, of those who are sick or disabled and unable to work, 61% assess their quality of life negatively.
 - It is interesting that retirement seems to be associated with a more favourable quality of life (20% defining their quality of life negatively) than looking after the home and family (27% in this category view their quality of life in negative terms). Similarly, only 7% of the retired group, compared with 22% of those

looking after home and family, feel they have no control over decisions affecting their lives.

- Depression seems to be particularly associated both with being sick or disabled and unable to work, and with looking after home and family (in 26% and 14% of those groups respectively).

4. Health and qualifications

- Given the close link between one's occupation and educational attainment, it is scarcely surprising that, as with health and occupation, there is a strong relationship between all the health measures and whether or not the individual has obtained any qualifications. For example :
 - While 77% of those who had qualifications described their health over the past year as excellent or good, only 54% of those without qualifications did so.
 - Among those who had qualifications, only 17% described themselves as having a condition that affected their daily lives compared with 33% among those who had no qualifications.
 - Only 3% of those with an educational qualification were identified as clinically depressed in contrast to 12% of those without.
 - Compared with those who had qualifications, a substantially higher proportion of those with no qualifications claimed they had no control over decisions affecting their lives (13% compared with 5%) and had a negative or neutral view of their quality of life (26% compared with 11%).

These results strongly indicate that success in reducing unemployment and increasing educational attainment should have a favourable effect on both health and quality of life in Greater Glasgow.

CHAPTER 8

HEALTH AND SOCIAL CONNECTEDNESS

There has, in recent years, been much discussion about the extent to which 'social capital' impacts on health. Its definition is not always clear, but it seems that the term 'social capital' usually refers to the totality of networks of informal and formal relationships and organisations that can bring support to the individual. Logic would suggest that enhancing social capital would reduce social exclusion, but would that impact on health?

In order to tease this out, the Glasgow City set of health measures was crosstabulated against the following indices of social connectedness:

- *Marital status* (treating the two sexes separately given the widespread belief that the relationship between marital status and health differs between the sexes)
- *Whether or not the respondent is a lone parent*
- *Whether the individual feels isolated from friends and family* for whatever reason.
- At the local community level:
 - *Whether the individual feels s/he belongs to the local area*
 - *Whether friendships and associations with local people mean a lot to him/her*
 - *Whether s/he feels valued as a member of the community*
- At a more global level:
 - *Whether the respondent is part of a social network* - defined as attending regularly any organisation locally or elsewhere and/or acting as a volunteer for at least one hour per week or four per month and/or belonging to a decision-making body (community council, political party, Glasgow Alliance/SIP, a school board, housing association or tenants' or residents' association.)

1. Overview

The majority of these measures are significantly associated with quality of life and there is therefore a strong argument that they should be considered as key components of strategies to reduce social exclusion. However, whether they impact on other measures of health is variable and will be examined below.

2. Health and domestic circumstances

- While the data undoubtedly show an effect of age on marital status, the situation can be summarised as follows:
 - For men: being single, married or co-habiting seems to enhance general health status and quality of life with over three quarters of respondents having a positive perception of these health measures while being widowed, divorced and (especially) separated, seems to depress it .
 - For women: the enhancing effect of a marital relationship on general health and quality of life is not as marked as in men. While the absence of such relationships through widowhood, divorce and separation undoubtedly impacts negatively on both general health and quality of life in women, the depressing effect of separation is not as marked as in men.
 - There tends to be a high prevalence of smoking in both men and women who are cohabiting, divorced or separated.
 - Marital status shows no significant relationship to clinical depression and, for women, the extent to which they feel in control of decisions affecting their lives.
- Being a lone parent appears to have no significant effect on general health, mental health, smoking levels or quality of life, but lone parents are significantly more likely to

feel that they have no control over the decisions affecting their lives (20% of lone parents compared with 10% in the rest of the sample).

3. Health and social isolation

- Feeling isolated from friends and family has a significant effect on all the health measures tested (with the exception of fruit and vegetable consumption and smoking). For example:
 - 49% of those feeling isolated rate their health over the past year as only poor or fair compared with 30% of those who do not feel isolated.
 - 22% of isolated people suffer from clinical depression compared with 4% in those who do not feel isolated.
 - 51% of isolated people rate their quality of life negatively in contrast to only 14% of those who do not feel isolated.
 - 26% of isolated people do not feel in control of decisions affecting life compared to 7% of those who do not feel isolated.
- Being part of a social network, whether it is in the local community or elsewhere, impacts significantly on quality of life and enhances the feeling of being in control of decisions affecting life.

4. Health and community ties

- If people feel that they belong to their local area or that the friendships and associations with local people mean a lot to them, their general health, quality of life and their control over decisions tends to be higher. A feeling of 'belonging' is not, however, directly associated with people's state of mental health.
- On the other hand, feeling valued as a member of the community seems to have a beneficial impact on general health, mental health, health behaviours and quality of life. Ninety two percent of those who felt valued also felt in control of life decisions compared to 33% of those who did not feel valued. Similarly 94% of those who felt valued had a positive perception of their quality of life compared to 65% who did not feel valued. It would seem to be very important to foster this feeling of being valued in order to enhance health and quality of life and reduce health inequalities.

CHAPTER 9

HEALTH AND THE SOCIAL AND PHYSICAL ENVIRONMENT

To what extent does the local environment affect physical and mental health?

The environmental indices that were crosstabulated against the health measures were:

- The socio-economic status of the area as assessed by the Carstairs Deprivation Categories (scored from 1 the most affluent, to 7 the most deprived, based on census criteria of the level in the area of overcrowding, male unemployment, low social class and no car ownership). *It should be noted that there are no areas in Glasgow City which can be classified as DEPCAT 1.*
- Whether the local area was perceived to have improved, stayed the same or deteriorated over the past year.
- Whether individuals feel safe walking alone around the area after dark
- Feelings about the local area as a place to live (assessed using the 7-point faces scale).
- Feelings about the local area as a place in which to bring up children (assessed similarly).

The survey respondents were also asked whether their housing had an effect on their health and 13% suggested that it did, the most common contributory components being noisy or difficult neighbours (by 29% of this group), the location of their home (26%), damp (23%), stairs (11%) (physical access to the building was cited by a further 5%), overcrowding (5%), difficulty moving round their home (4%) and dust (4%). Six percent cited cold and drafts as a problem with 6% mentioning a lack of central heating.

1. Overview

The majority of the components of the social and physical environment listed above were significantly associated with the different measures of health though not necessarily with the health behaviours. Thus the nature of the residential area and how people feel about living there, appears to impact not only on quality of life but also on health.

2. Health and the socio-economic status of the area (DEPCAT)

- There was a gradient on all the health measures with health status deteriorating as one moves from the most affluent (DEPCAT 2) to the most deprived areas (DEPCAT 7) in Glasgow City. e.g.
 - 6% of respondents from DEPCAT 2 areas had an illness/condition that affected their daily lives compared with 30% in DEPCAT 7 areas.
 - No one could be classed as clinically depressed in DEPCAT 2 while 10% were in DEPCAT 7.
 - Similarly no one felt they had no control over their lives in DEPCAT 2 areas compared with 16% in DEPCAT 7.
 - No one in DEPCAT 2 rated their quality of life negatively whereas 29% did so in DEPCAT 7.
- It is important to bear in mind that not all DEPCAT 6 and 7 areas have been designated Social Inclusion Partnership areas with the associated funding and commitment to address the quality of life and health of its residents. (Within Glasgow City, only 18% of those living in DEPCAT 6 areas, and 69% of those living in DEPCAT 7 areas are within an area-based SIP.)

3. Health and the perceived stability of the local area

- Interestingly, with regards to clinical depression, quality of life and health over the past year those with the best health status lived in areas they described as having stayed the same over the past 5 years. This was followed fairly closely by those who believed that their area had improved over that period with a marked tendency for the worst health status to be associated with living in 'deteriorating' areas.

4. Health and the perceived safety of the local area

- The gulf in status on all the health measures was substantial between those who strongly agreed that they felt safe walking alone in their local area even after dark (effectively very safe) and those who strongly disagreed and thus felt very unsafe. For example:
 - Only 13% of those who felt very safe assessed their quality of life negatively compared with 36% who felt very unsafe.
 - Only 3% of those who felt very safe were clinically depressed compared with 16% of those who felt unsafe.
 - 3% of those feeling very safe felt they had no control over life decisions while 18% of those who felt very unsafe had no control.
- It would seem that making an area safer for its residents and ensuring that they recognise that it is safer, is likely to improve their health and quality of life.

5. Health and people's perception of their area as a place to live and to bring up children

- The differentials were substantial on all the health measures and on the health behaviours of smoking and fruit and vegetable consumption, between those who felt very positive about their area and those who felt very negative. For example:
 - 6% of those who liked their area very much were assessed as clinically depressed compared with 34% of those who disliked it very much.
 - 7% of those who were very positive about their area felt they had no control over life decisions whereas the figure was as high as 40% amongst those who were very negative about it.
 - 24% of those who liked their area very much area had a condition/illness affecting their daily life compared with 51% of those who strongly disliked it.
 - Only 28% smoked amongst those who were very positive about their area compared to 55% amongst those who were very negative; likewise, 26% met the fruit and vegetable target of 5 portions a day amongst those who felt very positive compared with only 4% amongst those who felt very negative.
- As might be expected, differentials in health status also exist between those who viewed their area very favourably and very unfavourably as a place in which to bring up children, though the gap is not as wide as the overall perception of the area as a place to live. For example :
 - 5% of those who expressed a very positive view about their area as a place to bring up children were assessed as clinically depressed compared to 34% of those who expressed a very negative view.

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APPENDICES

**CORE INDICATORS OF HEALTH AND WELLBEING FROM THE 1999 GREATER GLASGOW HEALTH BOARD POPULATION STUDY
FOR GREATER GLASGOW HEALTH BOARD & GLASGOW CITY RESIDENTS
(Adult population aged 16 and over)**

CORE INDICATOR	DEFINITION	GGHB (n=1693)		G. CITY (n=1134)	
		%	95% Confidence Interval 1	%	95% Confidence Interval 1
Smoking	% who are current smokers i.e. smoke at least 1 cigarette per week	37.2%	34.9% - 39.5%	41.1%	38.2% - 44.0%
Alcohol	% who exceed the recommended maximum weekly intake of 21 units for men and 14 units for women	17.6%	15.8% - 19.4%	20.3%	18.0% - 22.6%
Exercise :					
a) Cumulative Moderate Exercise	% who accumulate at least 30 minutes of moderate physical exercise on at least 5 days per week	48.0%	45.6% - 50.4%	43.0%	40.1% - 45.9%
b) Vigorous Exercise	% who spend at least 20 continuous minutes doing vigorous exercise (enough to become sweaty and out of breath) 3 or more times per week	18.3%	16.5% - 20.1%	15.3%	13.2% - 17.4%
Diet :					
a) Fruit & Vegetables	% who on average eat at least 5 portions of fruit and/or vegetables per day	24.5%	22.5% - 26.5%	22.7%	20.3% - 25.1%
b) Bread	% who usually eat 5 or more slices of bread or rolls per day	16.7%	14.9% - 18.5%	17.0%	14.8% - 19.2%
c) Breakfast Cereal	% who usually eat breakfast cereal 5 or more times per week	43.0%	40.6% - 45.4%	42.1%	39.2% - 45.0%
d) Oily Fish	% who usually eat oily fish twice or more per week either in sandwiches or as part of a meal	27.2%	25.1% - 29.3%	26.9%	24.3% - 29.5%
e) High Fat Snacks	% who usually eat high fat snack items (such as cakes, pastries, chocolate biscuits, crisps) at least twice per day	54.0%	51.6% - 56.4%	62.1%	59.3% - 64.9%
Body Mass Index (BMI)	% who have a body mass index of 25 or more (indicating overweight) based on self-reported values 2	39.7%	37.4% - 42.0%	39.1%	36.3% - 41.9%
Waist Measurement	% whose self reported waist measurement indicates they are at risk of coronary heart disease (37" or more for men; 32" or more for women)	23.1%	21.1% - 25.1%	26.7%	24.1% - 29.3%
Self Perceived Health	% who describe their health over the past year as excellent or good, rather than fair or poor	69.3%	67.1% - 71.5%	66.3%	63.5% - 69.1%
Self Perceived General Physical Wellbeing	% who rated it positively on a face scale 3	78.9%	77.0% - 80.8%	75.9%	73.4% - 78.4%
Self Perceived General Mental or Emotional Wellbeing	% who rated it positively on a face scale 3	85.1%	83.4% - 86.8%	83.0%	80.8% - 85.2%
Self Perceived Overall Quality of Life	% who rated it positively on a face scale 3	83.5%	81.7% - 85.3%	78.9%	76.5% - 81.3%
Mental Health - Depression	% who were classified as 'cases' on the Hospital Anxiety and Depression Scale	6.6%	5.4% - 7.8%	8.0%	6.4% - 9.6%
Illness Interfering with Daily Living	% who has a condition or illness that interferes with daily living	21.9%	19.9% - 23.9%	24.3%	21.8% - 26.8%
Oral Health :					
a) Possess Own Teeth	% who has some or all of their own teeth (rather than none)	84.0%	82.3% - 85.7%	82.8%	80.6% - 85.0%
b) Dental Registration	% who say they are registered with either an NHS or private dentist	79.9%	78.0% - 81.8%	77.5%	75.1% - 79.9%

1. The core indicators relate to the percentages identified in a sample of the population. There is a 95% chance that the true value for the population lies within the range defined by the confidence interval.

2. BMI = weight (kg) / square of height(m²).

3. The 'face scale' shows 7 faces in varying moods ranging from very happy to very unhappy with a neutral mood in the centre (see the representation attached to the questionnaire). The positive perceptions relate to faces A to C.

SIGNIFICANCE LEVELS (p) FROM CROSSTABULATION OF MEASURES OF HEALTH AGAINST COMPONENTS OF LIFE – GLASGOW CITY

	Self perceived health	Self perceived quality of life	Any condition which interferes with daily living	Depression (HAD caseness)	In control of decisions which affect life	Smoking	Consumes recommended 5 portions of fruit/veg per day
INCOME							
Weekly income	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
In receipt of income support	<0.001	<0.001	<0.001	0.001	<0.001	<0.001	0.05
Proportion of income from state benefits	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Degree of difficulty meeting unexpected £100	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Perceived adequacy of income	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0.003
EMPLOYMENT							
Occupational grouping	<0.001	<0.001	0.001	<0.001	<0.001	<0.001	<0.001
Any adult employed in household	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0.62
Any qualification	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Employment status	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
SOCIAL CONNECTEDNESS							
Marital status	<0.001	<0.001	<0.001	0.53	0.04	<0.001	0.88
Whether lone parent	0.74	0.30	0.09	0.04	0.001	0.51	0.002
Whether feel isolated from friends and family	<0.001	<0.001	<0.001	<0.001	<0.001	0.01	0.27
Whether part of social network	0.06	0.002	0.43	0.04	<0.001	0.003	<0.001
Whether feel belong to area	0.01	0.001	0.001	0.11	<0.001	0.64	0.14
Whether local friends mean a lot	0.05	0.03	0.05	0.23	<0.001	0.47	0.12
Whether feel valued as member of community	<0.001	<0.001	0.001	<0.001	<0.001	<0.001	<0.001
SOCIAL/PHYSICAL ENVIRONMENT							
Depcat (7 groups)	0.07	<0.001	<0.001	0.03	<0.001	<0.001	<0.001
Any change in area over past 5 years	<0.001	<0.001	0.001	<0.001	<0.001	0.01	0.01
Whether feel safe in area after dark	0.01	<0.001	0.002	0.004	0.001	0.29	0.05
Feelings about area (7 groups)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0.05
Feelings about area as place to bring up children(7 groups)	0.07	<0.001	<0.001	0.02	<0.001	<0.001	0.002
Most serious problem	0.55	0.04	0.14	0.25	0.14	<0.001	0.13

FURTHER INFORMATION

Should you require further copies of this Summary Report or additional information on its contents, please contact:

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