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

Summary version:
GGHB POPULATION

Greater Glasgow Health Board

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CHAPTER 1

INTRODUCTION

Background

Since the publication of the Black Report in the early 1980s[1], 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 Paper[2], *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).

Four of the geographical SIPs – Greater Easterhouse, the East End, North Glasgow and West Dunbartonshire- have been converted from Priority Partnership Area (PPA) status; five new ones have been funded – Cambuslang, 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 Greater Glasgow - 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 footnote[1]); and replicable so that future surveys could track the indicators over time.
- to oversee the work at all stages and disseminate the findings.

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 one exception. The Glasgow City sub-sample was just large enough to justify the production of a table of the core indicators of health for both the Greater Glasgow Health Board and Glasgow City populations (Appendix 1). All other findings presented in this report relate to the total sample of the GGHB population.

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.

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

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 Greater Glasgow 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.

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[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 ones[4].

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*
    - 70% of the total sample (61% of SIP sample; 72% 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

MEASURE	RATING ON FACE SCALE **(%)**								MEAN SCORE [1]		
	A very +ve	B	C	D	E	F	G very -ve	TOTAL	Non-SIP (n=1234)	SIP (n=428)	GGHB (n=1662)
Physical well-being	15	33	30	10	6	4	2	100 [2]	5.4 [3]	4.9 [3]	5.2
Mental or emotional well being	24	36	25	6	4	2	2	100 [2]	5.7 [4]	5.2 [4]	5.5
Overall quality of life	21	37	25	7	4	3	2	100 [2]	5.7 [5]	4.8 [5]	5.4

[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 4 5] Independent samples t-test **$p<0.001$**

- on each of these measures, the mean is significantly higher for the non-SIP population, implying a more positive view of physical and mental well-being and quality of life in those areas than in the SIP areas.

- *Whether the respondent feels in control of decisions affecting his/her life* (such as planning the budget, moving house or changing job)
    - 94% of the non-SIP residents felt they had at least some control over those decisions compared with 85% in SIP areas (GGHB:92%).
    - Respondents were asked if they felt they had adequate information on which to base those decisions. 92% of the non-SIP sample claimed they definitely or to some extent did, whereas only 79% did in SIP areas (GGHB :89%).

3. Illness

- *A condition or illness that interferes with daily living*
    - 19% 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 (GGHB:22%).

- *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.
    - For most of these commoner conditions, almost three-quarters of those reporting having been diagnosed require ongoing treatment and the treatment-provider is 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 5% of the non-SIP population were categorised as 'cases' on this depression scale, the proportion was twice as high at 10% in the SIP areas (GGHB: 7%).
    - Indicative of a similar trend, the mean depression score was only 3.7 in non-SIP areas compared with the significantly higher mean score of 5.2 in the SIP areas (GGHB: 4.1).

Table 2

PERCENTAGE OF THE SAMPLE EVER DIAGNOSED AND THEIR CURRENT TREATMENT PATTERN FOR SPECIFIC NAMED CONDITIONS - GGHB (N=1693)

CONDITION [1]	DIAGNOSED %	DIAGNOSED CURRENTLY BEING TREATED %	TREATMENT PROVIDER (%)			
			GP	Hospital	Other	Total
Arthritis/rheumatism or painful joints	19.2	78	76	22	2	100
Asthma/bronchitis or persistant cough	12.9	77	79	19	2	100
High blood pressure	10.9	85	86	13	1	100
Stress related conditions e.g. difficulty sleeping etc	9.2	57	83	13	4	100
Gastrointestinal problems e.g. peptic ulcer, IBS	8.2	79	65	34	1	100
Coronary heart disease	7.1	82	57	42	1	100
Clinical depression	6.0	79	81	18	1	100
Accidental injury	4.5	33	54	42	4	100
Diabetes	4.5	76	62	36	2	100
Severe hearing problems	3.2	64	48	45	7	100
Severe eyesight problems	3.1	62	41	56	3	100
Cancer	2.7	58	12	88	0	100
Stroke	2.2	57	50	50	0	100
Drug or alcohol related conditions	2.2	69	61	17	22	100
Epilepsy	1.9	73	71	29	0	100

[1] Crosstabulation by SIP status applying a chi-square test, only reveals a statistically significant difference for clinical depression ($p<0.001$) and drug and alcohol related conditions ($p<0.001$) which were more likely to occur in SIP areas and accidental injury ($p<0.001$) and high blood pressure ($p=0.001$) 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.

- 15% of those living in non-SIP areas had no teeth of their own whereas for those in SIP areas it was found to be 20% (GGHB: 16%).
- Registration with a dentist was reported at 83% in non-SIP areas, but only 73% in SIP areas (GGHB: 80%). The commonest reason for not registering was "having dentures". [People with dentures should, of course, still attend a dentist.]
- 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, 15% in non-SIP ones (GGHB: 12%)

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 and dental 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 the local health centre and to the hospital 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 (92%) had used GP services in the past year compared to the non-SIP sample (86%) (GGHB: 88%). However, the mean number of visits made to the GP was not significantly higher in the SIP group.
- A significantly higher proportion of the non-SIP sample had used hospital out-patient departments (non-SIP: 35%; SIP: 26%; GGHB: 33%) and dentists (non-SIP: 69%; SIP: 59%; GGHB: 66%) in the previous year.
- The proportions making use of other health services (such as accident and emergency, in-patient services, 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, 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.

Table 3

ATTITUDES TO RECENT USE AND EXPERIENCE OF HEALTH SERVICES (%)
(e.g. GP, Dentist, Hospital)

	ATTITUDE (%)					SIGNIFICANCE (Chi-square test by SIP status)
	Definitely	To some extent	No	Cannot comment	Total	*p*
i) Had adequate access to the necessary information	30	38	17	15	100	**<0.001**
ii) Been encouraged to participate in decisions affecting own health/treatment	19	40	25	16	100	0.007
iii) Feel had a say in how services were delivered	11	30	42	17	100	0.012
iv) Feels views and circumstances are understood and valued	16	36	29	19	100	**0.003**

- Over 40% of the survey sample felt they had no say in the way that health services are delivered.
- About a quarter believe that their views and circumstances are not understood and valued in the treatment process, and a similar proportion feel that they are not encouraged to participate in decisions affecting their health or treatment.
- A lower proportion (17%) 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 and to feel that their views and circumstances are understood and valued.

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.

Table 4

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

		DEGREE OF DIFFICULTY (%)				SIGNIFICANCE (Chi-square test by SIP status)
	n	Great difficulty	Some difficulty	No difficulty	Total	*p*
i) Arranging a home visit	1370	6	13	81	100	0.01
ii) Making an appointment to see GP	1656	5	22	74	100	**<0.001**
iii) Getting to GP surgery/health centre	1654	2	9	88	100	**0.001**
iv) Getting to GP emergency service	1262	4	13	83	100	0.02
v) Obtaining hospital appointment	1194	5	18	77	100	0.40
vi) Reaching hospital for appointment	1467	3	13	84	100	**<0.001**
vii) Making a dentist appointment	1534	1	4	95	100	0.19
viii) Getting a prescription filled	1586	1	3	96	100	0.08
ix) Obtaining physiotherapy/chiropody	823	3	9	88	100	0.17
x) Obtaining other health services	1126	2	5	93	100	0.02

- 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 the GP surgery or to the health centre
  - Reaching hospital for an appointment

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.

- 4% 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:
  - Disability, old age or illness (37%)
  - Practical problems such as location of their home, lack of necessary public transport, living too far away (34%)
  - Shortage of money (21%)
  - They could not understand the system (10%)

CHAPTER 4

HEALTH BEHAVIOURS

1. Overview

High proportions of the population of Greater Glasgow, 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.

Table 5

FREQUENCY OF PASSIVE SMOKING
BY SIP STATUS (%)

FREQUENCY IN PLACES WHERE PEOPLE ARE SMOKING	PERCENTAGE OF RESPONDENTS		
	NON-SIP[1] (n=1250)	SIP[1] (n=434)	GGHB (n=1684)
Spend most of the day in places where others smoke	22	27	23
Spend some of the day in places where others smoke	27	43	31
Seldom in places where others smoke	51	30	46
TOTAL	100	100	100

[1] Chi-square test : **p<0.001**

- 54% of the GGHB sample spend most or some of their day in places where others smoke.
- Amongst the non-SIP population, 49% do so, whereas in the SIP sample, 70% spend at least some of their day exposed to others' smoke.

- *Active smoking*
  - In the Greater Glasgow sample as a whole, 37% of the respondents smoke
  - 40% of the males and 35% of the females smoke. In men, prevalence is highest amongst the 45-64 year olds (46%) and in women, worryingly, amongst the young age group aged 16-29 (43%).

- The discrepancy in smoking prevalence between non-SIP and SIP areas is large: in the non-SIP sample, 33% smoke while in the SIP one, 50% do so.
- The mean number of cigarettes smoked by those who do smoke is 96 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 18% of the Greater Glasgow Health Board sample as a whole (aged 16 and over), by 26% of the men, and 10% of the women.
- Amongst those who took any alcoholic drink in the past week, 34% exceeded this limit in the Greater Glasgow Health Board sample, (men: 41%; women: 24%).
- Of those who took any alcoholic drink in the past week, 30% in non-SIP and 46% in SIP areas exceeded the recommended maximum intake.
- The mean unit intake for the week is higher in SIP compared with non-SIP areas (16 units compared with 11). 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 4.3 and 4.9 units respectively, significantly higher than the comparable means of 2.5 and 3.4 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.

- 48% of the GGHB 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 substantially less likely than others to meet the vigorous exercise target of at least 20 minutes on at least 3 days per week – 9% meeting it in SIP areas, compared with 22% in non-SIP (GGHB: 18%).
- Not surprisingly, there is a 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 – 48% in SIPs and 57% in non-SIPs (GGHB: 55%).

5. Diet

The Scottish Diet Action Plan[5] 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.

Table 6

PERCENTAGE CONSUMING FOOD AT THE RECOMMENDED FREQUENCY BY SIP STATUS

FOOD GROUP	RECOMMENDED LEVEL	% CONSUMING AT RECOMMENDED LEVELS			SIGNIFICANCE
		NON-SIP (n=1254)	SIP (n=435)	GGHB (n=1689)	(Chi-square test) *p*
Fruit & vegetables	5 portions per day	27	18	25	**<0.001**
Bread	5 slices/rolls per day	16	19	17	0.160
Breakfast cereal	5 portions per week	45	36	43	**0.001**
Oily Fish	2 portions per week	30	18	27	**<0.001**

- A relatively low proportion of the GGHB 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*
  - 40% of the GGHB 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).
  - 23% 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 71% were brushing their teeth the recommended twice or more a day while in SIPs, this was as low as 59% (GGHB: 68%).
- 11% of the SIP and 6% 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 (14%) (GGHB: 17%).
  - The location of their home, living too far away from friends and family, and shortage of money were cited as reasons for feeling isolated by both groups, but particularly by those in SIP areas. Tensions or problems with the family; disability, ill-health or addiction of the respondent or his/her partner; and the respondent's way of life were other quite common reasons.

- *Establishing social links*
  - Only 19% of the SIP compared with 34% of the non-SIP sample (GGHB: 30%) 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 11% do so in non-SIP areas, the figure is much lower at 3% in SIP areas (GGHB: 9%).

- *Having a role in decision making processes*
  - About a third of the people interviewed in both SIP and non-SIP areas claimed that they had some say in decisions which affect their local area.
  - Slightly more would like to be more involved in decisions which affect it.
  - A significantly higher proportion in non-SIP (76%) compared with SIP areas (63%) would like more information on decisions which affect that local area (GGHB: 73%).

- *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 in contrast to 13% in the non-SIP group (GGHB: 16%).
  - 16% in SIP areas compared with only 8% in non-SIP ones felt that friendships and associations with other people in the local area do not mean a lot to them (GGHB: 10%)
  - While 20% of people in non-SIP areas feel they are not valued as members of their community, this figure rises to 30% in SIP areas (GGHB: 22%).

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 87% rated their area positively as a place to live in non-SIP areas, only 54% did so in SIP areas (GGHB: 79%).
    - 75% 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 30% (GGHB: 64%).

- *Perception of the area as improving or deteriorating*
    - Within the total GGHB sample, 14% claimed their local area had improved over the past 5 years, 57% 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*
    - 28% in non-SIP areas did not feel safe walking round their local area alone even after dark, but this figure was much higher at 46% in SIP areas (GGHB: 33%).

- *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=1256)	SIP (n=437)	GGHB (n=1693)	SIGNIFICANCE (Chi-square crosstab by SIP status) p	NON-SIP [1]	SIP [1]	GGHB
Unemployment	53	93	64	**<0.001**	22	34	25
Domestic violence	18	33	22	**<0.001**	*	2	1
Burglaries	42	41	42	0.299	14	1	10
Vandalism	48	67	53	**<0.001**	13	6	11
Assaults & mugging	22	31	24	**<0.001**	3	2	3
Bullying in schools	25	19	24	**<0.001**	2	0	2
Drug activity	51	82	59	**<0.001**	19	34	23
Excessive drinking	52	84	60	**<0.001**	8	12	9
Rubbish lying about	45	62	50	**<0.001**	6	4	6
Noise and disturbance	27	45	32	**<0.001**	3	2	2
Poor street lighting	15	17	16	**0.003**	1	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. Only bullying in schools was perceived to be an issue that was more common in non-SIP areas and then the difference was not great.
- The SIP sample unambiguously viewed unemployment and drug activity as the most serious problems (34% for each) with excessive drinking identified by 12%. 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 who could comment regarded them as very poor, poor or adequate (rather than good or excellent). However:
    - Over half the sample regarded the provision of activities for young people and the provision of leisure and sports facilities as at best adequate; the percentage feeling this in SIP areas in relation to activities for young people (64%), and for leisure and sports facilities (58%), was significantly higher than in non-SIP ones (56% and 53% respectively).

- The provision of food shops and of childcare was regarded as substantially worse in SIP areas. In the SIP areas, 47% regarded food shop provision as at best adequate compared with 29% in non-SIP areas; the corresponding figures for childcare provision were 25% in SIP and 15% 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.

Table 8

RESPONDENT CHARACTERISTICS THAT COULD LEAD TO SOCIAL EXCLUSION BY SIP STATUS

RESPONDENT CHARACTERISTIC	PERCENTAGE IN CATEGORY			SIGNIFICANCE
	NON-SIP	SIP	GGHB	(Chi-square by SIP status) *p*
Has children under 17	31	35	32	0.100
Is a lone parent	7	12	8	**<0.001**
Lives in a household where no-one is employed (as % of total sample)	41	64	47	**<0.001**
Lives in a household where no-one is employed (as % of those of working age)	26	57	34	**<0.001**
Comes from an ethnic minority	2	4	3	0.018
Is separated or divorced	7	14	9	**<0.001**
Lives in a household without a telephone	6	23	10	**<0.001**
Lives in a household without access to a car	32	63	40	**<0.001**
Lives in a house with no central heating	7	14	9	**<0.001**
Cares for someone on a day to day basis for 8 hours or more (outwith work & ordinary childcare)	5	7	5	0.043
In need of home support service and does not receive it	4	6	4	*
Is of working age but has no formal qualifications	25	47	31	**<0.001**
Lives in a house which is perceived to be very/slightly overcrowded	12	11	11	0.490
All the household income comes from state benefits (as a % of total sample)	17	45	25	**<0.001**
All the household income comes from state benefits (as a % of working age)	15	42	22	**<0.001**
Income is under £100 per week (as % of those divulging income)	16	32	21	**<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 Greater Glasgow 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 Greater Glasgow. 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 (58%) 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 15% 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 five-fold from those in the higher income group of over £350 (8%) to those in the low income group of £50-£75 (39%).
- Clinical depression affected almost a quarter (23%) 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 1% in the highest one.
- The highest smoking prevalence (56%) is in the lowest income group, reducing to 26% in the highest.
- Likewise, not consuming the recommended 5 portions per day of fruit and vegetables shows an income gradient – 86% of those in the lowest income group not meeting the target compared with 64% 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. Over a third of those in the lowest income group had a negative perception of their quality of life; this reduced to only 3% 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 who drew *no* benefits, only 13% described their health over the past year as merely poor or fair compared with 55% of those whose total income came from state benefits. 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 21% respectively compared with only 7% and 8% in the whole Greater Glasgow Health Board sample).
- Being in receipt of Income Support is likewise related to lower health status.

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:
    - 16% of those assessing income as very adequate described their health as poor or fair compared with 48% in those assessing their income as very *in*adequate.
    - Likewise, only 2% with the 'very adequate' income described their quality of life negatively compared with 63% with the 'very *in*adequate'; and 21% smoked in the 'very adequate' group compared with 77% in the 'very *in*adequate' income group.
    - About a third of those assessing their income as *in*adequate were suffering from clinical depression and/or described themselves as having no control over life decisions compared with 7% and 8% in the total Greater Glasgow Health Board 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 24% 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 58% of those who would find it *impossible* to find that sum.
    - The differential is greater in relation to quality of life – only 3% of those experiencing *no* problem described their quality of life negatively compared with 54% of those who would find it *impossible* to meet an unexpected expense of £100.
    - Again, clinical depression and a feeling of having no control over life decisions was especially common amongst those who found it *impossible* to find £100 for an unexpected expense.

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 or not 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 26% in occupational group A describe their health over the past year as poor or fair compared with 55% in group E.
    - 8% in group A assess their quality of life negatively while 39% in group E do so.
    - 13% in group A have an illness or condition affecting their daily life compared with 32% in group E.
    - 2% in group A have clinical depression whereas 17% do so in group E.

  The health behaviours too show comparable gradients:
    - 11% in occupational group A smoke whereas the prevalence is 54% in group E.
    - 55% 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 6% of the employed define their quality of life in negative terms while 27% of the unemployed who are seeking work do so. However, of those who are sick or disabled and unable to work, 59% assess their quality of life negatively..
    - It is interesting that retirement seems to be associated with a more favourable quality of life (16% defining their quality of life negatively) than looking after the home and family (22% in this category view their quality of life in negative terms). Similarly, only 5% of the retired group, compared with 16% 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 24% and 11% of those groups respectively).

4. Health and educational attainment

- 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 78% of those who had qualifications described their health over the past year as excellent or good, only 56% of those without qualifications did so.
    - Among those who had qualifications, only 16% described themselves as having a condition or illness that affected their daily lives compared with 32% 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 GGHB 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

All the measures of social connectedness (with one exception) are significantly associated with quality of life and therefore need to be considered as key components of strategies to reduce social exclusion. However, whether they impact on the 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 while being widowed, divorced and (especially) separated, seems to depress it substantially.
    - 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 seems to be unrelated 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 (17% of lone parents compared with 7% 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). For example:
    - 48% of those feeling isolated rate their health over the past year as only poor or fair compared with 27% of those who do not feel isolated.
    - 21% of isolated people suffer from clinical depression compared with 4% in those who do not feel isolated.
    - 46% of isolated people rate their quality of life negatively in contrast to only 11% 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 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 general or 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. Therefore 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).
- 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 11% suggested that it did, the most common contributory components being noisy or difficult neighbours (by 27% of this group), the location of their home (23%), damp (21%), physical access to the building (7%), overcrowding (5%), difficulty moving round their home (5%) and dust (4%).

1. Overview

All 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 1) to the most deprived areas (DEPCAT 7). e.g.
  - 9% of respondents from DEPCAT 1 areas had an illness/condition that affected their daily lives compared with 29% in DEPCAT 7 areas.
  - 2% were clinically depressed in DEPCAT 1 while 10% were in DEPCAT 7.
  - 1% felt they had no control over their lives in DEPCAT 1 areas compared with 16% in DEPCAT 7.
  - Only 5% rated their quality of life negatively in DEPCAT 1 whereas 28% 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 Greater Glasgow, only 22% 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, 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 18% of those who felt very safe assessed their quality of life negatively compared with 32% who felt very unsafe.
    - Only 2% of those who felt very safe were clinically depressed compared with 15% of those who felt unsafe.
    - 3% of those feeling safe felt they had no control over the decisions affecting their lives while 16% 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:
    - 5% of those who liked their area very much were assessed as clinically depressed compared with 33% of those who disliked it very much.
    - 4% of those who were very positive about their area felt they had no control over decisions affecting their lives whereas the figure was as high as 42% among those who were very negative about it.
    - 20% of those who liked their area very much had a condition/illness affecting their daily lives compared with 49% of those who strongly disliked it.
    - Only 27% smoked amongst those who were very positive about their area compared with 57% amongst those who were very negative; likewise, 32% 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.

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APPENDICES

Appendix 1

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 of 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 Intefering 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 registred 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.

Appendix 2

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

	Self perceived health	Self perceived quality of life	Any condition which inteferes with daily living	Depression (HAD casness)	In control of decisions which afffect 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	0.004
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
Percieved adequacy of income	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
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	0.43
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	0.01	<0.001	<0.001	0.11
Whether lone parent	0.94	0.15	0.04	0.1	<0.001	0.17	<0.001
Whether feel isolated from friends and family	<0.001	<0.001	<0.001	<0.001	<0.001	0.001	0.18
Whether part of social network	0.14	<0.001	0.27	0.008	<0.001	0.001	<0.001
Whether feel belong to area	0.004	<0.001	0.02	0.09	<0.001	0.09	0.14
Whether local friends mean a lot	0.12	<0.001	0.03	0.11	<0.001	0.35	0.08
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)	0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Any change in area over past 5 years	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	0.004
Whether feel safe in area after dark	<0.001	<0.001	<0.001	<0.001	<0.001	0.12	0.03
Feelings about area (7 groups)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Feelings about area as place to bring up children(7 groups)	0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Most serious problem	0.51	<0.001	0.001	0.13	0.08	<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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