

## Health

- In 2004 life expectancy at birth in the United Kingdom was 77 years for males and 81 years for females. (Figure 7.1)
- The number of cases of mumps recorded in the United Kingdom in 2004 was almost 21,000 – four and a half times the number recorded in 2003. (Figure 7.6)
- In 2003, 40 per cent of women and 27 per cent of men in the highest fifth of the income distribution in England ate five or more portions of fruit and vegetables a day compared with 17 per cent of women and 14 per cent of men in the lowest fifth. (Figure 7.8)
- In 2004/05, 39 per cent of men and 22 per cent of women in Great Britain exceeded the recommended daily benchmarks for sensible drinking at least one day in the previous week. (Table 7.11)
- In 2004/05 smoking was most common among adults in routine and manual households (33 per cent of men and 30 per cent of women) and least prevalent among those in managerial and professional households (20 per cent of men and 17 per cent of women). (Page 107)
- In 2004/05 more than a third of men aged under 25 in Great Britain reported having more than one sexual partner in the previous year compared with a fifth of women aged 16 to 19 and a quarter aged 20 to 24. (Table 7.22)

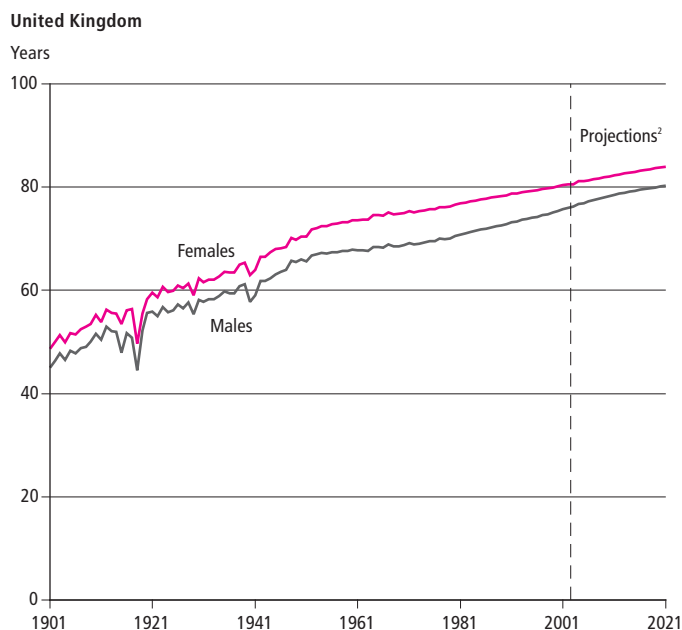
Over the past century improved nutrition, advances in medical science and technology, and the development of health services that are freely available to all have led to notable improvements in health in the United Kingdom. Many of the most common causes of morbidity and premature mortality are linked to a range of behaviours such as diet, sedentary lifestyles, smoking and drinking. Healthier lifestyles may reduce avoidable ill health, and so in recent years government health strategies throughout the United Kingdom have placed an increasing emphasis on promoting these.

### Key health indicators

Life expectancy is a widely used indicator of the state of the nation's health. Large improvements in expectation of life at birth have taken place over the past century for both males and females. In 1901 males born in the United Kingdom could expect to live around 45 years and females to around 49 (Figure 7.1). By 2004 life expectancy at birth had risen to almost 77 years for males and to just over 81 years for females. Life expectancy at birth is projected to continue rising, to reach 80 years for males and 84 years for females by 2021.

Life expectancy has increased at all ages over the past century, not just at birth. However, for those aged 65 there have been different patterns for men and women. Men aged 65 in 2004 could expect to live a further 16.7 years, an increase of

**Figure 7.1**  
**Expectation of life<sup>1</sup> at birth: by sex**



1 See Appendix, Part 7: Expectation of life. The average number of years a new-born baby would survive if he or she experienced age-specific mortality rates for that time period throughout his or her life.  
2 2004-based projections for 2005 to 2021.

Source: Government Actuary's Department

**Figure 7.2**  
**Life expectancy at birth:<sup>1</sup> by deprivation group<sup>2</sup> and sex, 1994–99**



1 See Appendix, Part 7: Expectation of life.  
2 See Appendix, Part 7: Area deprivation.

Source: Health Survey for England, Department of Health; Census 1991, Office for National Statistics; Small Area Health Statistics Unit, Imperial College

4.4 years since 1971. This compared with an increase of 1.7 years between 1901 and 1971. In contrast, there has been a more steady increase in life expectancy from the 1920s onwards for women aged 65. In 2004 they could expect to live for a further 19.6 years compared with 16.3 years in 1971, an increase of 3.3 years over this period.

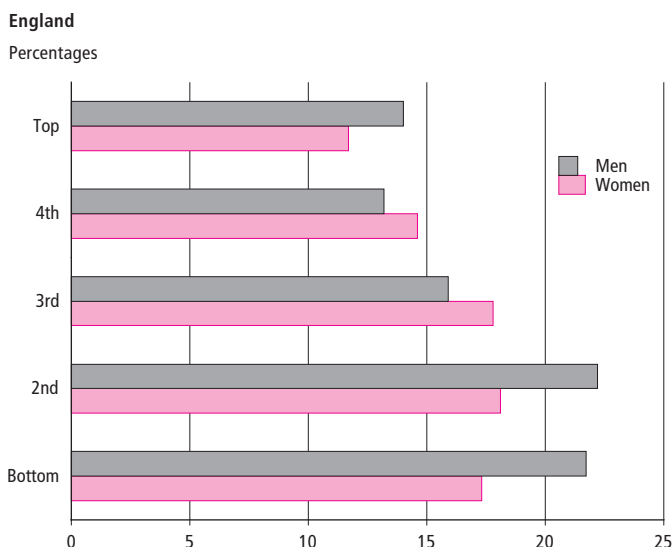
The association between health inequalities and socio-economic status is well established. Differences in life expectancy are often used to make comparisons of the health status of people living in advantaged and disadvantaged neighbourhoods and to track changes over time.

Results from a study of over 8,500 electoral wards in England revealed that averaged over the period 1994 to 1999, males living in the most deprived wards had a life expectancy at birth of 71.4 years, six years less than those living in the least deprived wards (Figure 7.2). Among females life expectancy at birth was also lowest among those living in the most deprived wards, at 78.0 years. The deprivation gap was not as great among females, with females in the least deprived wards having an extra three years of life expectancy compared with those living in the most deprived wards. Females in each deprivation group could expect to live longer than their male counterparts. This gap between the sexes widens with increasing levels of deprivation, from nearly four years in the least deprived wards to almost seven years in the most deprived wards.

Recent shifts in public policy have led to increased interest in the whole-life health experience, including longevity and health-related quality of life (see Appendix, Part 7: Healthy life expectancy). Although females can expect to live longer, they are also more likely to spend more years in poor health than males. Estimates for the period 1994 to 1999 show that at birth males and females living in the most deprived wards in England could expect to spend 22.0 years and 26.3 years respectively in poor health, around twice the number of years compared with those in the least deprived wards. The gap between the sexes in the number of years spent in poor health generally widened with levels of deprivation, from only 1.5 years between males and females in the least deprived wards to 4.3 years between those in the most deprived wards.

Cardiovascular disease (CVD), a generic term covering diseases of the heart or blood vessels, is a major cause of morbidity and mortality. The major types of CVD are angina and heart attack, known as coronary heart diseases, and stroke. These diseases are at least partially preventable, being associated with risk factors such as smoking, sedentary lifestyles, and diets that contain high levels of cholesterol, saturated fat and salt, and low levels of fresh fruit and vegetables.

**Figure 7.3**  
Prevalence<sup>1</sup> of cardiovascular disease: by quintile group of household income<sup>2</sup> and sex, 2003



1 Data are for those aged 35 and over and are age-standardised. See Appendix, Part 7: Standardised rates.  
2 Equivalised household income is a measure of household income that takes account of the number of persons in the household. Equivalised gross income has been used for ranking the households. See Appendix, Part 5: Equivalisation scales.

Source: Health Survey for England, Department of Health

The prevalence of CVD is related to income. In 2003, the prevalence of CVD for those aged 35 and over in England tended to increase as equivalised household income decreased, having taken account of the size of households (see Appendix, Part 5: Equivalisation scales). This trend was more apparent among men (Figure 7.3). Prevalence of CVD was between 13 and 14 per cent for men in the two highest income quintile groups, compared with 22 per cent in each of the two lowest quintile groups. Among women prevalence of CVD rose from 12 per cent in the highest income group to around 17 to 18 per cent in the three lowest income groups.

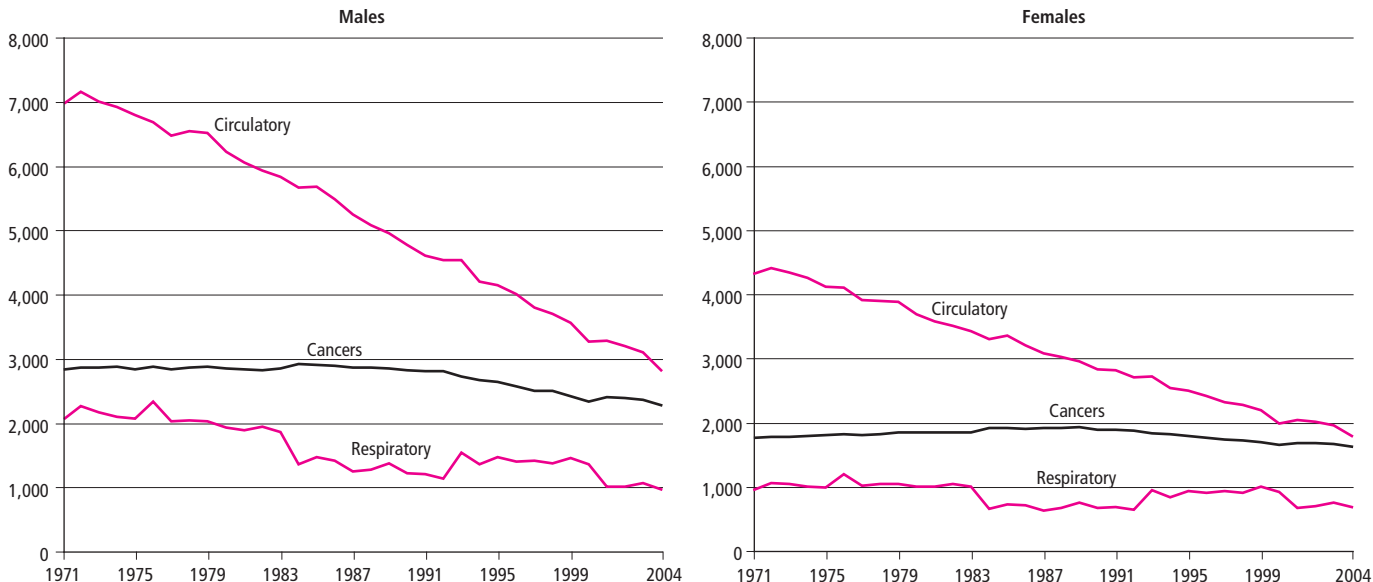
While circulatory diseases (which include CVD) have remained the most common cause of death in the United Kingdom over the past 30 years, they have also shown by far the greatest decline, particularly among males (Figure 7.4 overleaf). In 1971 age-standardised death rates were 6,900 per million males and 4,300 per million females. By 2004 these rates had fallen to 2,800 per million males and 1,800 per million females.

Cancers are the second most common cause of death among both sexes, but over the past 30 years have shown different trends for males and females. Death rates from cancer peaked in the mid 1980s for males at 2,900 per million, and by 2004 had fallen to 2,300 per million. Death rates from cancer for females did not reach a peak until the late 1980s since when

**Figure 7.4**  
**Mortality:<sup>1</sup> by sex and leading cause groups**

United Kingdom<sup>2</sup>

Rates per million population



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

2 Data for 2000 are for England and Wales only.

Source: Office for National Statistics

they have fallen gradually from 1,900 per million in 1989 to 1,600 per million in 2004. These variations in mortality trends partly reflect differences in the types of cancer men and women are likely to experience, the risk factors associated with them and the relative survival rates of different cancers. Cancer is a more common cause of death for women aged under 65 than it is for men. This is mainly because of breast cancer, which is the most common cause of cancer death among women aged under 65, and also because the cancers that are most likely to be diagnosed among men (lung and prostate) usually cause death at a later age.

The reduction in the infant mortality rate has been one of the major factors contributing to an overall increase in life expectancy over the past century (see Figure 7.1). In 1921, 84.0 children per 1,000 live births in the United Kingdom died before the age of one; by 2004 the rate was 5.0 per 1,000 live births. Projections suggest this rate will continue falling to 4.5 per 1,000 live births in 2021.

The development of vaccines and immunisation programmes have played an important part in reducing infant mortality rates. Nearly all children in the United Kingdom are now immunised against tetanus, diphtheria, poliomyelitis, whooping cough, haemophilus influenzae b, meningitis C and measles, mumps and rubella. Current government immunisation targets

are for 95 per cent of children to be immunised against these diseases by the age of two.

The measles/mumps/rubella (MMR) vaccine was introduced in the United Kingdom in 1988 and coverage levels of 90 per cent and over were achieved by the early 1990s (Table 7.5). However, in recent years, concerns over the safety of the MMR vaccine have led to a fall in the proportion of children

**Table 7.5**  
**Immunisation of children by their second birthday<sup>1</sup>**

United Kingdom	Percentages				
	1981 <sup>2</sup>	1991/92	1994/95	1999/2000	2004/05
Tetanus	83	94	93	95	94
Diphtheria	83	94	95	95	94
Poliomyelitis	82	94	95	94	94
Whooping cough	45	88	95	94	94
Measles, mumps rubella <sup>3</sup>	54	90	91	88	82

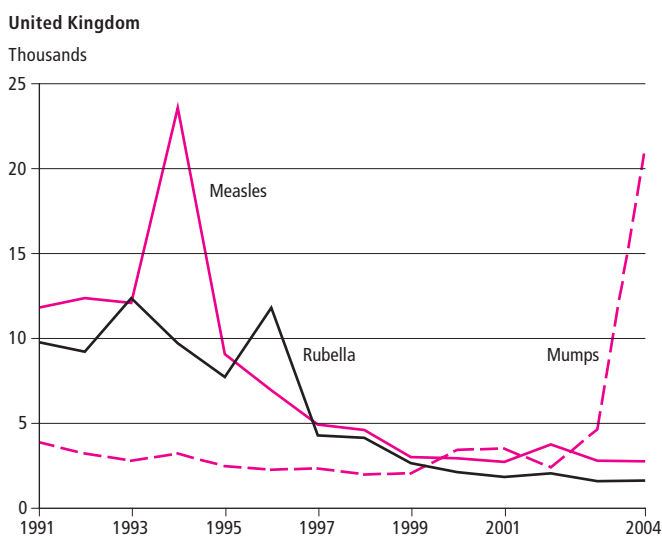
1 Children reaching and immunised by their second birthday.

2 Data exclude Scotland.

3 Includes measles-only vaccine for 1981. Combined vaccine was not available prior to 1988.

Source: Department of Health; National Assembly for Wales; National Health Service in Scotland; Department of Health, Social Services and Public Safety, Northern Ireland

**Figure 7.6**  
**Notifications of measles, mumps and rubella**



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

immunised against MMR. In 2004/05, 82 per cent of children had received the vaccine by their second birthday compared with 91 per cent in 1994/95. The regional variations in uptake were generally small, ranging from 81 to 88 per cent in most regions. However uptake in London was much lower, at only 71 per cent.

Over the past ten years there have been contrasting trends in the occurrence of the most commonly diagnosed childhood infections. A measles epidemic in 1994 in the United Kingdom had 23,500 notifications, twice the level of 1993. Since then, the underlying downward trend resumed (Figure 7.6).

In 2004 the number of cases of mumps notified in the United Kingdom was almost 21,000 – four and a half times the number recorded in 2003 and almost five times the combined 2004 total of measles and rubella notifications. Although mumps has historically been a disease most commonly experienced in early childhood, in 2004 over 80 per cent of cases were diagnosed among those aged 15 and over.

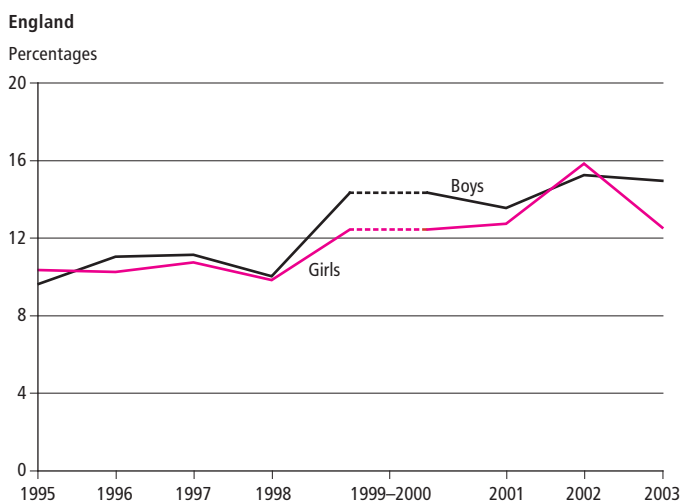
Rubella (also referred to as German measles), like measles, often occurs in epidemics in populations where vaccination has not been in use. The last epidemic occurred in 1996 when there were just under 12,000 notifications in the United Kingdom. Since 2000 the annual number of notifications has been between 1,500 and 2,100. The disease is rarely serious except in pregnant women, where it may lead to abnormalities in unborn babies.

### Obesity, diet and physical activity

Obesity is linked to heart disease, diabetes and premature death. The increase in the proportion of adults who are overweight, obese or morbidly obese (when a person’s weight reaches life threatening levels) has been well documented. In recent years the same trends have become apparent among children. Between 1995 and 2003 levels of obesity among children aged two to ten in England increased from around 10 per cent to 14 per cent (see Appendix, Part 7: Body mass index). Overall, levels of obesity were similar for both boys and girls. For boys aged two to ten, obesity rose from 10 per cent in 1995 to 15 per cent in 2003, while for girls in this age group the proportion classified as obese increased from 10 per cent to 16 per cent in 2002, before falling to 13 per cent in 2003 (Figure 7.7). Increases in obesity prevalence were most marked for children aged eight to ten, rising from 11 per cent in 1995 to 20 per cent in 2002, before falling to 17 per cent in 2003.

Levels of childhood obesity differ between income groups (see Appendix, Part 5: Equivalisation scales). In 2001–02, children aged two to ten living in households in the lowest two quintile groups had higher rates of obesity (16 per cent) than children from households in the top two income quintile groups (13 per cent). There was also an association between children’s obesity and that of their parents. Around 20 per cent of children living in households where both parents were either overweight or obese were themselves obese compared with 7 per cent of children living in households where neither parent was overweight or obese.

**Figure 7.7**  
**Proportion of children<sup>1</sup> who are obese:<sup>2</sup> by sex**



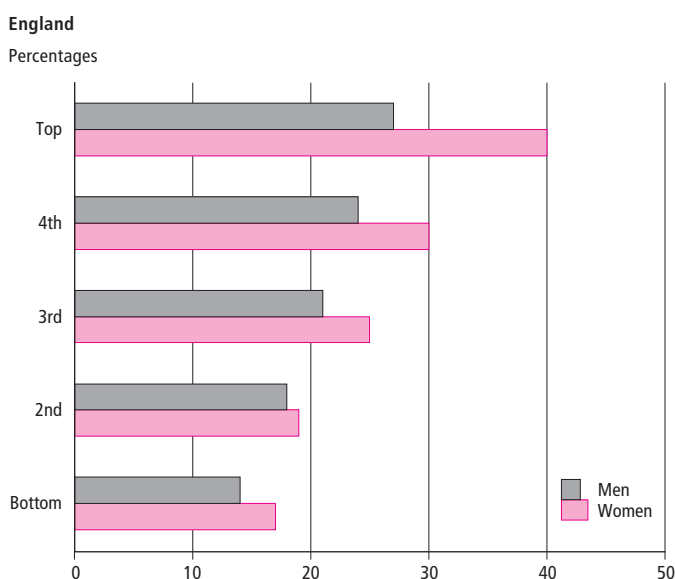
1 Children aged two to ten years.  
2 Using the UK national Body mass index percentile classification. See Appendix, Part 7: Body mass index.

Source: Health Survey for England, Department of Health

Diet has an important influence on weight and general health. A diet that is rich in complex carbohydrates (such as bread, cereals and potatoes), wholegrain cereals, fruit and vegetables, and low in total fat and salt can help to reduce the risk of obesity, diabetes, cardiovascular disease and some cancers. The Department of Health recommends that a healthy diet should include at least five portions a day of a variety of fruit and vegetables (excluding potatoes). In 2003, 22 per cent of men and 26 per cent of women in England consumed five or more portions a day, while 9 per cent of men and 6 per cent of women consumed no fruit and vegetables.

Household income may affect the affordability of a healthy diet. In 2003 consumption of the recommended five daily portions of fruit and vegetables in households in England decreased among both sexes as household income fell (Figure 7.8). Women consumed more fruit and vegetables than men at all income levels, though the gap decreased as income went down. Of women in the highest income quintile group, 40 per cent ate five or more portions a day compared with 17 per cent in the lowest income group. Among men, 27 per cent in the highest income group consumed at least five portions a day compared with 14 per cent in the lowest income group.

**Figure 7.8**  
**Consumption of five or more portions of fruit and vegetables a day: by sex and income group,<sup>1</sup> 2003**



<sup>1</sup> Equivalised household income is a measure of household income that takes account of the number of persons in the household. Equivalised gross income has been used for ranking the households. See Appendix, Part 5: Equivalisation scales. Data are age standardised. See Appendix, Part 7: Standardised rates.

Source: Health Survey for England, Department of Health

High salt intake has been linked to high blood pressure, which is a risk factor for cardiovascular disease. In the United Kingdom the Scientific Advisory Committee on Nutrition recommended in 2003 a reduction in salt intake among adults from 9 grams to 6 grams per day, with lower levels set for children. On this advice, the Government has set a target for adult salt intake to be reduced to 6 grams a day by 2010. Around three quarters of salt intake comes from processed foods. The other sources are salt used in cooking and salt added at the table. In 2003 over half of men and women in England used salt in cooking (Table 7.9). This practice was most common among men and women aged 75 and over, two thirds of whom added salt during cooking. A higher proportion of men (24 per cent) than women (15 per cent) added salt to food at the table without tasting it first, while a greater proportion of women (46 per cent) than men (38 per cent) reported that they never or rarely used salt at the table.

The use of salt in cooking increased as household income decreased, even when the age distribution of the population is adjusted for; 53 per cent of men in the highest income quintile group used salt to cook compared with 64 per cent of men in the lowest income group. For women the proportions were 52 per cent and 59 per cent respectively.

Evidence suggests that regular physical activity is related to reduced incidence of many chronic conditions, particularly cardiovascular disease, obesity, type 2 diabetes, some types of cancer and osteoporosis. The Chief Medical Officer recommends that adults should do moderately intense physical activity for at least 30 minutes a day on five or more days a week. This target can be accumulated in short periods of ten minutes to reach the daily target.

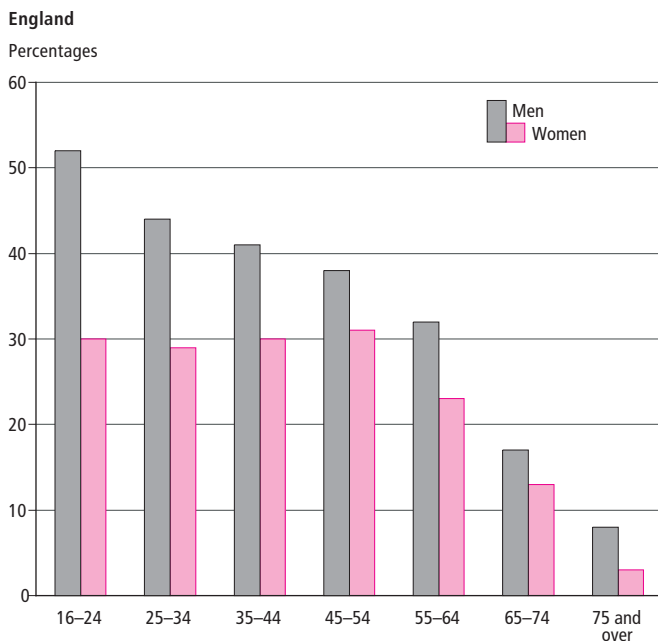
**Table 7.9**  
**Use of salt in cooking and at the table:<sup>1</sup> by sex, 2003**

England	Percentages	
	Men	Women
<b>During cooking</b>		
Adds salt	56	53
<b>After cooking</b>		
Generally adds salt, without tasting	24	15
Tastes, generally adds salt	14	13
Tastes, occasionally adds salt	24	26
Rarely, or never, adds salt	38	46
<b>Total (after cooking)</b>	<b>100</b>	<b>100</b>

<sup>1</sup> Data are age-standardised. See Appendix, Part 7: Standardised rates.

Source: Health Survey for England, Department of Health

**Figure 7.10**  
**Proportions achieving recommended levels of physical activity:<sup>1</sup> by sex and age, 2003**



<sup>1</sup> Participation in moderately intense activity for at least 30 minutes on five or more occasions a week.

Source: Health Survey for England, Department of Health

In 2003, 36 per cent of men aged 16 and over in England achieved the recommended levels of physical activity compared with 24 per cent of women. For men who had achieved this level in the four weeks before interview, the most common activities were sports and exercise (40 per cent), heavy housework (38 per cent) and walking (32 per cent). For women heavy housework was the most commonly reported activity (53 per cent) followed by sports and exercise (34 per cent) and walking (25 per cent).

The proportion of men achieving the recommended level of physical activity declined with age, from 52 per cent of men aged 16 to 24 to 8 per cent of those aged 75 and over (Figure 7.10). In contrast, the proportion of women achieving the recommended levels of physical activity remained stable at around 30 per cent of all those aged 16 to 54, and decreased thereafter to 3 per cent for women aged 75 and over. These differences largely reflect the greater participation in sports activities by men at younger ages.

Physical activity levels are related to a person's body mass index (BMI) (see Appendix, Part 7: Body mass index). The age-standardised proportion of men achieving the recommended weekly level of physical activity in 2003 was around 40 per cent for those who were underweight, normal weight and overweight. However this fell to 33 per cent for those who

were obese and 21 per cent for those who were morbidly obese. Around 30 per cent of women who were underweight and normal weight achieved the recommended weekly activity target compared with 19 per cent of those who were obese and 16 per cent who were morbidly obese.

**Alcohol, drugs and smoking**

The consumption of alcohol in excessive amounts can lead to ill health, with an increased likelihood of problems such as high blood pressure, cancer and cirrhosis of the liver. The Department of Health advises that consumption of three to four units of alcohol a day for men and two to three units a day for women should not lead to significant health risks. Consistently drinking more than these levels is not advised because of the associated health risks.

In 2004/05, two fifths of men and a fifth of women in Great Britain exceeded the recommended amount of alcohol on at least one day during the week before interview (Table 7.11). Men in all age groups were more likely than women to have exceeded these levels, but the difference between the sexes was smallest in the 16 to 24 age group. Young people were also more likely than older people to have exceeded the recommended daily units, though the relationship between age and excess consumption was stronger for women than for men. The proportion of women aged 16 to 24 who had

**Table 7.11**  
**Adults exceeding specified levels of alcohol:<sup>1</sup> by sex and age, 2004/05**

Great Britain	Percentages				
	16-24	25-44	45-64	65 and over	All aged 16 and over
<b>Men</b>					
More than 4 units and up to 8 units	15	17	19	13	16
More than 8 units	32	31	18	7	22
More than 4 units	47	48	37	20	39
<b>Women</b>					
More than 3 units and up to 6 units	15	16	15	4	13
More than 6 units	24	13	6	1	9
More than 3 units	39	28	20	5	22

<sup>1</sup> On at least one day in the previous week. Current Department of Health advice is that consumption of between three and four units a day for men and two to three units for women should not lead to significant health risks.

Source: General Household Survey, Office for National Statistics



exceeded recommended levels of alcohol on at least one day during the previous week was twice that of those aged 45 to 64 and eight times that of those aged 65 and over. The proportion for men remained relatively similar up to age 44, after which it fell sharply.

Drinking moderate amounts regularly is considered to be better for a person's health than drinking to excess occasionally. 'Binge' drinking is defined as consuming twice the recommended daily limits. Men aged 16 to 24 are the most likely to binge drink, 32 per cent having done so in the previous week in 2004/05, although this proportion was 5 percentage points lower than in 2003/04. Since 1998/99 the gap between the proportion of men and women in this age group who binge drink has narrowed from 15 percentage points to 8 percentage points.

The proportion of women consuming more than the recommended daily units of alcohol is considerably higher among those in managerial and professional occupational groups than those in routine and manual groups. In 2004/05, 28 per cent of women in the large employer and higher managerial group had exceeded the daily limit in the previous week compared with 19 per cent of women in the routine group. Higher proportions of men exceeded the recommended levels in each group, although the relationship with socio-economic classification was not so apparent (see Appendix, Part 1: National Statistics Socio-economic Classification).

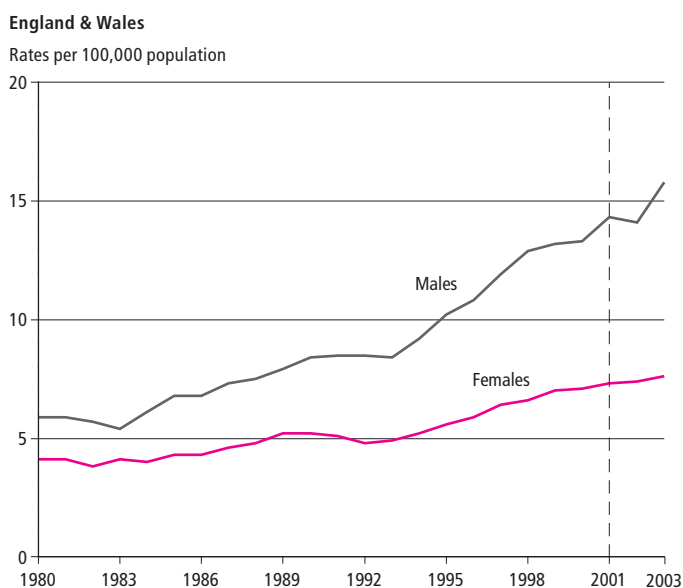
There is growing concern about the amount of alcohol consumed by children. Although the prevalence of drinking has remained at similar levels since 1990, between 1990 and 2000 the amount consumed per week almost doubled and has remained at around this level. In 2004 the mean weekly consumption of boys and girls aged 11 to 15 in England who had drunk alcohol in the previous week was around ten units, compared with around five units in 1990. Between 1990 and 2004 there was an increase in the proportion of boys who had never had a drink, rising from 35 per cent to 41 per cent. The proportion of girls who had never had a drink in 2004 was also 41 per cent, a similar level to 1990.

The number of alcohol-related deaths in England and Wales, which rose throughout the 1980s and 1990s, has continued to rise in more recent years, from 5,970 in 2001 to 6,580 in 2003. The death rate for alcohol-related deaths also increased, from 10.7 per 100,000 population in 2001 to 11.6 per 100,000 in 2003.

Alcohol-related deaths are more common for males than females. In 2003 males accounted for almost two thirds of the total number of alcohol-related deaths. Between 1980 and

**Figure 7.12**

**Death rates<sup>1</sup> from alcohol-related causes:<sup>2</sup> by sex**



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

2 See Appendix, Part 7: Alcohol-related causes of death.

Source: Office for National Statistics

2003 the death rate among males rose by over two and a half times to reach 15.8 per 100,000 (Figure 7.12). During the same period the death rate for females almost doubled to reach 7.6 per 100,000.

During the period 2001–03 there were considerable regional variations in alcohol-related deaths in England and Wales. The highest rates were found in the North West and North East while the lowest were in the East of England, South West and South East. The rate for the North West was almost double that for the East of England (15.1 and 7.7 deaths per 100,000 respectively). The West Midlands, London and Wales also had rates that were above the average for England and Wales.

The misuse of drugs is both a serious social and health problem. Results from the 2004/05 British Crime Survey indicate that 16 per cent of men and 9 per cent of women aged 16 to 59 in England and Wales had taken an illicit drug in the previous year. Young people were more likely than older people to misuse drugs; 33 per cent of men and 21 per cent of women aged 16 to 24 had done so in the previous year (Table 7.13). Cannabis remained the most commonly used drug among young people, used by 30 per cent of men and 18 per cent of women in the previous year. Ecstasy and cocaine were the most commonly used Class A drugs for this age group, each taken by 7 per cent of men and 3 per cent of women. Between 1996 and 2004/05



**Table 7.13**  
**Prevalence of drug misuse by young adults<sup>1</sup> in the previous year: by drug category and sex, 1996 and 2004/05**

England & Wales	Percentages			
	Men		Women	
	1996	2004/05	1996	2004/05
Cannabis	30	30	22	18
Ecstasy	9	7	4	3
Cocaine	2	7	-	3
Amphetamines	15	4	9	3
Magic mushrooms or LSD	9	5	2	2
All Class A drugs <sup>2</sup>	13	11	6	5
Any drug <sup>3</sup>	34	33	25	21

1 Those aged 16 to 24 years.  
 2 Includes heroin, cocaine (both cocaine powder and 'crack'), ecstasy, magic mushrooms, LSD and un-prescribed use of methadone.  
 3 Includes less commonly used drugs not listed in the table.

Source: British Crime Survey, Home Office

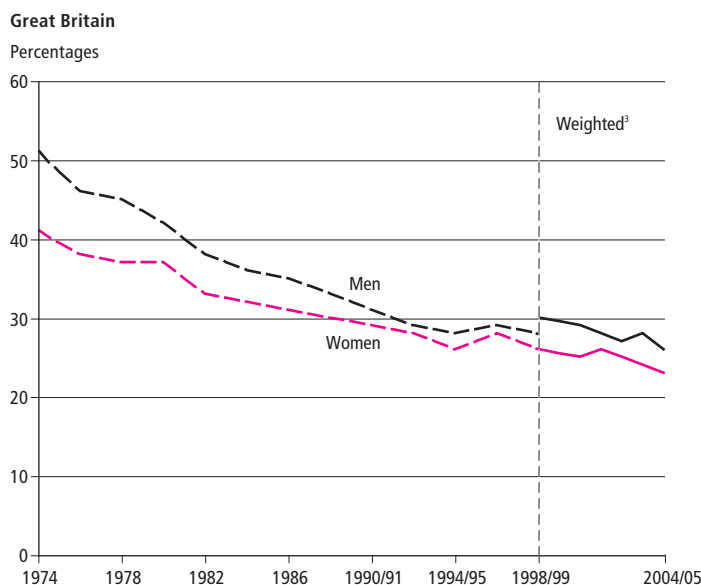
there was a decline in the proportions of young people using amphetamines. However, cocaine use during this period increased among both sexes (see also Table 9.8).

Drug misuse also occurs among those under the age of 16. In a survey of schoolchildren in England in 2004, almost a fifth of boys and girls aged 11 to 15 reported that they had taken illicit drugs in the last year. The proportion of those taking drugs increased with age, from 1 in 20 of all 11 year olds to 1 in 3 of all 15 year olds. Cannabis was the most common drug, used by 11 per cent of pupils aged 11 to 15 in the previous year. Six per cent reported using volatile substances such as gas, glue, aerosols or solvents in the last year.

Over the past 30 years there has been a substantial decline in the proportion of adults aged 16 and over in Great Britain who smoke cigarettes. The reduction has been greater among men, though from a higher initial level, so that the difference in prevalence between men and women has narrowed considerably. In 1974, 51 per cent of men aged 16 and over smoked compared with 41 per cent of women. By 2004/05, 26 per cent of men and 23 per cent of women were smokers (Figure 7.14). Much of the decline occurred in the 1970s and early 1980s, after which the rate of decline slowed.

The trends show different patterns for smoking. Among men the greatest fall in smoking prevalence has been in the oldest age group. Between 1974 and 2004/05 the proportion of men aged 60 and over who smoked fell by 29 percentage points from 44 per cent to 15 per cent. In contrast, for women the greatest

**Figure 7.14**  
**Prevalence of adult<sup>1</sup> cigarette smoking:<sup>2</sup> by sex**



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

Source: General Household Survey, Office for National Statistics

decline in smoking over this period was among those aged 50 to 59. In 1974, 48 per cent of this age group smoked; by 2004/05 the proportion had fallen to 22 per cent. In 2004/05 a similar proportion of men and women smoked in the youngest (16 to 19) and oldest (60 and over) age groups. In all other age groups smoking prevalence was higher among men.

Smoking is strongly associated with socio-economic classification, being far more common among those in routine and manual occupational groups than those in managerial and professional groups. In 2004/05, 33 per cent of men and 30 per cent of women living in routine or manual households were smokers compared with 20 per cent of men and 17 per cent of women in managerial and professional households (Table 7.15 overleaf). The Government has set a target for England to reduce the proportion of smokers in households headed by someone in a manual occupation from 32 per cent in 1998 to 26 per cent by 2010.

Quitting smoking can lead to better health and extended life expectancy. In 2004, 73 per cent of smokers in Great Britain said they wanted to give up. Older smokers were the least likely to want to stop smoking (43 per cent of smokers aged 65 and over compared with 80 per cent of smokers aged 25 to 44). As smoking prevalence is lower among older age groups, this suggests that smokers in these age groups who may have

**Table 7.15**  
**Prevalence of cigarette smoking: by sex and socio-economic classification<sup>1</sup>**

Great Britain	Percentages			
	Men		Women	
	2001/02	2004/05	2001/02	2004/05
Managerial and professional				
Large employers and higher managerial occupations	16	19	15	13
Higher professional occupations	17	16	13	11
Lower managerial and professional occupations	24	22	20	20
Intermediate				
Intermediate occupations	28	26	26	22
Small employers/ own account workers	30	25	26	20
Routine and manual				
Lower supervisory and technical occupations	33	30	29	26
Semi-routine occupations	33	34	32	30
Routine occupations	38	33	33	33
All people <sup>2</sup>	28	26	26	23

1 Of the household reference person. See Appendix, Part 1: National Statistics Socio-economic Classification.

2 Where the household reference person was a full-time student, had an inadequately described occupation, had never worked or was long-term unemployed these are not shown as separate categories, but are included in the figure for all people aged 16 and over.

Source: General Household Survey, Office for National Statistics

wanted to give up smoking are likely to have already done so by the age of 65, or to have died.

Although smokers may have many different reasons for wishing to stop, the main reasons given for both sexes were health related. In 2004, 91 per cent of men and 85 per cent of women who wanted to quit mentioned at least one health reason for doing so. Smokers with children under 16 years of age in the household were more likely to want to quit than those without children (78 per cent and 71 per cent respectively). For those with children in the household, the belief that second-hand smoking could have a damaging effect on children's health was a major motivation to stop, given by almost 40 per cent of both men and women (Table 7.16).

Trends in lung cancer incidence and mortality are strongly linked to those of cigarette smoking, which is by far the greatest single risk factor for the disease, being the cause of 90 per cent of cases

**Table 7.16**  
**Main reasons for wanting to stop smoking:<sup>1</sup> by sex and presence of children in the household, 2004**

Great Britain	Percentages <sup>2</sup>		
	Children under 16 in household	No children in household	All
<b>Men</b>			
Better for health in general	76	70	72
Less risk of getting smoking-related illness	32	25	27
Present health problems	10	16	14
Financial reasons	14	24	21
Family pressure	21	14	16
Harms children	39	5	15
Doctor's advice	1	6	5
Pregnancy of partner	1	1	1
Other	1	-	1
<b>Women</b>			
Better for health in general	60	69	66
Less risk of getting smoking-related illness	29	27	28
Present health problems	16	17	17
Financial reasons	28	33	31
Family pressure	21	20	20
Harms children	37	4	16
Doctor's advice	7	6	6
Pregnancy	1	1	1
Other	2	3	3

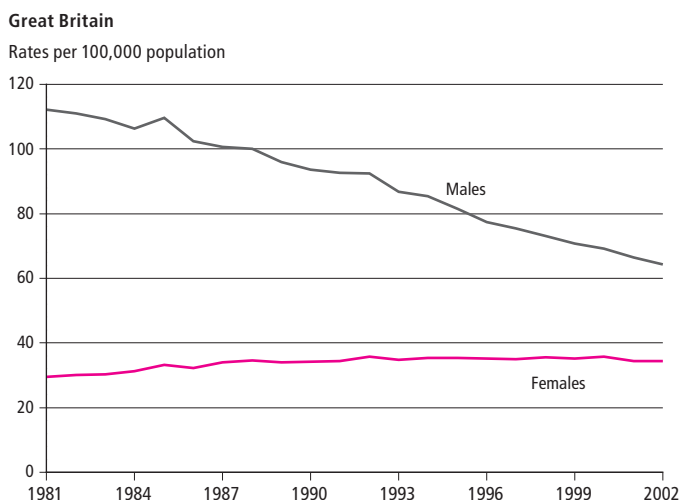
1 Smokers who want to stop smoking.

2 Percentages do not add up to 100 per cent as respondents could give more than one answer.

Source: Omnibus Survey, Office for National Statistics

among men and 80 per cent of cases among women in 2004. The incidence of lung cancer has fallen sharply in males since the early 1980s, mainly as a result of the decline in cigarette smoking (see Figure 7.14). In 1981 the age-standardised incidence rate in Great Britain was 112 per 100,000 male population. By 2002 the rate had fallen by 43 per cent to 64 per 100,000 (Figure 7.17). Lung cancer incidence rates among females were lower, largely as a consequence of lower levels of smoking in earlier years. Although similar proportions of men and women smoke, this has not always been the case. Larger proportions of men than women smoked during the 1970s and 1980s, becoming more equal in the 1990s (see Figure 7.14). This has resulted in a lower incidence of lung cancer among females and has also contributed to a different trend. The age-standardised incidence rate of lung cancer in females rose gradually to reach a plateau of around 35 per 100,000 population from 1993.

**Figure 7.17**  
**Standardised incidence rates<sup>1</sup> of lung cancer: by sex**



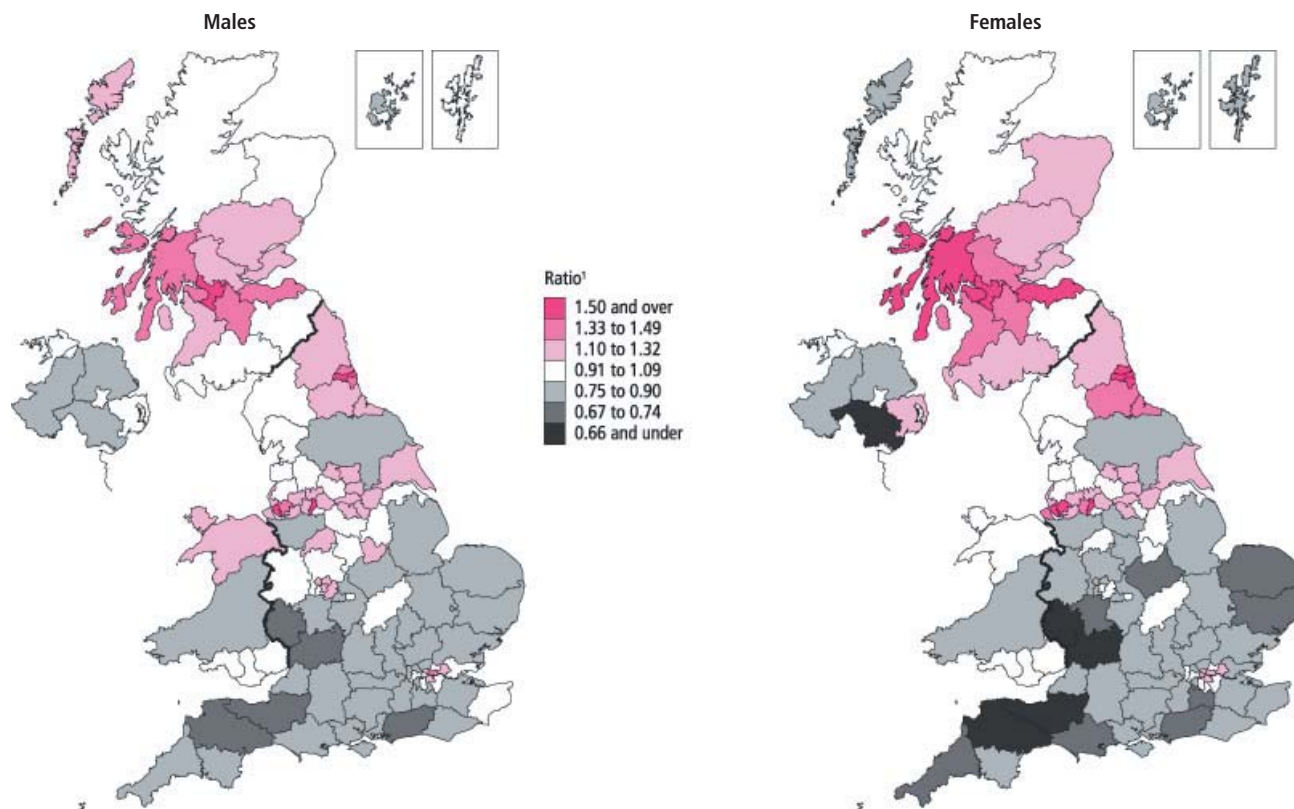
1 Age standardised using the European standard population. See Appendix, Part 7: Standardised rates.

Source: Office for National Statistics; Welsh Cancer Intelligence Centre and Surveillance Unit; Scottish Cancer Registry

Research has shown that there are distinct regional variations in the incidence of lung cancer across the United Kingdom. Between 1991 and 1999 the highest incidence rates were in Scotland, where the rates were 108 per 100,000 males and 52 per 100,000 females. Compared with the overall UK and Ireland average these rates were 34 per cent higher for males and 48 per cent higher for females (Map 7.18). Within England there were further regional variations, with incidence rates for lung cancer being higher than average in the North West, and Northern and Yorkshire regions, and below average in the South West, South East and Eastern regions. Many of the areas with the highest levels of deprivation corresponded to areas with high incidence of, and mortality from, lung cancer: Greater Glasgow; Gateshead and South Tyneside; Liverpool; Manchester; and East London and the City of London.

Lung cancer has one of the lowest survival rates of any cancer, with little variation by region or deprivation area. This is because of the frequently advanced stage of the disease at diagnosis, the aggressiveness of the disease, and the small number of patients for whom surgery is appropriate.

**Map 7.18**  
**Incidence of lung cancer:<sup>1</sup> by sex, 1991–1999<sup>2</sup>**



1 Ratio of directly age-standardised rate in health authority to UK and Ireland average. Data originally published in the Cancer Atlas of the United Kingdom and Ireland 1991–2000.

2 Health authorities in England and Wales, health boards in Scotland and health and social services boards in Northern Ireland. All boundaries are as at 2001.

Source: National Cancer Intelligence Centre; Welsh Cancer Intelligence and Surveillance Unit; Scottish Cancer Registry; Northern Ireland Cancer Registry; National Cancer Registry of Ireland

### Mental health

Mental health problems may result in poorer social functioning and physical health, and higher rates of mortality. In 2000 about one in six people aged 16 to 74 living in private households in Great Britain had a neurotic disorder in the seven days prior to interview, such as depression, anxiety or a phobia.

In recent years there has been a growing awareness of the mental health problems experienced by children and young people. In 2004, 10 per cent of 5 to 16 year olds living in private households in Great Britain had a clinically recognised mental disorder. Overall, boys were more likely to have a mental disorder than girls. While boys were more likely than girls to have a conduct or hyperkinetic disorder, they were slightly less likely than girls to have an emotional disorder (Table 7.19). The prevalence of mental disorder was higher among older children of both sexes. Among five to ten year olds, 10 per cent of boys and 5 per cent of girls had a mental disorder. The proportions were larger for 11 to 16 year olds, at 13 and 10 per cent respectively.

There are socio-demographic variations in the prevalence of mental disorders in children. Children who lived in a lone-parent family in Great Britain were twice as likely to experience a mental disorder as those living with married parents in 2004. Prevalence was highest for boys who lived with a lone parent who was widowed, divorced or separated (20 per cent) (Figure 7.20). Among children who lived with married parents the proportions were lower, 8 per cent for boys and 6 per cent for girls. There was also a higher prevalence of mental disorder in children who lived in reconstituted families (14 per cent) compared with those containing no stepchildren (9 per cent).

The type of area in which children lived was also related to the likelihood of experiencing a childhood mental disorder. A higher proportion of those living in areas classed as 'hard pressed' had a mental disorder (15 per cent) compared with those living in areas classed as 'wealthy achievers' or 'urban prosperity' (6 per cent and 7 per cent respectively).

Children with mental disorders are more likely than other children to have time off school. In 2004, 17 per cent of those with an emotional disorder, 14 per cent with conduct disorders and 11 per cent with hyperkinetic disorders had been absent from school for over 15 days in the previous term. This compared with 4 per cent for other children. Around a third of children with a conduct disorder had been excluded from school and nearly a quarter had been excluded more than once (see also Table 3.7).

Mental illness is a risk factor for suicide. Trends in suicide rates have varied by age group and sex in the United Kingdom over

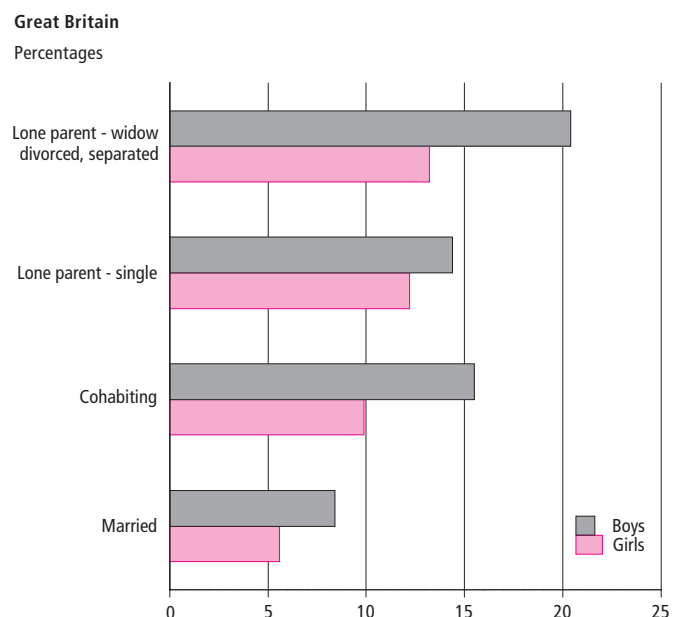
**Table 7.19**  
Prevalence of mental disorders<sup>1</sup> among children:<sup>2</sup> by type of disorder, sex and age, 2004

Great Britain	Percentages			
	Boys		Girls	
	5-10	11-16	5-10	11-16
Emotional disorder <sup>3</sup>	2.2	4.0	2.5	6.1
Conduct disorder	6.9	8.1	2.8	5.1
Hyperkinetic disorder <sup>4</sup>	2.7	2.4	0.4	0.4
Less common disorder <sup>5</sup>	2.2	1.6	0.4	1.1
Any disorder <sup>6</sup>	10.2	12.6	5.1	10.3

- 1 See Appendix, Part 7: Mental disorders.
- 2 Aged 5 to 16 years and living in private households.
- 3 Includes separation anxiety, specific phobia, social phobia, panic disorder, agoraphobia, post traumatic stress disorder, obsessive-compulsive disorder and depression.
- 4 Characterised by behaviour that is hyperactive, impulsive or inattentive.
- 5 Includes autism, tics, eating disorders and selective mutism.
- 6 Individual disorder categories may sum to more than the total as more than one disorder may be reported.

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

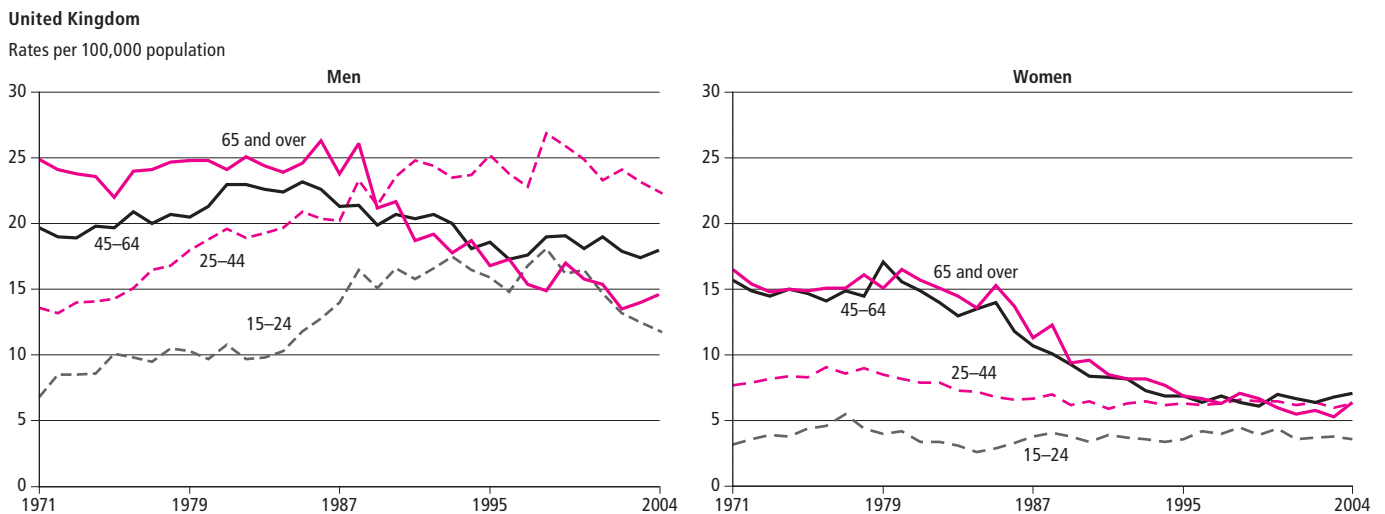
**Figure 7.20**  
Prevalence of mental disorders<sup>1</sup> among children:<sup>2</sup> by sex and family type, 2004



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

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

**Figure 7.21**  
**Suicide rates:<sup>1</sup> by sex and age**



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

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

the last 30 years (Figure 7.21). Until the end of the 1980s older men aged 65 and over had the highest suicide rates. In 1986 the suicide rate among men aged 65 and over peaked at 26 per 100,000 population and then fell to 15 per 100,000 in 2004. In contrast suicide rates for younger men rose, in particular for those aged 25 to 44, for whom the suicide rate almost doubled from 14 per 100,000 in 1971 to a peak of 27 per 100,000 in 1998. The suicide rate among men in this age group has since declined, but in 2004 remained the highest, at 23 per 100,000.

There is a distinct difference in suicide rates between men and women. In 2004 the age-standardised rate for all men aged 15 and over was 18 per 100,000, three times that of women at 6 per 100,000. This gap has widened considerably since 1973, when the suicide rate among all men aged 15 and over was around one and a half times that of all women. Among women aged 45 and over, suicide rates have fallen since the early 1980s. However for younger women the rates have remained fairly stable since the mid-1980s.

The likelihood of a person committing suicide depends in part on the ease of access to, and knowledge of, effective means of doing so. In 2003 the main methods of suicide for men in England and Wales were: hanging and suffocation (47 per cent); drug-related poisoning (18 per cent); and 'other poisoning' (8 per cent), which mainly comprised poisoning by motor vehicle exhaust gas. Among women the most common methods of suicide were: drug-related poisoning (44 per cent); hanging and suffocation (26 per cent); and drowning (7 per cent).

**Sexual health**

Since the late 1990s the increase in the prevalence of sexually transmitted diseases, especially among young people, has become a major public health concern across the United Kingdom. Those who have unprotected sex and multiple sexual partners are at the greatest risk of contracting a sexually transmitted infection. During 2004/05 men were more likely than women in Great Britain to have had more than one sexual partner in the previous year for all age groups aged under 50 (Table 7.22).

**Table 7.22**  
**Number of sexual partners<sup>1</sup> in the previous year: by sex and age, 2004/05**

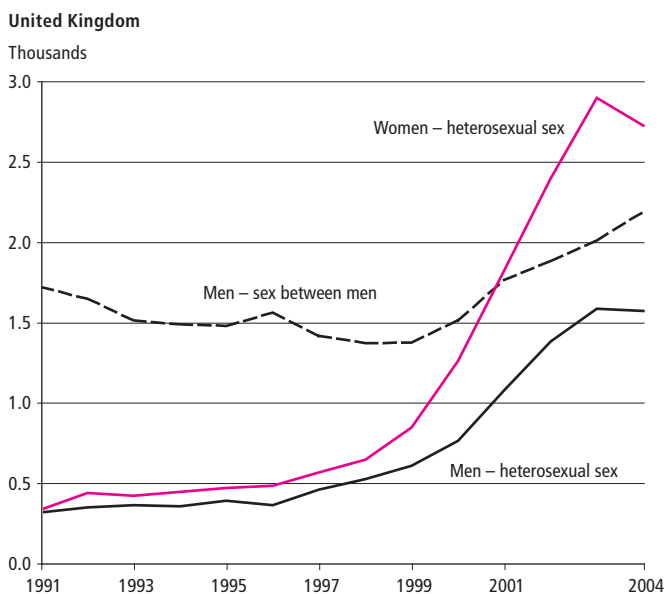
Great Britain	Percentages				
	16-19	20-24	25-34	35-44	45-49
<b>Men</b>					
No partners	34	13	7	6	7
1 partner	28	53	71	85	88
2 or 3 partners	29	24	14	6	4
4 or more partners	9	10	8	3	2
All aged 16-49	100	100	100	100	100
<b>Women</b>					
No partners	28	9	7	9	13
1 partner	50	62	85	87	84
2 or 3 partners	16	22	6	4	2
4 or more partners	6	7	2	-	-
All aged 16-49	100	100	100	100	100

<sup>1</sup> Self-reported in the 12 months prior to interview.  
 Source: Omnibus Survey, Office for National Statistics



**Figure 7.23**

**Sexually transmitted HIV infections:<sup>1</sup> by sex and year of diagnosis**



<sup>1</sup> Numbers of diagnoses recorded, particularly for recent years, will rise as further reports are received. Those where the probable route of infection was not known, particularly for recent years, will fall as follow-up continues.

Source: Health Protection Agency

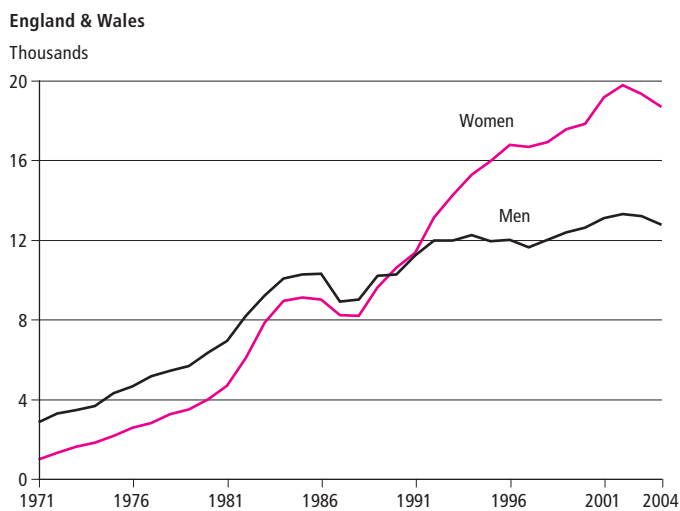
For both sexes, multiple sexual partnerships were most common among those below the age of 25. Over a third of men aged under 25, a fifth of women aged 16 to 19 and a quarter of women aged 20 to 24 reported having more than one sexual partner in the previous year. Men and women aged 25 to 49 were most likely to have only one sexual partner and also least likely to have none.

An estimated 58,300 adults aged 15 to 59 were living with HIV in the United Kingdom at the end of 2004. In the early stages of the disease in 1991, infections were predominantly diagnosed among men who had sex with men (Figure 7.23). However, since 1999 there have been increasing numbers of diagnoses of HIV infections acquired through heterosexual contact. By 2004, 42 per cent of the 6,500 sexually transmitted infections were among women.

In 2004 over 2,700 women diagnosed with HIV in the United Kingdom had been infected through heterosexual contact, eight times the number who had been infected in this way in 1991. Over half as many men (1,600) were infected through heterosexual sex in 2004, five times the number in 1991. In 2004 nearly 80 per cent of infections in heterosexual men and women were acquired in high prevalence areas of the world, particularly Africa.

**Figure 7.24**

**Diagnoses<sup>1</sup> of genital herpes simplex virus (type 2): by sex**



<sup>1</sup> First and recurrent episodes.

Source: Health Protection Agency

The trends in HIV diagnoses among men who have sex with men have been different to those for heterosexual men and women. Between 1991 and 1999 the number in the United Kingdom remained relatively stable. However, since 2000 the annual number of diagnoses has been rising, reaching almost 2,200 in 2004. This increase probably reflects increasing HIV testing among men who have sex with men, as well as continuing, and possibly increasing, HIV transmission.

HIV can also be acquired through injecting drug use. The number of this type of diagnoses has remained relatively low in recent years, with 128 diagnoses in 2004. A small number of infections were acquired through blood transfusions, although almost all of these individuals received transfusions in countries outside the United Kingdom, where exclusion or screening procedures for donors are less rigorous.

Genital herpes simplex virus (HSV) infection is the most common sexually transmitted disease of an ulcerative form in the United Kingdom. The infection may be painful, disabling and recurrent and is associated with considerable physical and psychological ill-health. The genital HSV infection may also facilitate HIV transmission. Type 1 HSV causes oral herpes (or cold sores) but has increasingly been implicated in genital infections. Type 2 HSV is almost exclusively associated with genital infection. During the 1970s and 1980s the rate of increase in the number of diagnoses of HSV (type 2) in England and Wales was similar for men and women (Figure 7.24). However, since the early 1990s the increase in the number of diagnoses has been much



greater for women than for men. In 2004 there were almost 18,700 diagnoses among women, 76 per cent more than in 1990. Among men the number of cases diagnosed increased by 25 per cent over the same period to reach just over 12,700 in 2004. Genital herpes is most commonly diagnosed in men and women aged 25 to 34. In 2004, 38 per cent of first attack cases among men and 30 per cent among women in England and Wales were diagnosed in this age group.

In recent years the incidence of other sexually transmitted infections has been increasing. In 2004 genital chlamydia was the most common sexually transmitted infection diagnosed in genito-urinary medicine clinics in England and Wales. Almost 96,000 cases were diagnosed, 8 per cent more than in 2003 and over 200 per cent more than in 1995. Between 1995 and 2003 the increase was greatest among those aged under 25. Uncomplicated gonorrhoea was the second most common infection with over 21,000 cases diagnosed in 2004, 11 per cent lower than the number recorded in 2003.

For people who have multiple sexual partnerships, condom use can help reduce the risk of contracting sexually transmitted diseases. In 2004/05, 80 per cent of men aged 16 to 69 and 75 per cent of women aged 16 to 49 who had more than one sexual partner in the previous year used a condom in Great Britain. This compared with 33 per cent of men and 44 per cent of women who had one partner.

People's reasons for using a condom vary by age and whether or not they have multiple partners. In 2004/05, 71 per cent of men

**Table 7.25**

**Reasons for using a condom: by sex and age, 2004/05**

Great Britain	Percentages				
	16–19	20–24	25–34	35–44	45–49
<b>Men</b>					
Prevent pregnancy	25	39	44	70	73
Prevent infection	8	4	9	5	6
Both reasons	63	57	44	23	19
Other reason	4	-	3	2	1
All aged 16–49	100	100	100	100	100
<b>Women</b>					
Prevent pregnancy	29	31	59	65	60
Prevent infection	2	6	7	6	12
Both reasons	68	62	33	25	22
Other reason	-	-	1	4	5
All aged 16–49	100	100	100	100	100

Source: *Omnibus Survey, Office for National Statistics*

and 70 per cent of women aged 16 to 19 reported using a condom either solely as a means of preventing infection or both to prevent infection and for contraceptive purposes (Table 7.25). Most people aged 25 and over used condoms only as a form of contraceptive, which reflects the likelihood that older people are in a monogamous relationship (see Table 7.22).

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