

Chapter 9: Health

Summary

Good health is not only an asset in itself; it also enables people to further their careers, look after families, and pursue their other interests to the full. Many Britons think that their health is 'good' or 'very good'. Most of us are confident that when we need help the National Health Service will treat us with respect and dignity.

The evidence suggests, however, that there are some groups of people who are more likely than average to experience 'poor' health, and some who find it difficult to access care and support that meets their particular needs.

While there are obvious differences in the health needs of men and women, the evidence does not suggest a clear trend of either gender experiencing worse health than the other. Both genders may find that their health needs are not met: men are less likely to use their GP; women have specific concerns about maternity services. Both genders have a mixed record when it comes to looking after health. Men are more likely to take exercise but less likely to eat the recommended amounts of fruit and vegetables, and women vice-versa.

Our health needs change as we age. The incidence of disability rises with age and older people (65 and over) also have a higher rate of depression than younger people. There is evidence to suggest that the health service sometimes deals with some older people in ways that they find humiliating or distressing.

Overall, around 1 in 5 of us report a disability or limiting long-term illness. The available evidence suggests that people who report a disability or limiting long-term illness are as likely as average to say that the health services treats them with dignity and respect.

In terms of ethnicity, evidence indicates that Pakistani and Bangladeshi groups are more likely to report 'poor' health than average. These groups are more likely to experience poor mental health, more likely to report a disability or limiting long-term illness, and more likely to find it hard to access and communicate with their GPs than other groups. Among groups defined by religion, Muslim people tend to report worse health than average. It is unclear how far these worse-than-average outcomes are related to Pakistani, Bangladeshi and Muslim people's relatively poor socio-economic position.

Research has suggested that there may be an association between harassment and poor mental health. Some evidence suggests that lesbian, gay and bisexual (LGB) and transgender people, Gypsies and Travellers and asylum seekers, who are perhaps more likely than other groups to face hostility and misunderstanding, are all more likely to experience poor mental health.

Sometimes, these same groups can feel misunderstood by the health services themselves. Some transgender people do not feel that their doctor supports their decision to seek gender reassignment, and some Gypsies and Travellers find it difficult to register with a GP.

Finally, there is a strong association between low socio-economic status and poorer health: in England and Wales, those who have never worked or are long-term unemployed have the highest rates of self-reported 'poor' health; people in routine occupations are more than twice as likely to say their health is 'poor' than people in higher managerial and professional occupations; and people from lower socio-economic groups are more likely to have a poor diet and less likely to take regular exercise.

Introduction

Good health is an end in itself. Good health also liberates; it enables individuals to do more in life, at home and in work.

Every individual's health is influenced by a number of factors, including their genes, their experiences in life, and the quality of care and treatment they receive when they need it. For the purpose of this chapter, we look at different groups' experience of health with a particular focus on health outcomes, and the extent to which they follow a healthy lifestyle, with a balanced diet and regular exercise.

The majority of Britons rely on the National Health Service (NHS) for advice and treatment. The NHS is founded on the principles of dignity for its patients and respect for their human rights. This chapter also gives some evidence which shows how successfully the NHS puts the ideals of respect and dignity into practice when dealing with certain groups, but this is an area that needs much more research.

Following the 2010 election, the government said that NHS budgets would be protected from cuts to a greater extent than other areas of public expenditure. In July 2010, the government published a White Paper which set out proposals for reform to the NHS.¹ They include changes in management structures, and proposals to hand greater control to patients and frontline care providers. These proposals have the potential to change the way different groups access advice and support.

¹ Department of Health, 2010. *Equity and Excellence: Liberating the NHS*. London: Department of Health.

The White Paper also included a renewed focus on public health. There is an ongoing public debate about what the state should do, if anything, to encourage people to take greater responsibility for managing their own health (by, for example, eating more sensibly, taking regular exercise, stopping drinking to excess, or stopping smoking). Some indicators of public health have improved over the past 10 years (smoking rates and excess drinking rates have fallen), while levels of obesity have risen. The evidence in this chapter suggests that different groups vary in the extent to which they live a healthy lifestyle. This evidence could help illuminate public debate.

Indicators

1. **'Poor' health and limiting long-term illness or disability**
2. **Poor mental health**
3. **Living a healthy lifestyle**
4. **Dignity and respect in health treatment**

Under **'poor' health and limiting long-term illness or disability**, we give the percentage of people who report their current health as 'poor', and the percentage who report a limiting long-term or long-standing illness or disability.

Under **poor mental health**, we give the percentage of people who attain a score in psychological questionnaires that indicate possible mental health conditions, such as depression or anxiety.

For **living a healthy lifestyle**, we give the percentages of people who: currently smoke; exceed recommended alcohol limits; achieve recommended levels of physical activity; or eat five portions of fruit and vegetables a day. We also give the percentages of people who are obese, and who are of healthy weight, according to body mass index.

For **dignity and respect in health treatment**, we give the percentages of people who feel they are treated with respect when using health services.

As in the rest of Part II, this chapter explores what we know about these indicators and what the evidence tells us about the experiences of different groups.

9.1 What we know about ‘poor’ health and limiting long-term illness or disability

Measures:

‘Poor’ Health – Percentage of people who report ‘poor’ current health status

LLTI/Disability – Percentage of people who report a limiting long-term or long-standing illness or disability (LLTI/disability)

How these measures work:

These two measures use the Health Surveys for England, Scotland and Wales. Two measures are used to allow comparison between a measure where an individual is asked to rate their general health against a set of options such as ‘fair’ or ‘bad’; and a second measure which asks people to report on the existence of a condition (‘Limiting Long-Term Illness’ or disability). Because they are ‘reported’ they are in general subjective measures, and there may be other more objective measures (for example, vital signs such as blood pressure) that could be used to measure health.

Such generalised measures also need to be interpreted carefully as a measure of health equalities, since they do not take account of some natural differences between certain population groups (e.g. by age, gender) in their tendency to have certain conditions. More specific information is needed to compare the ‘capabilities’ of different groups to achieve their health potential.

Ethnicity data are only available from the Census 2001 for England and Wales, and Scotland, and the booster sample in the 2004 Health Survey for England. Although the focus of this latter booster was ethnicity, they did collect information on religion and do allow some exploration of health across the largest religious groups.

Lack of impairment-specific data for disabled people in the Health Surveys mean that we have evidence of a general association between reported ‘poor’ health and those who also report LLTI/disability, but no evidence of the specific impairments that may have a greater association with poor health.

For socio-economic groups, the 2001 Census for England and Wales provides data against socio-economic categories; the Health Surveys for Scotland and Wales look at the most deprived areas (based on the Indices of Multiple Deprivation) which limits the extent we can compare them.

There are very limited data for sexual orientation and transgender, so we are reliant on smaller studies which limits the extent to which we can make any generalisations to the wider population.

‘Poor’ health

Except in the Welsh Health Survey, ‘poor’ is not one of the available options that respondents can select to describe their own health status. Moreover, the possible responses on health status differ between the Census and the Health Surveys for England, Scotland and Wales (and also between the Health Survey in Wales and those in the other two nations) making it difficult to compare surveys directly.

In the Health Surveys for England and Scotland, the options in 2008 (the most recent available source) were: ‘very good/good/fair/bad/very bad’. In this report, the responses ‘fair’/‘bad’/‘very bad’ have been included within the definition of ‘poor’ health. In the Health Survey for Wales, the options were ‘excellent/very good/good/fair/poor’ and our ‘poor’ health definition consists of the ‘fair’ and ‘poor’ categories only.²

In the 2001 Census which we use in part for ethnic minority groups, the options were ‘good/fairly good/not good’; therefore ‘not good’ rather than ‘poor’ health has been used as the measure of poor health when the Census is cited.

LLTI or disability

The three Health Surveys for England, Scotland and Wales use very slightly different questions to define these terms. However, for the purposes of this section we will compare their results.

Overview

These two complementary measures of people’s state of health show very similar patterns in terms of trends and group differences. **The proportion of people with Limiting Long-Term Illness (LLTI) or disabilities rises with age, so that a large proportion of people over 75 report these conditions.**

The likelihood of having such impairment is not evenly spread across the population. **Women are more likely than men overall, and people from some ethnic and religious groups – especially some Asian Muslims**

² The full definitions used in all health surveys are set out in Allmark, P. *et al.* 2010. *Life and Health: An evidence review and synthesis for the Equality and Human Rights Commission’s Triennial Review 2010*. Sheffield Hallam University. This paper is available on the Equality and Human Rights Commission’s Triennial Review web pages. Chapter 3, page 20.

– **appear more likely to report an LLTI or disability.** In both cases, the differences tend to become more accentuated at older ages, so for example nearly 2 in 3 Pakistani and Indian women over 65 had a LLTI or disability in 2001. **A similar pattern applies to Welsh people in general and to older Welsh women in particular,** two-thirds of the latter group have disabilities or LLTIs at age 75+, compared to only half of women in England and Scotland.

What we know about the overall situation and current trends

Around 1 in 5 people in Britain have an LLTI/disability (over 10 million),³ which is strongly associated with self-reported poor general health. Trend tables are routinely produced for the Health Survey for England. Data from 1993 to 2007 do not suggest any consistent patterns among men or women in the proportion reporting ‘poor’ health. The differential between men and women has remained reasonably stable throughout this period.⁴

What we know about the situation for different groups

Gender and age

‘Poor’ health

Overall, from the 2008 Health Surveys in England, Scotland and Wales, although measured slightly differently, the following proportions of adults aged 16+ reported their health to be ‘poor’: England 24% of men and 25% of women; Wales 21% of men and 23% of women; and Scotland 25% of men and 25% of women – these were small differences that were not statistically significant.⁵

Figure 9.1.1 below shows that in the Health Surveys, when examined by age group, the proportion of the population reporting ‘poor’ health clearly increases with age for both men and women across all three nations.

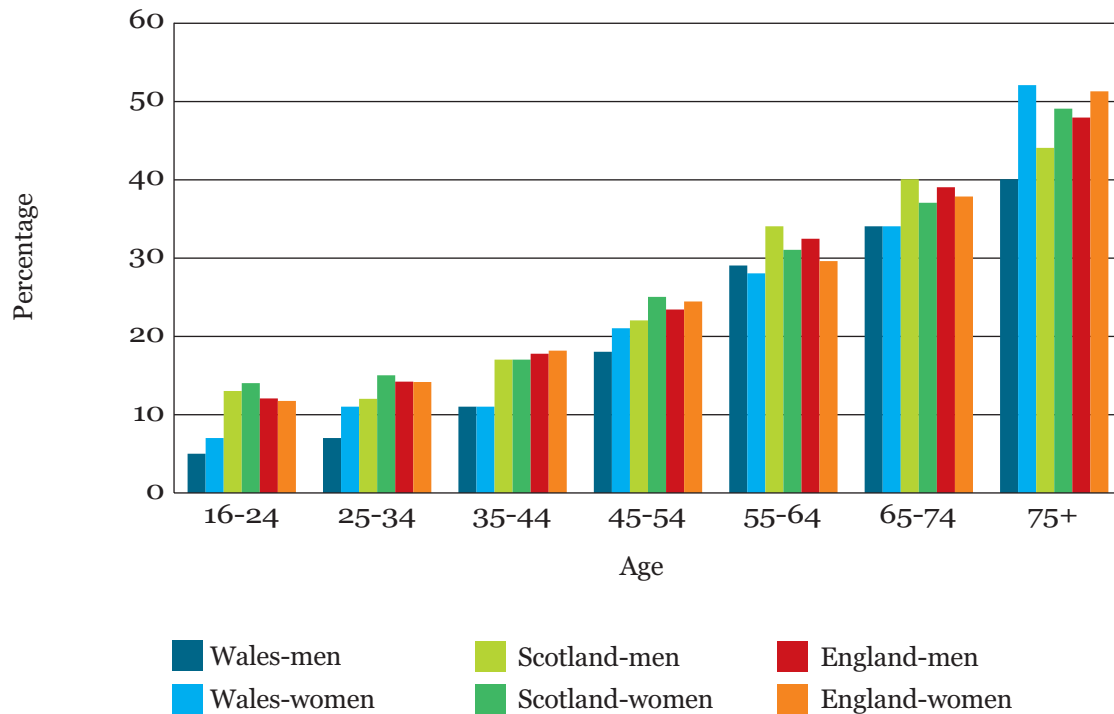
There are no clear patterns of difference between the genders and generally the likelihood of one gender reporting ‘poor’ health fluctuates. There are sharp increases for some groups in older age ranges, such as for women in Wales.

³ Office for Disability Issues (ODI) 2009. *Prevalence Estimates 2008/9*. ODI Factsheet. Available at: <http://www.odi.gov.uk/docs/res/factsheets/disability-prevalence.pdf> Accessed 02/09/2010.

⁴ Allmark, P. *et al.* 2010. Chapter 8. Page 52.

⁵ Allmark, P. *et al.* 2010. Chapter 8. Page 50.

Figure 9.1.1 Percentage reporting 'poor' health in gender in England, Scotland and Wales, 2008⁶



Source: Health Survey for England 2008, Scottish Health Survey 2008, Welsh Health Survey 2008.

Note: Question wording varied slightly between the surveys. Welsh figures group responses 'fair' and 'poor', while Scottish and English figures group responses 'fair', 'bad' and 'very bad'.

LLTI/disability

Overall results from the 2008 Health Surveys show that women's level of reported LLTI was statistically significantly higher than men's in the Health Survey for England, in which 22% of men and 25% of women aged 16+ reported having at least one LLTI or disability. Similar patterns are shown in the Scottish Health Survey, where 23% of men and 28% of women reported an LLTI and in the Welsh Health Survey, where 26% of men and 29% of women reported an LLTI.⁷

Broken down into age groups, a large proportion of the working-age population of England, Scotland and Wales report having an LLTI/disability (see Figure 9.1.2, below: for the 45-54 age group, percentages range from 20% for men in England to 26% of women in Scotland and Wales).

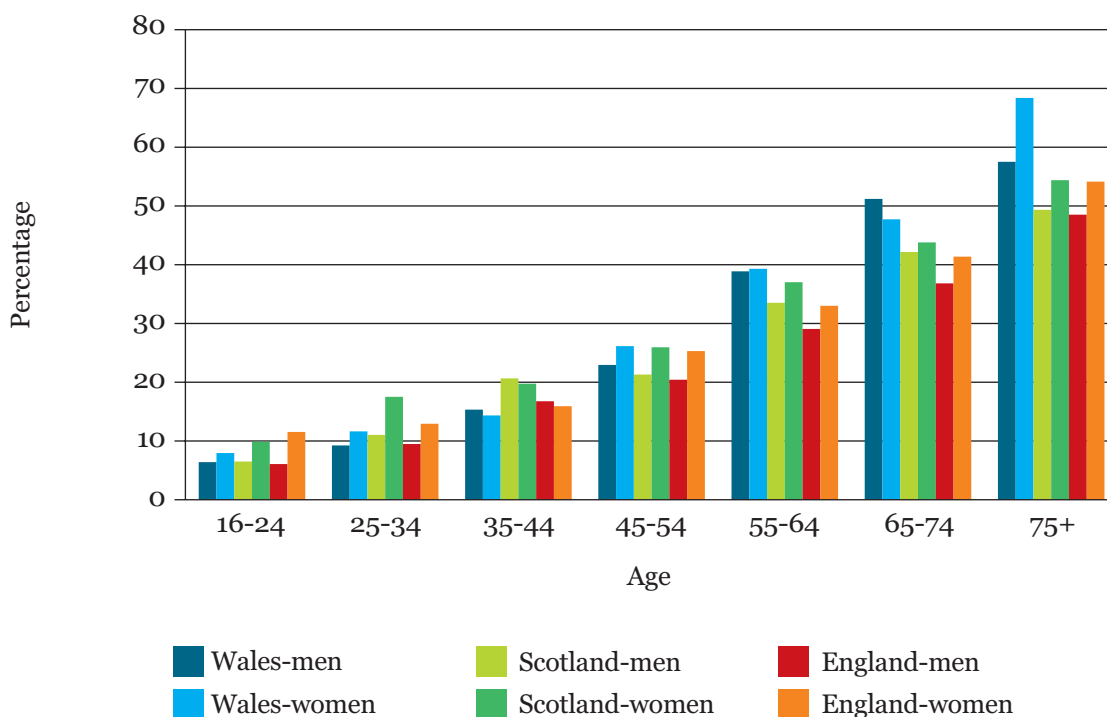
The proportion of people reporting an LLTI/disability increases with age. Moreover, the increase was greater for women in Wales than for any other group. In Wales, the proportion of women reporting an LLTI/disability rose by 29

⁶ Allmark, P. *et al.* 2010. Chapter 8. Page 50.

⁷ Allmark, P. *et al.* 2010. Chapter 8. Page 51.

percentage points from 39% for those aged 55-64 to 68% for those aged 75+. The equivalent increases were 21 percentage points in England (from 33% to 54%) and 17 percentage points in Scotland (from 37% to 54%).

Figure 9.1.2 Percentage of people reporting a limiting long-term illness or disability by gender and age in England, Scotland and Wales, 2008⁸



Source: Health Survey for England 2008, Scottish Health Survey 2008, Welsh Health Survey 2008.

Note: Question wording varied slightly between the surveys as in Figure 9.1.1.

Socio-economic groups

'Poor' health

In England and Wales using the 2001 Census which measures 'not good' health, those who had never worked or were long-term unemployed had the highest rates of 'not good' health (19%), although as set out in the 'how this measure works' section, 'not good' health is not directly comparable to the 'poor' health measure. Rates of 'not good' health for people in routine occupations were more than double those for people in higher managerial and professional occupations (9% compared to 3%).⁹

For Wales and Scotland, both 2008 Health Surveys show an association between 'poor' health and area deprivation.

⁸ Allmark, P. *et al.* 2010. Chapter 8. Page 51.

⁹ Allmark, P. *et al.* 2010 analysis of the Census Longitudinal Study 2001. Chapter 4. Page 62.

LLTI/disability

For England, Scotland and Wales, although variously measured, evidence shows a strong association with having never worked, or being in the more deprived or lower quintiles and having an LLTI or disability.

- Across Britain as a whole, more than 40% of those aged 45-64 who have never worked or are long-term unemployed report an LLTI or disability, compared to around 18% with managerial or professional backgrounds (figures given for 2006-08).¹⁰
- Wales – 41% of adults aged 16+ who have never worked or are long-term unemployed report an LLTI or disability, compared to around 23% with managerial or professional backgrounds.¹¹
- Scotland – 32% of adults 16+ in the most deprived areas reported a long-standing illness, disability or health problem compared to only 14% in the least deprived areas.¹²

The association between adults with LLTI/disability and poor socio-economic position, as also set out in Chapter 11: Employment and Chapter 12: Standard of living, is possibly due to the poor employment prospects of disabled people. Chapter 12 also shows that families with disabled children live in greater levels of poverty – in part due to the cost of providing care and the limits that caring for a disabled child can place on parents' economic prospects. There is also evidence that you are possibly more likely to have a child with a disability if you are from a lower socio-economic background.¹³ This flags up a potentially more complex relationship between socio-economic status and disability in part due to lower levels of general health, and healthy lifestyle among those with lower socio-economic backgrounds – discussed further under the healthy living section below.

Box 9.1.1 Related issue: Poor health and socio-economic status

In discussing socio-economic groups and health, it is worth examining the overlap between many equality groups and their socio-economic status. Worse health outcomes for those who are poor are often compounded when equality characteristics are 'added', for example, disability or ethnicity.

Just one example is the excess risk of 'poor' health for some ethnic minority groups due to poorer socio-economic circumstances. Controlling for

¹⁰ Allmark, P. *et al.* 2010 Chapter 4. Page 69.

¹¹ Allmark, P. *et al.* 2010 analysis of the Welsh Health Survey 2008. Chapter 4. Page 70.

¹² Allmark, P. *et al.* 2010, comparing 5 (most deprived) to 1 (least deprived) on the Scottish Index of Multiple Deprivation quintile 07/08 Scottish Household Survey. Chapter 4. Page 72.

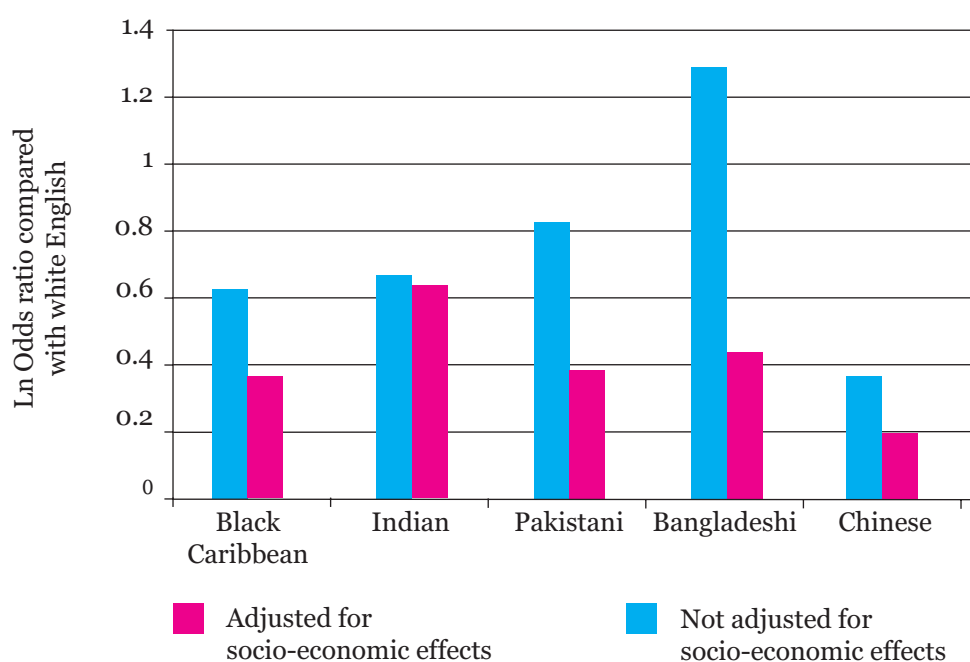
¹³ Spencer, N. 2008. *Health Consequences of Poverty for Children*. London: End Child Poverty.

Box 9.1.1 Continued

socio-economic status in any analysis of the poorer health outcomes of ethnic minority groups is difficult. Within any measure of socio-economic status, the profile for ethnic minority groups tends to be less favourable, so that there will always be some degree of socio-economic effect that cannot be accounted for.¹⁴

An analysis using data from the Health Survey for England 1999 allows us to show the relationship between health and socio-economic circumstances across a large number of ethnic groups. Looking at the outcome of self-reported 'poor' health (defined by the authors as 'fair or poor' health), and controlling simultaneously for several socio-economic indicators (income, housing tenure, economic activity), this analysis found a clear and large reduction in relative risk compared to the White British comparator group for most groups (shown in Figure 9.1.3, below). Only the White minority (predominantly Irish) group (which had odds close to 1) and the Indian group (for whom the reduction in relative risk was small) were the exceptions.

Figure 9.1.3 Effect of adjusting for socio-economic factors on odds ratio of reporting 'poor' health minority ethnic groups in England, 1999¹⁵



Source: Health Survey for England 1999.

Notes: An odds ratio of 1 means there is no difference in odds of a given outcome between a particular ethnic minority group (e.g. Black Caribbean) and the White English population; an odds ratio of < 1 means the event is less likely to occur for a particular ethnic minority group; an odds ratio of > 1 means the event is more likely to occur for a particular ethnic minority group.

¹⁴ Allmark, P. *et al.* 2010. Chapter 7. Page 97.

¹⁵ Allmark, P. *et al.* 2010. Chapter 7. Page 99.

Box 9.1.1 Continued

A second analysis using pooled data from the Health Survey for England 1999 and 2004 of religion, ethnicity and socio-economic status, found that the odds of reporting 'poor' health were reduced for all groups when controlling for socio-economic status, and particularly so for Pakistani and Bangladeshi Muslims, but less so for Christian Black Caribbean. These findings suggest that lower socio-economic status is playing an important role in the excess risk of 'poor' health for these groups, but it is not the whole story.¹⁶

Disability

The Office for Disability Issues estimate around 1 in 5 people in Britain have an LLTI/disability (over 10 million).¹⁷ Those with LLTI unsurprisingly report higher rates of 'poor' health status compared to those without:

Reporting 'poor' health¹⁸ (for all adults 16+):¹⁹

- England – 64% of those with LLTI, compared to 10% without LLTI
- Scotland – 64% of those with LLTI, compared to 9% without LLTI
- Wales – 57% of those with LLTI, compared to 6% without LLTI

One study found 15% of those with a learning disability reported their health as not good. The rates were highest for those who were unemployed, socially isolated, older and from an ethnic minority community.²⁰

Ethnicity**'Poor' health**

Using the measure of 'not good' health in the 2001 Census for England and Wales, the Pakistani and Bangladeshi groups stand out as having the worst health (Figure 9.1.3 below shows for England and Wales combined, age-standardised rates of over 13% for men and over 15% for women, compared to around 8% for all ethnic groups reporting "not good" health), whilst Chinese men and women report the best health.²¹

¹⁶ Allmark, P. *et al.* 2010. Chapter 9. Page 55.

¹⁷ ODI. 2009.

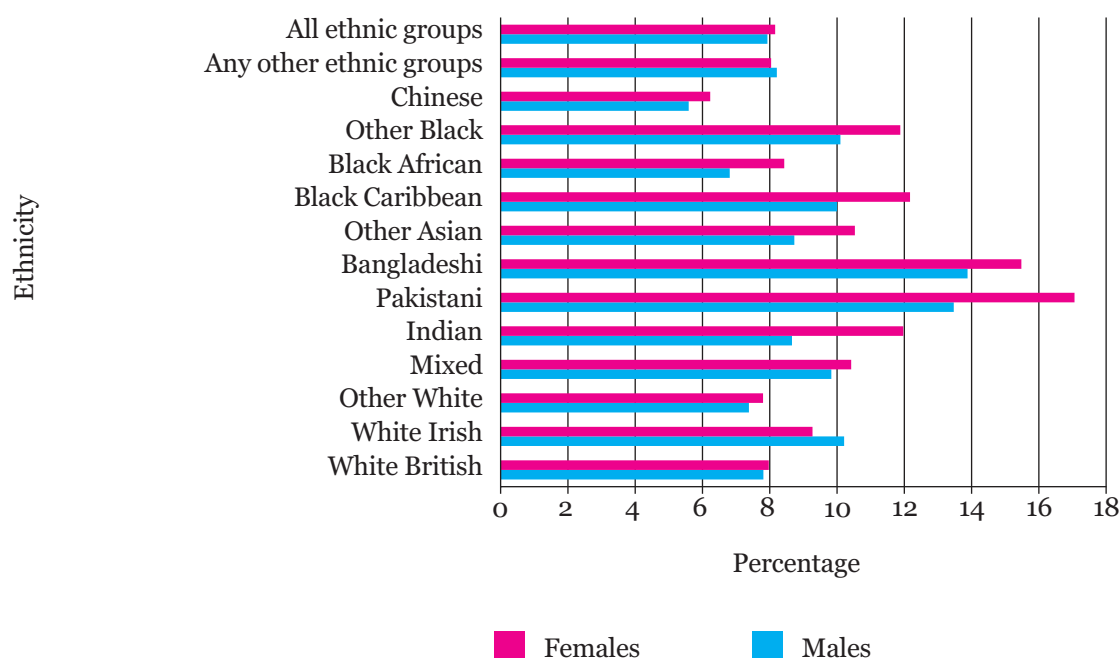
¹⁸ Welsh figures group responses 'fair' and 'poor', while Scottish and English figures group responses 'fair', 'bad' and 'very bad' as in the Gender and Age analysis above.

¹⁹ Allmark, P. *et al.* 2010 analysis of Health Surveys for England, Scotland and Wales. Chapter 6. Pages 19-21.

²⁰ Allmark, P. *et al.* 2010. Chapter 6. Page 21.

²¹ Allmark, P. *et al.* 2010. Chapter 7. Page 56.

Figure 9.1.4 Age-standardised percentages of people reporting 'not good' health by ethnicity in England and Wales, 2001²⁴



Source: Census, April 2001, ONS.

Note: Differences between males and females were significant for White British, White Irish, Indian, Pakistani, Other Asian, Black Caribbean and Black African groups.

Looking at age-specific breakdowns of the raw 2001 Census data, although there is variation between age groups, Bangladeshi and Pakistani men and women stand out as being most likely to report not good health, and Chinese men and women being most likely to report good health at most ages.²³

A similar analysis of the age breakdowns of the 2001 Census in Scotland shows that Bangladeshi and Pakistani people again stand out as reporting 'not good' health in high numbers. Over age 60 years, a high proportion of Indian and Pakistani men, and particularly women, report their health to be 'not good'. The White Irish and White Scottish groups are more likely to report 'not good' health than the other White British and Other White groups at almost all ages.²⁴

²² Office for National Statistics 2001. *Focus on ethnicity*. Available at: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=10991>. Accessed on 23/08/2010.

²³ Allmark, P. *et al.* 2010. Chapter 7. Pages 57-59 for a full breakdown by age and ethnicity.

²⁴ Allmark, P. *et al.* 2010, figures calculated from raw figures supplied by General Register Office (Scotland) (GRO(S)). Chapter 7. Pages 60-61.

More recent data are available for England from the 2004 Health Survey for England which included a 'booster' sample of people from seven main enumerated ethnic minority groups. This uses same the measure of 'poor' health as used for gender and age above (i.e. all those who described their health as fair, bad or very bad) so it allows us to show patterns by ethnicity, and to compare to gender/age results in the previous section.

The percentages of women reporting 'poor' health for each group were:

- Bangladeshi 52%
- Pakistani 48%
- Black Caribbean 40%
- Indian 33%
- Black African 30%
- Chinese 26%

Among men, a similar pattern was seen for each group:

- Bangladeshi 47%
- Pakistani 34%
- Indian 33%
- Chinese 26%
- Black Caribbean 25%
- Black African 24%.²⁵

As with the wider population, health inequalities experienced by ethnic minorities increases with age. In England and Wales:²⁶

- Among younger men (16-49 years), the Irish are more likely to report 'not good' health than other groups.
- The disadvantaged position of the Bangladeshi and Pakistani populations worsens with increasing age among both genders – Bangladeshi men are the most likely to report 'not good' health in the 50-64 and 65+ age groups; Pakistani women are the most likely to report 'not good' health in the same age groups.
- Among the Indian group, the proportion reporting 'not good' health increases steeply with age, especially for women.

It should be remembered that smaller ethnic groups that remain un-enumerated or hidden within larger categories, such as Somalis within the broad Black African group, may experience even worse health than the Bangladeshi and Pakistani groups.

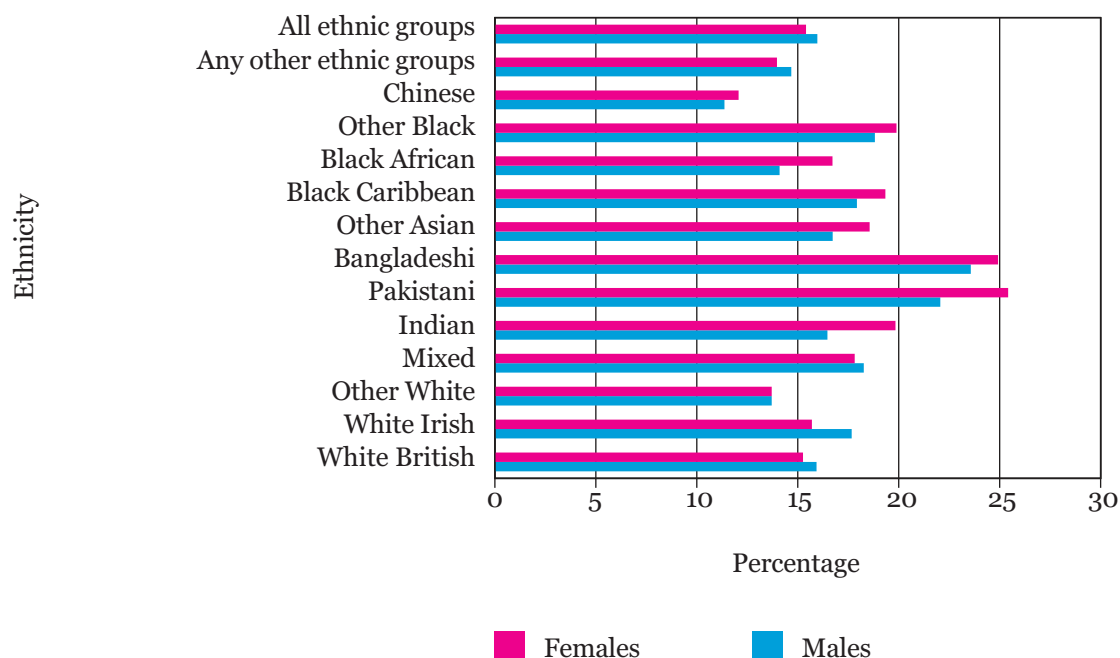
²⁵ Allmark, P. *et al.* 2010. Chapter 7. Page 62.

²⁶ Allmark, P. *et al.* 2010, figures calculated from Census 2001 raw figures. Chapter 7. Page 59.

LLTI/disability

The 2001 Census for England and Wales shows that, among males, in comparison with the White British group, the White Irish, Mixed, Indian, Pakistani, Bangladeshi, Black Caribbean and Other Black groups all had higher age-standardised rates of reporting LLTI or disability, while the Other White, Black African and Chinese had lower rates. Among women, only the Other White and Chinese groups had lower rates than the White British, with all other ethnic minority groups having higher rates. The highest rate was for Pakistani and Bangladeshi women – 25% reported ‘LLTI or disability’, compared to 15% for all ethnic groups.

Figure 9.1.5 Age-standardised percentages of people reporting ‘disability or LLTI’ by ethnic group and gender in England and Wales, April 2001²⁷



Source: Census, April 2001, ONS.

Note: Differences between males and females were significant for White British, White Irish, Indian, Pakistani, Black Caribbean and Black African groups.

An analysis of raw 2001 Census data shows that the prevalence of LLTI/disability increases with age across all age groups: in England and Wales, very high levels of LLTI/disability are found for the over 65s among Indian, Pakistani, Bangladeshi and Black Caribbean groups. The highest rates were for Indian and Pakistani women aged 65 years or over, with over 65% reporting an LLTI/disability. While rates of LLTI/disability are markedly lower among the Chinese than in all other ethnic groups

²⁷ Office for National Statistics 2001. *Focus on ethnicity*. Available at: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=10991>. Accessed on 23/08/2010.

in the two younger age-groups (16-49 and 50-64 years), at ages over 65 their advantageous position is less apparent.²⁸

In Scotland, small numbers of ethnic minority groups in the 2001 Census data make analyses by age more difficult. Nevertheless, similar patterns are observed to those in England and Wales, with the Chinese having particularly low rates of LLTI/disability at younger ages, Pakistani men and women having high rates across all ages, and Indian women having high rates at older ages. White Scottish and White Irish have rates that are higher than Other White British for both genders and all ages.²⁹

Gypsies and Travellers

A 2004 study of Gypsy and Traveller health (with a sample of 293) found high levels of self-reported 'poor' health. Overall, around 30% of the sample reported 'not good' health, with a further 31% reporting 'fairly good' health and just 40% reporting 'good health'. Whilst these are small samples, the figures diverge considerably from the overall national estimates for even the worst-off Pakistani and Bangladeshi groups. The same study found 39% of respondents had an LLTI or disability, far higher than the comparator sample (N=260) included in the study, and higher than figures from other sources for any of the regularly enumerated ethnic minority groups.³⁰

Asylum seekers

Asylum seekers and refugees have particular health concerns due to the impact of relocation and possible past experience of trauma. Research is generally limited on their general levels of health due to the hidden nature of the population.³¹ The specific health issues that may face them include the impact of detention, particularly on children if they are detained.³² This is an issue of concern raised by the 2006-07 Joint Committee on Human Rights.³³

²⁸ Allmark, P. *et al.* 2010, figures calculated from Census 2001 raw figures. Chapter 7. Page 66.

²⁹ Allmark, P. *et al.* 2010, figures calculated from raw figures supplied by GRO(S). Chapter 7. Page 68.

³⁰ Allmark, P. *et al.* 2010. Chapter 7. Page 63 [see also page 27].

³¹ Allmark, P. *et al.* 2010. Chapter 7. Page 14. Also see: Roberts, K. and Harris, J. 2002. *Disabled people in refugee and asylum-seeking communities in Britain*. Joseph Rowntree Foundation Findings. York: JRF.

³² HM Chief Inspector of Prisons 2006. *Inquiry into the quality of healthcare at Yarls Wood immigration removal centre*. 20-24 February 2006. London:HMIP Available at: <http://www.medicaljustice.org.uk/images/documents/yarlswoodhealthcarereport.pdf>. Accessed on 23/08/2010.

³³ Joint Committee on Human Rights 2007. *The Treatment of Asylum Seekers*. Tenth Report of Session 2006-07. Volume I – Report and formal minutes. London: The Stationery Office. Pages 69-95.

Religion or belief

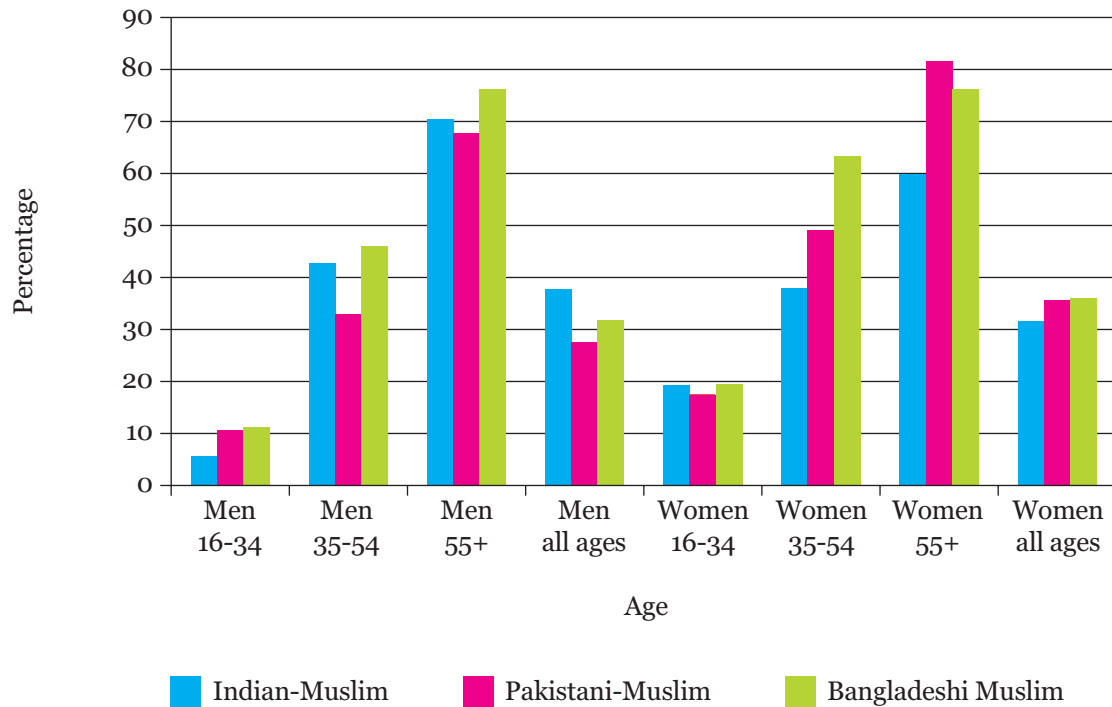
‘Poor’ health

2001 Census data for Britain as a whole reveal large differences in self-reported ‘not good’ health between religious groups. Among men, the age-standardised percentage of people reporting ‘not good’ health was highest among Muslims (13%) and those reporting ‘Any other religion’ (12%) and lowest among Jewish men (7%). Among women, the highest percentage was again among Muslims (16%) with the percentage among Sikhs (14%) and ‘Any other religion’ (14%) also being high, and lowest again among the Jewish group (7%) (compared to around 8% for Christian men and women).³⁴

The figures below, using Health Survey for England (2004) data, illustrate the variation in ‘poor’ health within ethnic groups by religion, and within religious groups by ethnicity. Sample sizes for other religion–ethnicity combinations are too small to sustain analyses, but it is clear that this type of exploration is helpful. Numbers of Black African Muslims were very small in the survey and so are not included. The patterns by age and gender are complex – particularly among the men, and the Indian Muslim rates are based on small numbers meaning that the estimates are imprecise. Among women aged 35 and over, the data suggest that levels of ‘poor’ health may be higher among Pakistani and Bangladeshi Muslims than among Indian Muslims, though small numbers preclude any firm conclusions.

³⁴ Allmark, P. *et al.* 2010. Chapter 9. Page 25.

Figure 9.1.6 Percentage of people reporting 'poor' health at 34, 54 and 55 by gender and Muslim-ethnic group compared in England, 2004³⁵



Source: Health Survey for England 2004.

Note: All age estimates are crude rates, not standardised for age.

LLTI/disability

2001 Census data for Britain also show that the prevalence of LLTI/disability varies between religious groups. Age-standardised rates of LLTI for Britain as a whole were highest among Muslims for both men (21%) and women (24%), though men and women reporting 'any other religion' and also Sikh women, had high rates. Jewish men (13%) and women (13%) were the least likely to report an LLTI when age-standardised rates were compared. Levels of 'not good' health and LLTI among Muslims appear to be particularly high in comparison to other religious groups in the middle age-range 30-74.³⁶

More recent data for England only, from the Health Survey for England (1999 and 2004 pooled data), examine odds of reporting LLTI/disability for different religious-ethnic groups – highest odds were for Bangladeshi Muslim men (1.79) and Pakistani Muslim women (1.75) but notably also for Black Caribbean women with 'no religion' (2.15).³⁷

³⁵ Allmark, P. *et al.* 2010. Chapter 9. Page 30.

³⁶ Allmark, P. *et al.* 2010 analysis of Census, April 2001. Chapter 9. Page 34.

³⁷ Allmark, P. *et al.* 2010. Chapter 9. Page 37.

Sexual orientation

Data for England and Wales from the Citizenship Survey 2007 indicate that perceived health levels for the LGB respondents were largely similar to heterosexual respondents, and similarly that there is no significant difference between levels of LLTI/disability.³⁸

Prescription for change, a large-scale opportunistically recruited survey which explored the general health of over 6,000 lesbian women from England, Scotland and Wales reports similar findings; 80% of lesbians who completed the survey reported good or excellent health whilst 2% reported 'not good' health.³⁹

Transgender

'Poor' health

The 'Count me In Too Survey' undertaken in Brighton and Hove in 2008, which had a small sample (N=800) and was geographically specific, nonetheless shows *possible* differences in the experience of transgender people compared to the population as a whole: 30% (N=13) transgender respondents said that their physical health was 'poor or very poor' compared to 8% non-transgender; 44% (N=19) transgender respondents reported 'good or very good' health status compared to 77% non-transgender.⁴⁰

There is no clear evidence from the small amount of data available about the levels of long-standing health problems or disability in this population.⁴¹

Box 9.1.2 Related issues: Patterns of access and take up of services

There is evidence across a range of health services that patterns of access, uptake and treatment diverge between women and men. The patterns are, however, complex, so that both men and women appear to be disadvantaged in some areas of healthcare.⁴²

Men tend to access GP services less often than women – this may only in part be based on need but on the appropriateness of services and how accessible they are to men. They also appear to ignore symptoms of ill health and delay seeking healthcare more often than women. Men may be more likely than women to self-medicate in harmful ways, e.g. through use of alcohol and drugs when experiencing mental distress. However, there is evidence that maternity services frequently fail to provide satisfactory services to women, and particularly to women from ethnic minority backgrounds.⁴³

³⁸ Allmark, P. *et al.* 2010. Chapter 10. Pages 20-22.

³⁹ Allmark, P. *et al.* 2010. Chapter 10. Page 20.

⁴⁰ Allmark, P. *et al.* 2010. Chapter 11. Page 15.

⁴¹ Allmark, P. *et al.* 2010. Chapter 11. Page 16.

⁴² Allmark, P. *et al.* 2010. Chapter 8. Pages 100-108.

⁴³ Allmark, P. *et al.* 2010. Chapter 8. Page 60.

Box 9.1.2 Continued

Women are more likely than men to receive treatment for minor mental health conditions. However, more than twice as many male as female psychiatric inpatients are detained and treated compulsorily.⁴⁴

New migrant communities have different health needs from established minority communities, and increasing ethnic, linguistic and cultural diversity demands new responses from health services. Asylum seekers and refugees may be affected by:

- Difficulties accessing GP treatment and consequent increased reliance on Accident and Emergency services.
- Uncertainty and lack of clarity among service providers about asylum seekers' eligibility for secondary healthcare services resulting in care being withheld in some cases.
- Inadequate response to communicable diseases, particularly Tuberculosis.
- The health of asylum seekers with HIV/AIDs is negatively affected by the policy of dispersal at short notice and chargeable HIV treatment for refused asylum seekers. Also the human rights implications around the deportation of failed asylum seekers with HIV/AIDs.
- The Joint Committee on Human Rights has highlighted the need to address health concerns of asylum seekers in detention through adequate provision.⁴⁵

Effective diagnosis and treatment may be undermined when ethnic minority people do not present with the 'typical' symptoms that have been identified on the basis of research and clinical experience with the majority White British population.

There is also evidence that Gypsies and Travellers have poorer access to GPs and other primary care services. One study reported difficulties in registering with a GP among Gypsies and Travellers. It found that 16% (N=47) of respondents were not registered with a GP and the proportion was as high as 38% (N=111) for those living in trailers on empty land and 37% (N=108) for those who travel all year.⁴⁶

Take-up of screening services: There is evidence also from varied sources that men are less likely than women to take up preventive measures, such as screening. For instance, the evaluation of phase 2 of the National bowel cancer screening programme in England found lower rates of uptake in men than women (48% versus 56%).⁴⁷

⁴⁴ Allmark, P. *et al.* 2010. Chapter 8. Page 12.

⁴⁵ Allmark, P. *et al.* 2010. Chapter 7. Page 14. UK Borders Agency Research into GP access for refugees is forthcoming in September 2010 which will add to this evidence base.

⁴⁶ Allmark, P. *et al.* 2010. Chapter 7. Page 106.

⁴⁷ Allmark, P. *et al.* 2010. Chapter 8. Page 105.

Box 9.1.2 Continued

Several studies have documented lower levels of screening among ethnic minority groups and also specific issues relating to access for asylum seekers and refugees.⁴⁸

There are specific issues related to health screening in relation to transgender people. For some screening programmes, such as breast and cervical screening, GP action is required to ensure invitations to attend are sent, and appropriate screening may not be offered when it relates to an individual's former gender. However this is a complex and under-researched area.⁴⁹

⁴⁸ Allmark, P. *et al.* 2010. Chapter 7. Page 107.

⁴⁹ Allmark, P. *et al.* 2010. Chapter 11. Page 27.

9.2 What we know about poor mental health

Measure:

Poor mental health – Percentage of people that attain a score in specific psychological questionnaires indicating possible mental health conditions.

How this measure works:

These questionnaires vary between nations which limits comparability – in England and Scotland, this is based on in the General Health Questionnaire (GHQ)-12, where a score of 4 or more indicates a possible mental health condition. In Wales, a mean Mental Component Summary (MCS) score from the SF-36 questionnaire of health status is used to determine mental health – a higher score is better. We report generally against a benchmark of 50 as the ‘norm’.⁵⁰

These scores are available in the 2008 Health Surveys for England, Scotland and Wales.

In terms of socio-economic groups in Scotland, we use a score of less than 50 in the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). Consequently, as socio-economic groups are also variously measured in England and Wales, using income level and occupation, we cannot compare socio-economic groups in Scotland to other groups, or compare England, Scotland and Wales but we can look at patterns within the socio-economic groups of each nation.

A lack of disaggregated data for disabled people means that we have a general association between poor mental health and disability but no more detailed information of the particular impairments that may be associated with poor mental health.

Data on ethnicity and religion or belief are only available for England, from the 2004 booster sample to the Health Survey for England.

⁵⁰ Welsh Assembly Government 2009. *Welsh Health Survey 2008*. Cardiff: Welsh Assembly Government. Glossary, Pages 119-120. In the WHS: ‘...norm-based scoring has been used, to transform all scores to a mean of 50 and standard deviation of 10 using the general United States population (for the purpose of comparability and simplicity). Higher scores indicate better health.’

There is limited evidence for sexual orientation and transgender groups and therefore we are reliant on varied literature which limits the extent to which we can make any generalisations to the wider population.

There are issues with under-reporting and diagnosis that apply across all groups, and which limit the reliability of the indicator – particularly for men. This is because reporting and diagnosis of mental illness are generally low, which contradicts, for example, the higher suicide levels for men reported in Chapter 6: Life. Issues of diagnosis also apply to the use of such questionnaires for those who do not speak English as a first language, or who have a different cultural background.

Overview

Over 1 in 10 adults in England, Scotland and Wales report potential mental health difficulties. While the incidence is significantly higher for women, reporting of mental health difficulties does not have as pronounced a pattern across groups as some health and other outcomes. For example, there appears to be no overall pattern for age.

Nevertheless, more specific data on particular conditions show, for example, that **from the age of about 65, older people have a much higher rate of depression than younger people.**

However, some groups do seem to be at greater risk than others – including Pakistanis and Bangladeshis, LGB and transgender people, Gypsies and Travellers and asylum seekers. In some cases, there are signs that mental illnesses may be linked to other disadvantages and pressures felt by such groups. Some analysis has shown an association between the experience of victimisation for different religious groups and poor mental health.

In this sense, **mental health problems can sometimes be seen as a potential symptom of wider difficulties that minorities face within society.** This is particularly pertinent for groups facing the greatest disadvantages. At the extreme, these conditions can lead to suicide, as reported in Chapter 6: Life.

What we know about the general situation and trends

The 2008 Health Survey for England shows that the proportion of all men and women with a 12 item General Health Questionnaire (GHQ-12) score of 4 or more which indicates possible problems have decreased slightly since 1999. There are less clear patterns of change for Scotland and trends are not available for Wales.⁵¹

In both England and Scotland, there is a persistent gender gap, where the proportion of women of different ages with a GHQ-12 score of 4 or more over time is higher than for men.⁵²

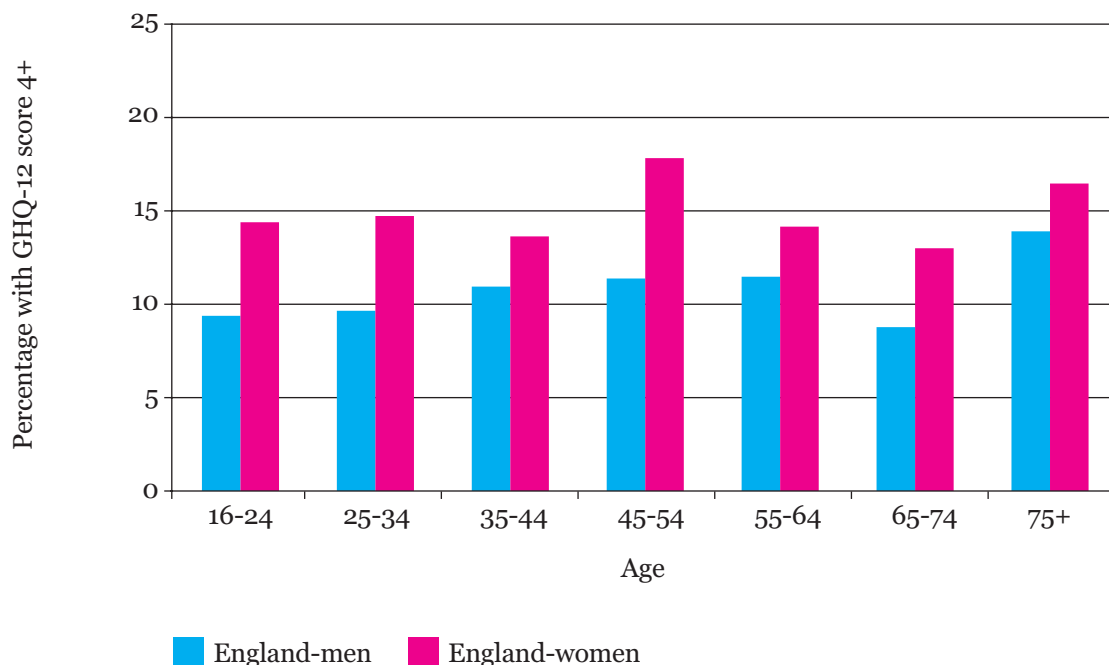
What we know about the situation for different groups

Gender and age

In terms of assessment of poor mental health via these questionnaires, women are more likely than men to have scores that indicate possible mental health conditions but there is little consistency in the pattern across age groups.

In the Health Survey for England, 11% of all men had GHQ-12 score of 4 or more compared to 15% of women, which breaks down across the age groups as follows:

Figure 9.2.1 Percentage of people with GHQ-12 score of 4 or more by age and gender in England, 2008⁵³



Source: Health Survey for England 2008.

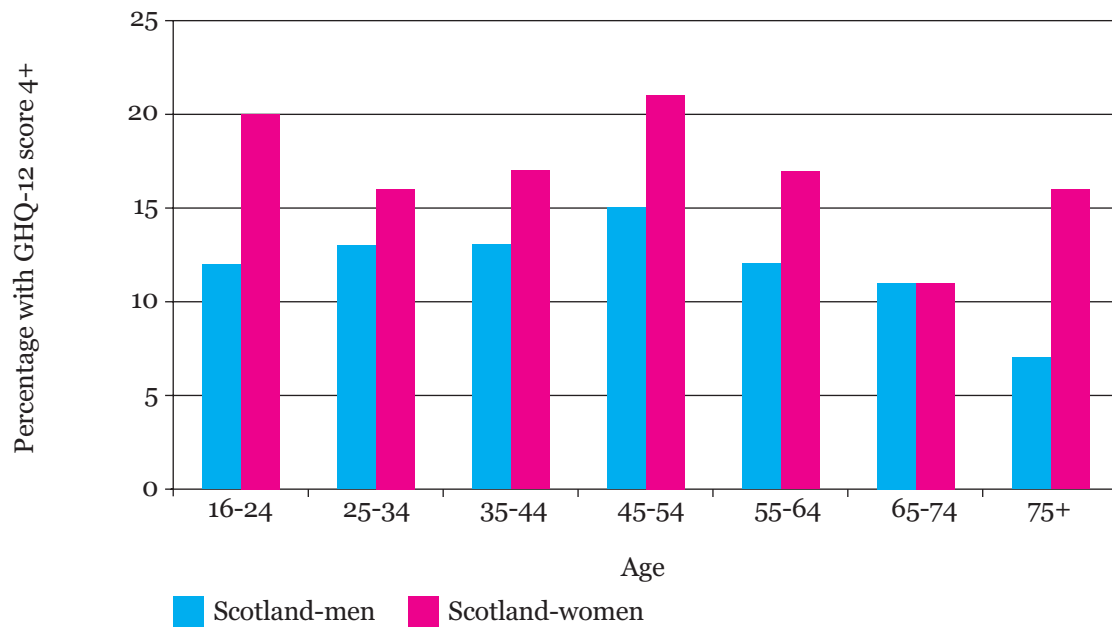
⁵¹ Allmark, P. *et al.* 2010. Chapter 8. Page 56.

⁵² Allmark, P. *et al.* 2010. Chapter 8. Page 56.

⁵³ Allmark, P. *et al.* 2010. Chapter 8. Page 55.

In Scotland, these figures were higher, with 12% of men and 17% of women obtaining GHQ-12 scores of 4 or more.

Figure 9.2.2 Percentage of people with GHQ-12 score of 4 or more by age and gender in Scotland, 2008⁵⁴

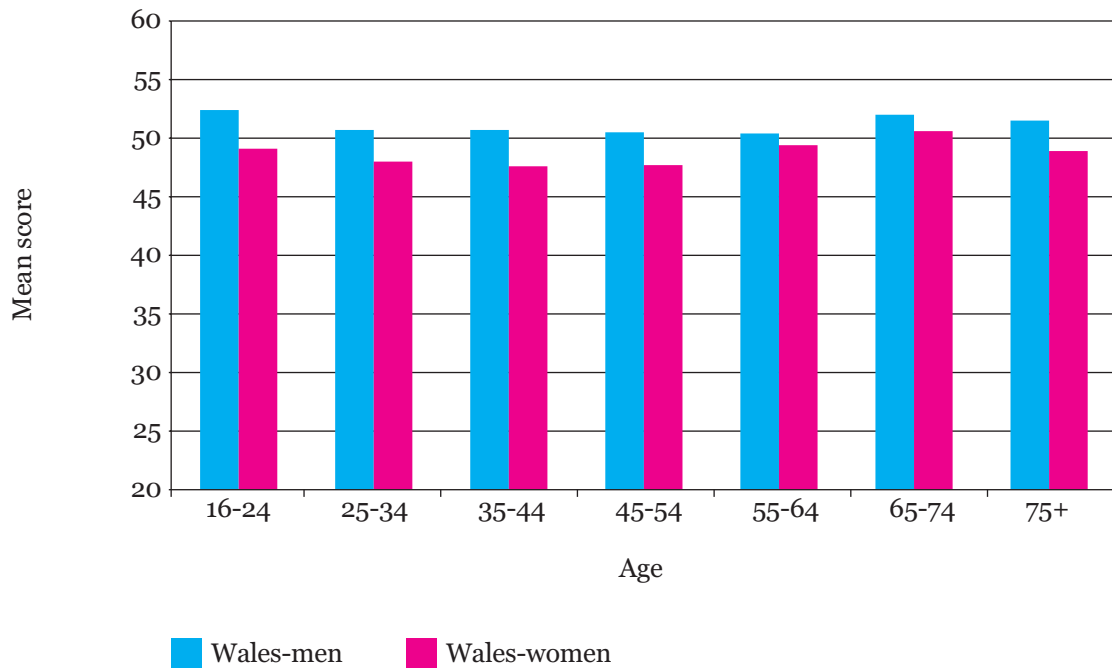


Source: Scottish Health Survey 2008.

⁵⁴ Scottish Government 2009. *The Scottish Health Survey 2008, Part 1: Main Report*. Edinburgh: Scottish Government. Table 1.6.

The data available for Wales from the Welsh Health Survey, which uses a different questionnaire, show a similar gender pattern, with women consistently having a lower SF-36 score than men (a lower score indicates possible problems).⁵⁵

Figure 9.2.3 Mean SF-36 Mental Component Summary score by age and gender in Wales, 2008⁵⁶



Source: Welsh Health Survey 2008.

The Health Survey for England (2005) expresses caution about the apparent lack of association between increasing age and mental ill health. The 10-item Geriatric

Depression Scale (GDS-10) was used for the first time in the Health Survey for England in 2005 for those over 65 years. It is a self-administered questionnaire consisting of 10 questions which measure depressive symptoms. Scores of three or more depressive symptoms were more likely among older respondents (of both genders) and higher scores were more prevalent in those reporting LLTI and mobility problems. Around 25% of those over 65 had significant depressive symptoms in 2005. The comparable figure in the general population is around 10%.⁵⁷

There are clear gender differences once specific disorders are examined. Anxiety, depression and eating disorders are more commonly reported in women, substance misuse and anti-social personality disorders are more commonly reported in men.⁵⁸

⁵⁵ Allmark, P. *et al.* 2010. Chapter 8. Page 55.

⁵⁶ Allmark, P. *et al.* 2010. Chapter 8. Page 55.

⁵⁷ Allmark, P. *et al.* 2010. Chapter 5. Page 51.

⁵⁸ Allmark, P. *et al.* 2010. Chapter 8. Page 53.

For men, there are particular concerns around the under-diagnosis, and therefore lack of treatment for mental health conditions which are not captured in evidence in the previous points. These are believed to account, at least in part, for the much higher risk to men of becoming homeless or being imprisoned, for example.

For women, there are particular concerns around the risk of domestic and sexual violence and its links to poor mental and physical health.⁵⁹

Socio-economic groups

In the 2008 Health Survey for England data there appears to be an association between income level and a GHQ score of 4 or more. Women in the poorest 5th of the population are more than twice as likely to have a score of 4 or more than those in the richest 5th. For men, the difference is almost three-fold.

Table 9.2.1 Percentage of people with GHQ score of 4 or more by level of income in England, 2006 and 2008⁶⁰

Income quintile	Men	Women
Poorest fifth	20%	24%
2nd	15%	17%
3rd	8%	15%
4th	8%	13%
Richest fifth	7%	10%

Source: Health Survey for England average between 2006 and 2008.

For Wales, 27% of those who have never worked or are long term unemployed report being treated for depression, anxiety or any other mental illness compared to 11% for those with routine or manual employment and 7% of those with managerial or professional backgrounds.⁶¹ The 2008 mean SF-36 Mental Component Summary score for those who have never worked was 42.6 (indicating possible problems), compared to 51.1 for those with managerial or professional backgrounds.⁶²

In the Scottish Health Survey, the measurement reported for socio-economic groups is the Warwick–Edinburgh Mental Wellbeing Scale. Data for both socio-economic group and income show an association between lower income, and routine employment and poorer mental health but the figures are not statistically significant.⁶³

⁵⁹ Allmark, P. *et al.* 2010. Chapter 8. Page 57.

⁶⁰ Allmark, P. *et al.* 2010. Chapter 4. Page 75.

⁶¹ Allmark, P. *et al.* 2010, citing WHS 2008. Chapter 4. Page 78.

⁶² Allmark, P. *et al.* 2010, analysis of WHS 2008. Chapter 4. Page 78.

⁶³ Allmark, P. *et al.* 2010. Chapter 4. Page 79. See also Scottish Government 2009. Pages 33-34.

Disability

In England and Scotland, more people with LLTI/disability have a GHQ score of 4 or more compared to people with no LLTI/disability:

Table 9.2.2 Percentage of people with a GHQ-12 score of 4 or more, with/without LLTI/disability in England and Scotland, 2008⁶⁴

	England	Scotland
Has LLTI/disability	26%	27%
No LLTI/disability	7%	6%

Source: Health Survey for England 2008; Scottish Health Survey 2008.

In Wales, 52% of people with LLTI/disability have a lower score which indicates poor mental health, compared to 24% of those without LLTI/disability. As these are measured differently, it is not possible to directly compare them to the results for England and Scotland:

Table 9.2.3 Percentage of people with a score 0-46 from SF-36 Mental Component, with/without LLTI/disability in Wales, 2008⁶⁵

	Score 0-46	Score 47+
Has LLTI/disability	52%	48%
No LLTI/disability	24%	76%

Source: Welsh Health Survey 2008.

It is not clear from this evidence how independent LLTI/disability and poor mental health results are. The LLTI/disability itself may in fact be a mental health condition, or be a factor or a consequence of the LLTI/disability or indeed a result of the broader barriers and issues faced by the individual as a consequence of their illness or disability. This is an area where more detailed impairment-specific data are critical to our understanding of the processes at play.

Ethnicity

Patterns of mental wellbeing by ethnicity are complex and there are ongoing debates as to how assessment of this issue is affected by cultural and or linguistic differences. In the Health Survey for England 2004, Pakistani men and women, and Bangladeshi men had higher risk of high GHQ-12 scores than the general population (see Figure 9.2.4, below).

Neither the Scottish Health Survey nor the Welsh Health Survey includes sufficient numbers of people from ethnic minority groups to allow analyses by ethnicity.⁶⁶

⁶⁴ Allmark, P. *et al.* 2010. Chapter 6. Pages 25-27.

⁶⁵ Allmark, P. *et al.* 2010. Chapter 6. Page 26.

⁶⁶ Allmark, P. *et al.* 2010. Chapter 7. Page 71.

Figure 9.2.4 Percentage of people with a GHQ-12 score 4 or more and standardised risk ratios classified by ethnic group in England, 2004⁶⁷

		Black Caribbean	Black African	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Men	% 4+	13	11	16	15	18	9	12	11
	RR	1.21 (0.22)	0.88 (0.17)	1.32 (0.19)	1.56 (0.28)	1.83 (0.35)	0.76 (0.15)	1.08 (0.21)	1
Women	% 4+	18	19	14	20	15	13	15	15
	RR	1.27 (0.17)	1.19 (0.19)	0.99 (0.19)	1.73 (0.24)	1.37 (0.23)	0.83 (0.15)	0.95 (0.13)	1

Source: Health Survey for England 2004.

Notes:

1. Risk ratios were calculated that compared the prevalence for a given ethnic minority group with the prevalence in the general population, after adjusting for age in each group. For example, a risk ratio of 2.0 means that a particular group is twice as likely as the general population to have that condition, allowing for age differences; a risk ratio of 0.5 means that the group is half as likely as the general population to have that condition, allowing for age differences.
2. Figures in bold are statistically significantly different from the general population figure of 1 with standard errors given in brackets.

Findings from a survey in 2000 of Ethnic Minority Psychiatric Illness Rates (England only), suggest very few ethnic differences in the prevalence of common mental disorders once age is adjusted for. Only Bangladeshi women stand out as having a lower risk of mental disorder than White women.⁶⁸

Rates of admission and of compulsory detention in mental health institutions are higher among Black Africans, Black Caribbean, mixed White/Black Caribbean, White/Black African and also Black other groups which represents an enduring and worrying inequality⁶⁹ – a factor which may be reflected in the higher rates of suicide among young Black Caribbean and Black African men aged 13-24 years set out in Chapter 6: Life.

⁶⁷ Allmark, P. *et al.* 2010. Chapter 7. Page 71.

⁶⁸ Allmark, P. *et al.* 2010. Chapter 7. Pages 25 and 75.

⁶⁹ Care Quality Commission 2009. *Count me in 2009* Available at: [http://www.cqc.org.uk/_db/_documents/Count_me_in_2009_\(FINAL_tagged\).pdf](http://www.cqc.org.uk/_db/_documents/Count_me_in_2009_(FINAL_tagged).pdf) Accessed 23/08/2010.

Gypsies and Travellers

One study of 293 Gypsies and Travellers found much higher levels of anxiety and depression among this group than among a group of comparators matched on age and gender.⁷⁰

Asylum seekers

Some studies report that mental health is one of the most commonly reported health issues among **asylum seekers**; disorders commonly reported include anxiety, depression, phobias and post-traumatic stress disorder. Additionally, the provision of mental health services for this group, particularly for those that are survivors of torture and organised violence, is widely regarded as inadequate.⁷¹

Religion or belief

Data for religious groups and those with no religion are available from the Health Survey for England only, for 2004. These data show that the percentage of people with an age-adjusted GHQ-12 score of 4 or more was highest for Muslim men and women (19% and 26% respectively, compared to 12% and 15% for men and women with no religion); however, none of the differences were statistically significant.⁷²

Significance aside, because the data on religion only indicate affiliation with a particular group it does not show the extent to which an individual is practicing their religion and to what degree it affects their life. Therefore, it is not possible to ascertain whether religious identity is affecting mental health outcomes.

Some analysis has shown an association between the experience of victimisation for different religious groups and poor mental health. Nevertheless, we should be wary of assuming that some religious groups are more likely to experience mental ill health due to their religion, victimisation or other reasons, particularly because it is difficult to distinguish whether these experiences are due to religious or ethnic identity.⁷³

Sexual orientation

Although sexual orientation is not captured in large-scale datasets, a number of research pieces suggest that mental health issues may be a cause of concern in relation to sexual orientation.

- A meta-analysis of international data published in 2008, extracted on 214,344 heterosexual and 11,971 LGB people revealed that the risk for depression and anxiety disorder was at least 1.5 times higher in LGB people.

⁷⁰ Allmark, P. *et al.* 2010. Chapter 7. Page 72.

⁷¹ Allmark, P. *et al.* 2010. Chapter 7. Page 72.

⁷² Allmark, P. *et al.* 2010. Chapter 9. Page 38.

⁷³ Allmark, P. *et al.* 2010. Chapter 9. Page 64.

- A survey of 1,285 LGB people in England (2004) found that 43% had a mental disorder as defined by the revised Clinical Interview Schedule.⁷⁴
- In a piece of local research that captured the experiences of LGBT people living in Brighton and Hove, 55% of respondents (N= 302) reported experiencing three or more mental health difficulties in the past five years and 79% (N = 643) reported a wide range of mental health difficulties.⁷⁵

Transgender

Localised and small-scale survey data suggest that levels of poor mental health may be higher in the transgender population. One 2006 study of 819 LGBT people in Brighton and Hove indicated higher levels of the following disorders in the transgender population as compared to the LGB population over the past five years: insomnia, fears and phobias.⁷⁶

⁷⁴ Allmark, P. *et al.* 2010. Chapter 10. Page 23.

⁷⁵ Allmark, P. *et al.* 2010. Chapter 10. Page 23.

⁷⁶ Allmark, P. *et al.* 2010. Chapter 11. Page 18.

9.3 What we know about living a healthy life

Measures:

Smoking – Percentage who currently smoke

Alcohol – Percentage exceeding recommended alcohol limits

Physical activity – Percentage achieving recommended levels of physical activity

Healthy eating – Percentage who consume five or more portions of fruit and vegetables a day

Weight – Percentage who are obese/healthy weight according to body mass index

How these measures work:

The Health Surveys for England, Scotland and Wales provide data for all these indicators. These indicators give good comparisons across gender and age, data for LLTI/disability, although there is no impairment based breakdown.

Ethnicity and Religion or Belief are available for the booster sample in the 2004 Health Survey for England.

There are no data from these surveys for LGB or transgender people and therefore we are reliant on other studies.

Across the surveys, some of the indicators, such as smoking rates, exercise and fruit/vegetable consumption, are measured slightly differently, which means we can show patterns within each nation but we cannot directly compare them.⁷⁷

Overview

On crude indicators, **British adults appear to be less likely to smoke or drink to excess and more likely to eat healthily and take physical exercise than they were a decade ago.** However, the one main trend in the opposite direction, a rise in obesity, shows that a substantial minority of the population is living an unhealthy lifestyle.

⁷⁷ Details of question wording are provided in Allmark, P. *et al.* 2010. Chapter 3. Page 21.

There is no systematic way in which particular groups are unhealthy, but rather there are different areas of concern for different groups.

Women are more likely to eat healthily than men, but many women do not get enough exercise. Among some ethnic minority groups and among older people there is a similar pattern of relatively healthy eating – at least in terms of fruit and vegetables – but a lack of sufficient exercise.

People from lower socio-economic groups are less able to be healthy than those in higher socio-economic groups both in terms of diet and exercise. The majority of the population express a desire to do more exercise. Since 1 in 4 British adults is now classified as obese, this will be a crucial factor influencing health inequalities in the future.

What we know about the overall situation and trends

Smoking has been in decline for some time, with the gap between men and women closing. The proportion of men exceeding four units and women exceeding three units on their heaviest drinking day has also been in decline.

The Health Surveys for England and Scotland show that between 1997 and 2008 the proportion reporting having achieved the recommended levels of physical activity has been increasing for both men and women. Rates in Wales have fluctuated over time, with no clear trend.⁷⁸

In terms of diet, consumption of five or more portions of fruit and vegetables per day has risen in England since 2005, with trends less clear in Scotland and Wales.⁷⁹ Across the three nations, obesity levels have been rising for the past 10 years.⁸⁰

⁷⁸ Allmark, P. *et al.* 2010 analysis of Health Survey for England (HSE) and Scotland (SHeS) 1997-2008. Chapter 8. Page 73.

⁷⁹ Allmark, P. *et al.* 2010 analysis of HSE, SHeS and WHS 2001-08. Chapter 8. Page 76.

⁸⁰ Allmark, P. *et al.* 2010 analysis of the SHeS 1995, 1998, 2003 and 2008; WHS 2003/04-2008; HSE 1993 to 2008. Chapter 8. Page 69.

What we know about the situation for different groups

Gender and age

Indicators of healthy lifestyle show complex patterns across gender and age, with neither men nor women being uniformly disadvantaged.

Smoking

Among adults, differences between men and women are far smaller than in the past.⁸¹ However, among teenagers and the youngest adults, females are as likely as, or more likely than, males to smoke in England, Scotland and in Wales.⁸² There has been a downward trend since 2000 in the proportion of men and women who report that they are current smokers.⁸³

Those aged 65 and over are less likely to smoke than those under 65 years and the highest proportion of non-smokers is found in the oldest age group for both genders.⁸⁴

Alcohol

Patterns of alcohol consumption vary greatly by age, but males tend both to consume more alcohol, and to drink alcohol more frequently than females in all three nations. While trends over time suggest a rise in 'sensible' levels of drinking for both men and women, the increase has been smaller for women than men.⁸⁵ In terms of those who reported that they did not drink above government guidelines on any day in the week prior to interview, the largest gender gaps in 2008 were to be found in Wales (48% of men and 62% of women).⁸⁶

Physical activity

Levels of physical activity tend to be lower in women than in men across the three nations at all ages. However, while a rising minority of women and men now meet the recommended levels of physical activity, the majority in almost every age group in England in 2008 (apart from 16-24-year-old men) fell below them. Recent data for England suggest that physical activity levels are lower among teenagers than among younger children, and there are large differences between teenage girls and boys with girls being less likely to take recommended levels of exercise.⁸⁷

⁸¹ Details of question wording are provided in Allmark, P. et al. 2010. Chapter 3. Page 21.

⁸² Allmark, P. et al. 2010 analysis of Health Survey for England (HSE) and Scotland (SHeS) 1997-2008. Chapter 8. Page 73.

⁸³ Allmark, P. et al. 2010 analysis of SHeS 1995, 1998, 2003 and 2008; HSE 1993 to 2008. Chapter 8. Page 62.

⁸⁴ Allmark, P. et al. 2010 analysis of HSE 2008; WHS 2008; SHeS 2008. Chapter 8. Page 62.

⁸⁵ Allmark, P. et al. 2010 analysis of HSE 2008; SHeS 2008; WHS 2008.

⁸⁶ Allmark, P. et al. 2010 analysis of WHS 2008. Chapter 8. Page 76.

⁸⁷ Allmark, P. et al. 2010 analysis of HSE 2008; SHeS 2008; WHS 2008. Chapter 8. Page 72.

In contrast, in Scotland there were large increases for men among those aged 25-34 and 35-44, both of which saw rises of 10 percentage points of those meeting the recommendations.⁸⁸

Exercise levels are lower in those over 65 years. This is likely to be largely accounted for by the increase in 'poor' health and life-limiting illnesses and the decrease in mobility that is associated with older age; however, social and environmental factors, including increasing personal security concerns may also contribute to this situation.⁸⁹

Healthy eating

Indicators of healthy eating (i.e. eating recommended levels of fruit and vegetables)⁹⁰ tend to show that women have better habits than men. This is consistently the case across the age groups, except among the over-65s where men's rates of healthy eating are better than women's. This may be partly due to the different life expectancy rates for men and women with poor diets. The overall pattern is the same in England, Scotland and Wales.⁹¹

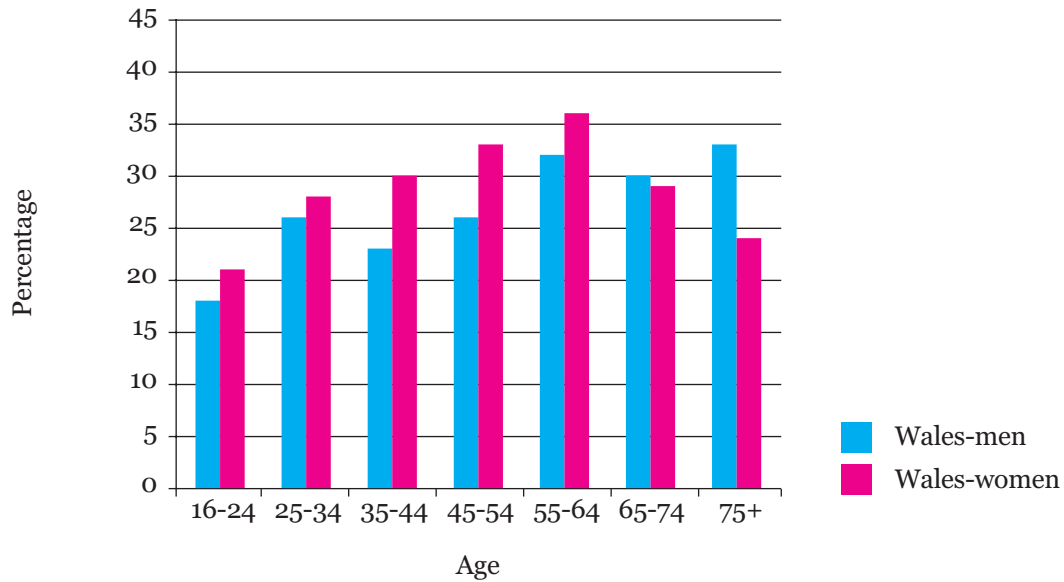
⁸⁸ Allmark, P. *et al.* 2010 analysis of HSE 2008; SHes 2008; WHS 2008. Chapter 8. Page 73.

⁸⁹ Allmark, P. *et al.* 2010 analysis of HSE 2008; WHS 2008; SHes 2008. Chapter 5. Page 68. For more information about fear of crime see Chapter 8: Physical Security. Indicator 3.

⁹⁰ Allmark, P. *et al.* 2010 Chapter 3. Page 21.

⁹¹ Allmark, P. *et al.* 2010 analysis of HSE 2008; SHes 2008; WHS 2008. Chapter 8. Page 74.

Figure 9.3.1 Proportion of people meeting government recommendations for daily fruit and vegetable consumption by gender and age in England, 2008⁹²



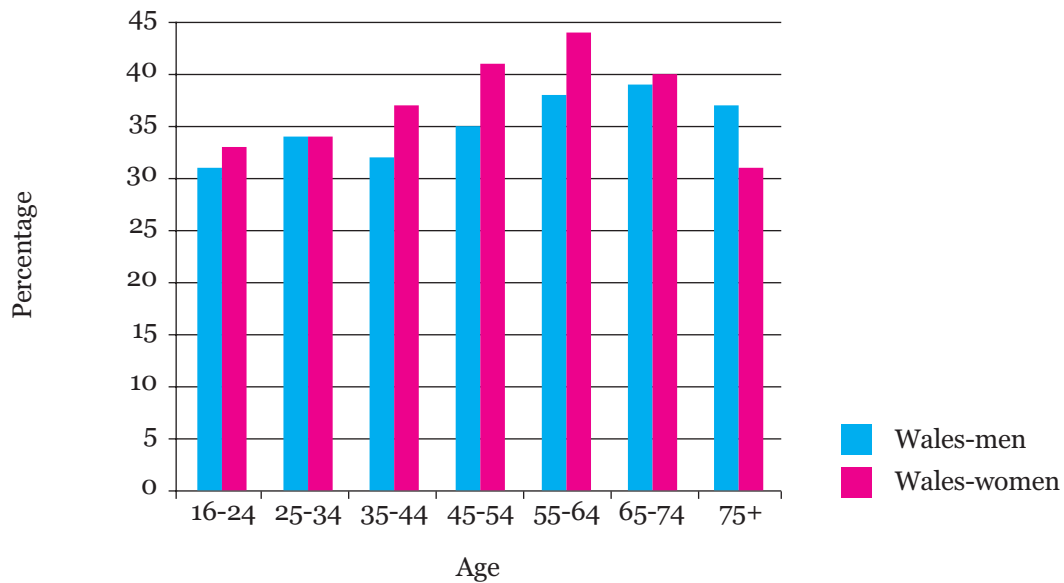
Source: Health Survey for England 2008.

Notes: Measure was based on the reported number of portions of fruit and vegetables consumed in the day prior to interview.

Government recommendations are for 5 or more a day.

⁹² Allmark, P. *et al.* 2010. Chapter 8. Page 72.

Figure 9.3.2 Proportion of people meeting government recommendations for daily fruit and vegetable consumption by gender and age in Wales, 2008⁹³



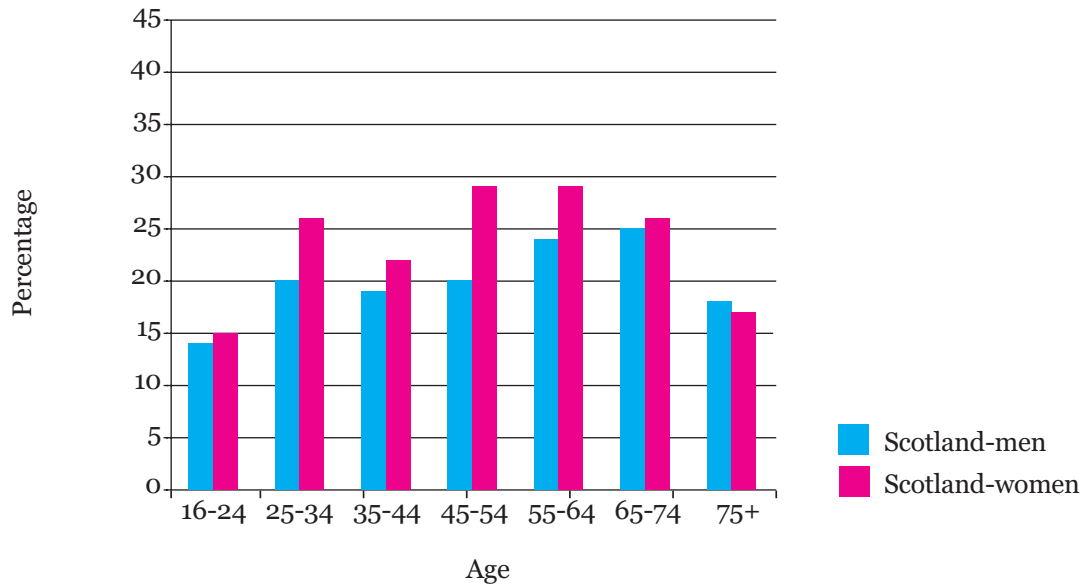
Source: Welsh Health Survey 2008.

Notes: Measure was based on the reported number of portions of fruit and vegetables consumed in the day prior to interview.

Government recommendations are for 5 or more a day.

⁹³ Allmark, P. *et al.* 2010. Chapter 8. Page 72.

Figure 9.3.3 Proportion of people meeting government recommendations for daily fruit and vegetable consumption by gender and age in Scotland, 2008⁹⁴



Source: Scottish Health Survey 2008.

Notes: Measure was based on the reported number of portions of fruit and vegetables consumed in the day prior to interview.

Government recommendations are for 5 or more a day.

The proportion of people who are of normal/healthy weight (neither overweight nor obese, and not underweight) has declined over the last 10-15 years across Britain, and is consistently lower among men than women.⁹⁵ In 2008, 37% of Welsh men and 44% of Welsh women were of normal/healthy weight. In England, the equivalent figures were 32% for men and 41% for women and in Scotland, 30% of men and 36% of women were of 'normal/healthy' weight.⁹⁶

The proportion of men and women with a normal weight declines gradually with increasing age up to the age group 65-74, and then rises again among the oldest age group (75+ years) across all three nations and for both men and women.⁹⁷

⁹⁴ Allmark, P. *et al.* 2010. Chapter 8. Page 72.

⁹⁵ Allmark, P. *et al.* 2010 analysis of SHeS 2008; HSE latest trend tables (1993 to 2008); WHS 2003/2004 and 2008. Chapter 8. Page 68.

⁹⁶ Allmark, P. *et al.* 2010 analysis of HSE 2008; SHeS 2008; WHS 2008. Chapter 8. Page 65.

⁹⁷ Allmark, P. *et al.* 2010 analysis of HSE 2008; SHeS 2008; WHS 2008. Chapter 8. Page 68.

Socio-economic groups

Several markers of unhealthy lifestyle are directly related to lower social class compared to other class groups. Cigarette smoking, lower exercise levels and poor diet are associated with lower social class, but not levels of overweight and obesity.⁹⁸

The pattern for alcohol is more complicated, with some differences across nations and by gender. In England and Wales, those in higher social classes drink most alcohol. In England, this is true also of problematic alcohol use, although in Wales, there is no clear pattern in relation to higher levels of alcohol use.

In Scotland, the situation is even more complex. There is a clear social gradient in the proportion of men drinking above Government guidelines, with those in the highest income quintile most likely to exceed limits. But men in the most deprived areas are the most likely to drink in excess of 50 units a week.⁹⁹

Disability

A summary of the measures show:

- People with LLTI/disability in England are neither more nor less likely to smoke than the rest of the population.¹⁰⁰ In Wales, they are slightly less likely to smoke¹⁰¹ whereas in Scotland, men with an LLTI are slightly more likely to do so.¹⁰²
- People with LLTI in England, Scotland and Wales are less likely to drink alcohol above the Government recommended limit.¹⁰³
- People with LLTI in England, Wales and Scotland are less likely to meet Government guidelines for exercise than those without an LLTI.¹⁰⁴
- In England, Wales and Scotland, there is no noticeable association between LLTI and eating fruit and vegetables.¹⁰⁵

There is a clear association between LLTI and obesity. Medication side effects, reduced mobility and socio-economic circumstances could all increase likelihood of obesity. In England, 72% of people with an LLTI do not have a healthy weight compared with 61% of those without an LLTI.¹⁰⁶

⁹⁸ Allmark, P *et al.* 2010 analysis of HSE 2007 and 2008; WHS 2008; SHeS 2008. Chapter 4. Pages 87-134.

⁹⁹ Allmark, P. *et al.* 2010 analysis of HSE 2008; WHS 2008; SHeS. Chapter 4. Pages 89, 109 and 123.

¹⁰⁰ Allmark, P. *et al.* 2010 analysis of HSE 2008. Chapter 6. Page 34.

¹⁰¹ Allmark, P. *et al.* 2010 analysis of WHS 2008. Chapter 6. Page 39

¹⁰² Allmark, P. *et al.* 2010 analysis of SHeS 2008. Chapter 6. Page 44.

¹⁰³ Allmark, P. *et al.* 2010 analysis of HSE 2008; SHeS 2008. Chapter 6. Pages 35 and 45.

¹⁰⁴ Allmark, P. *et al.* 2010 analysis of HSE 2008; WHS 2008; SHeS 2008. Chapter 6. Pages 36, 41 and 46.

¹⁰⁵ Allmark, P. *et al.* 2010 analysis of HSE 2008; WHS 2008; SHeS 2008. Chapter 6. Pages 37, 42 and 47.

¹⁰⁶ Allmark, P. *et al.* 2010 analysis of HSE 2008. Chapter 6. Page 38.

In Wales, having an LLTI is positively associated with being overweight or obese (66% versus 55%); this difference is true of both genders although it is particularly marked in women (63% versus 50%).¹⁰⁷

In Scotland, 75% of people with LLTI/disability compared to 66% of people without are overweight or obese.¹⁰⁸ Overall, the data on exercise and obesity suggest there may be an important inequality in that disabled people do not have equal access to opportunities to exercise.

Ethnicity

Health-related lifestyle factors vary greatly across ethnic groups. Different ethnic groups exhibit different behaviours which contribute to increased health risks, and there are no clear patterns – consequently, this is an area where further research is needed.

Issues that were of particular cause for concern in the Health Survey for England 2004 included:¹⁰⁹

- High levels of smoking among Bangladeshi men. The Health Survey for England found 60% of Bangladeshi men were ‘not currently smoking’ cigarettes compared with 76% of men in the general population.¹¹⁰
- The Turkish population, who are not currently enumerated as a separate ethnic category, have been found to have very high levels of smoking among both men and women.¹¹¹
- White Irish men were more likely than other ethnic minority groups to report drinking on 3 or more days a week.¹¹²
- Men were less likely to be of normal/healthy weight than women in the general population but among Pakistani, Bangladeshi and Black African populations, women are less likely to be of normal/healthy weight than men.¹¹³
- Levels of physical activity were lower among all the ethnic minority groups (with the exception of White Irish) with men and women in the Indian, Pakistani, Bangladeshi and Chinese groups statistically significantly less likely to meet Government guidelines for physical activity.¹¹⁴

¹⁰⁷ Allmark, P. *et al.* 2010 analysis of HSE 2008. Chapter 6. Page 43.

¹⁰⁸ Allmark, P. *et al.* 2010 analysis of SHeS 2008. Chapter 6. Page 48.

¹⁰⁹ Allmark, P. *et al.* 2010. Chapter 7. Pages 77-83.

¹¹⁰ Allmark, P. *et al.* 2010 analysis of HSE 2004. Chapter 7. Page 79.

¹¹¹ Allmark, P. *et al.* 2010. Chapter 7. Page 79.

¹¹² Allmark, P. *et al.* 2010 analysis of HSE 2004. Chapter 7. Pages 84-85.

¹¹³ Allmark, P. *et al.* 2010 analysis of HSE 2004. Chapter 7. Page 81.

¹¹⁴ Allmark, P. *et al.* 2010 analysis of HSE 2004. Chapter 7. Pages 82-83.

- In contrast, ethnic minority people (except the White Irish) are more likely than the general population to eat the recommended amounts of fruit and vegetables, particularly men.¹¹⁵

Religion or belief

There are differences between religious groups in the extent to which healthy life styles are followed – patterns vary within religious groups and along ethnic lines as well as by gender.

Key patterns include:

- Very low prevalence of alcohol consumption among Muslims, and Hindus and Sikhs are also more likely to report that they do not drink at all or that they drink within the recommended Government guidelines.¹¹⁶
- Overall, there are lower than average smoking rates among Sikhs. But looking at gender differences, Muslim, Hindu and Sikh women stand out at all ages as being less likely than other religions to be current smokers.¹¹⁷
- Research suggests that there may be higher levels of obesity/overweight for some groups such as Pakistani Muslim women, who are more likely to be obese and less likely to exercise than other groups, but sample sizes are small.¹¹⁸

Sexual orientation

Some research suggests that LGB people may be more likely to smoke than heterosexual people, although there is a lack of agreement in terms of differential rates within LGB groups – there are, for example, conflicting findings in relation to lesbians and smoking.¹¹⁹

There is some evidence that alcohol and drug use among LGB people is higher than in the general population.¹²⁰ In general, however, evidence is severely limited in this area, and for the other lifestyle indicators.

Transgender

Data relating to healthy lifestyle and transgender people are very limited, and those available are based on very small samples. In one survey, transgender individuals appeared to be more likely not to consume alcohol than non-transgender LGB. There was also some evidence that a lack of trans-friendly spaces limited physical activity.¹²¹

¹¹⁵ Allmark, P. *et al.* 2010 analysis of HSE 2004. Chapter 7. Page 83.

¹¹⁶ Allmark, P. *et al.* 2010 analysis of HSE 2004. Chapter 9. Page 49.

¹¹⁷ Allmark, P. *et al.* 2010 analysis of HSE 2004. Chapter 9 Page 43.

¹¹⁸ Allmark, P. *et al.* 2010. Chapter 9. Pages 46-48.

¹¹⁹ Allmark, P. *et al.* 2010 Chapter 10. Page 32.

¹²⁰ Allmark, P. *et al.* 2010 Chapter 10. Page 33.

¹²¹ Allmark, P. *et al.* 2010 Chapter 11. Pages 25-26.

9.4 What we know about dignity and respect in health treatment

Measure:

Treatment with respect – Percentage who feel they are treated with respect when using health services

How this measure works:

The Citizenship Survey 2007 is used for this measure for England and asks *‘In general, would you say that you are treated with respect when using health services?’*

The survey provides data for all equality groups with the exception of transgender people. Sample sizes for ethnicity, religion and sexual orientation mean it is hard to draw meaningful results. It should be noted it refers to the general population rather than service users only, and therefore relates to a wide range of service use and experiences.

Additionally, the Living in Wales survey asks respondents to agree/disagree with the statement *‘I was treated with dignity and respect’* in respect of GP services, inpatient, outpatient or day case hospital experiences. Due to the different wording, it is not possible to make direct comparisons with the Citizenship Survey, but this is a useful extra resource.

Better Together, Scotland’s Patient Experience Programme, has undertaken recent surveys of people registered with a GP practice and inpatients but this is the first year these surveys have been completed and national results were not available at time of writing. It should however be possible in the future for Better Together data to allow examination of potential inequalities by gender.

A key limitation of the data is that it only reflects those that have the capacity to report on their perceptions of treatment and does not include for example, groups such as older people with dementia or those who may not feel able to access health services at all, such as Gypsies and Travellers, asylum seekers or the homeless.

Overview

The great majority of people in Britain are able to use the health service confident that they will be treated with respect and dignity.

This is true across different parts of Britain, for men and women and for different socio-economic groups.

However, members of some groups frequently feel otherwise. In particular, Pakistanis and Bangladeshis find it harder to access and communicate with their GPs than other groups. Some difficulties may relate to language difficulties, but this is not the only reason. In some cases, there may be a lack of cultural sensitivity among those providing the service. Other groups encountering difficulties include some transgender people whose doctors do not support their decision to seek gender reassignment and Gypsies and Travellers who find it difficult to register with a GP, suggesting that those outside the mainstream of the system do not find that it respects their individual needs.

One aspect of lack of respect that is difficult to measure overall is the loss of dignity of older people, especially in care. On the one hand, older people who are able to answer surveys seem less likely than younger people to say that the system fails to treat them with respect, but may have lower expectations. On the other, evidence shows that some practices in the care system bring humiliation and disrespect.

What we know about the situation for different groups

Gender and age

Indicators of perception of treatment with dignity and respect within healthcare do not appear to vary by gender. The 2007 Citizenship Survey shows that 91% of both men and women in England answered ‘all the time’ or ‘most of the time’, with 8% and 9% respectively saying ‘some of the time or less’ to the question *‘In general, would you say that you are treated with respect when using health services?’*¹²²

Similarly, the Living in Wales Survey 2008 found no significant difference between men and women in the percentages agreeing with the statement *‘I was treated with dignity and respect’* when referring to: GP services, with just 3% of men and 4% of women disagreeing; or when referring to inpatient, outpatient or day case hospital experience, with 4% of men and women disagreeing.¹²³

A qualitative study of patient preferences and experiences within the Scottish NHS has recently been completed. Being treated with dignity and respect was identified by patients as an important dimension of GP care, but the study did not highlight any particular gendered concerns about lack of respect or dignity in treatment.¹²⁴

¹²² Communities and Local Government (CLG) 2009. *Citizenship Survey 2007/08: Race, Religion and Equalities Topic Report*. London: CLG.

¹²³ Allmark, P. *et al.* 2010. Chapter 8. Page 59.

¹²⁴ Allmark, P. *et al.* 2010. Chapter 8. Page 59.

The Citizenship Survey suggests, for England, that older people are more likely than younger people to feel they are treated with respect; 97% of those aged 75+ said they felt treated with respect 'All the time' or 'most of the time', the highest result for any age group; compared to 88% of those aged 16-24, and 25-34, the lowest of all age groups.¹²⁵

There are, however, some doubts as to the usefulness of these results. Partly they are limited because they are based on perceptions of treatment, and therefore will be governed by differing expectations about 'dignity and respect' in service provision (for example between older and younger people). Also, surveys only reflect the views of people with the capacity to answer and, arguably, exclude the experiences of the most vulnerable groups. This may explain in part the inconsistency of these findings with other research that highlights the poor treatment of elderly patients.¹²⁶

In terms of the experiences of older people in particular, one key area of concern is the use of restraint. In 2007 a report, *Rights, risks and restraints* from the Commission for Social Care Inspection gave many examples of restraint undermining the wellbeing and dignity of vulnerable older people. The Commission used qualitative methods primarily and says it cannot, from this work, give an idea of the prevalence of restraint. The implication of the report, however, is that it is widespread and troubling, and should be the focus of future research.¹²⁷

A second area of concern is the meeting of nutritional needs in hospital, which is a proposed Equality Measurement Framework indicator, not included in depth in this report due to scarcity of data. Initial analysis conducted to test the viability of the measures suggests significant results for the over 81's age group with a long-standing disability or illness, in terms of the percentage reporting 'not always receiving adequate nutritional support' (figures based on responses to the following question: *did you get enough help from staff to eat your meals?*).¹²⁸

¹²⁵ Allmark, P. *et al.* 2010 Chapter 5, Page 53.

¹²⁶ Allmark, P. *et al.* 2010. Chapter 5. Page 53.

¹²⁷ Allmark, P. *et al.* 2010 Chapter 5. Page 54.

¹²⁸ Alkire, S. *et al.* 2009. *Developing the Equality Measurement Framework: selecting the indicators*. Research Report 31. Manchester: Equality and Human Rights Commission. Chapter 5. Page 111. In the development of the Equality Measurement Framework indicators, the technical phase was to check sample size rather than generate final data analysis tables, so these are preliminary results for group means and the significance of the variations in group means, as well as a report on sample size. Significance tests are reported at the 95 per cent level. A series of cross-checks are required at the next stage of the development of the Equality Measurement Framework before final data tables can be produced.

Other literature seems to support the claim that the nutritional needs of elderly people who enter hospital malnourished are not met.¹²⁹

Box 9.4.1 Related issue: ‘Quality Adjusted Life Years’ (QALYs)¹³⁰

The Quality Adjusted Life Years (QALYs) system used by the National Institute for Health and Clinical Excellence (NICE) in deciding whether a treatment should be funded by the NHS, looks at the number of years someone benefits from a treatment and the quality of those years. A cheap treatment that contributes to a long and disability-free life will score highly; an expensive treatment that contributes only a few months of life but that life is of poor quality, will get a low score.

This system has been criticised as unfair and older people have been cited as a group vulnerable to this unfairness. Thus QALY scores will tend to encourage the decision that where a treatment is effective, younger people should receive it as a priority and older people tend to be excluded.

Socio-economic groups

The Citizenship Survey in England suggests there is no clear association between feeling that you are treated with respect when using health services and socio-economic groups. However, those who have never worked or are long-term unemployed appear slightly less likely to perceive they are treated with respect ‘all of the time or most of the time’ compared to those in all other occupations.¹³¹

The ‘Living in Wales’ survey shows no difference in social classes for the corresponding measure.¹³²

Disability

Perceptions of treatment with respect for those with LLTI/disability seem to be very similar to those without. The Citizenship Survey and the Living in Wales survey do not show any significant differences.¹³³

As in the section on Age (above), these results are based on those able to complete the respective survey. Those who face barriers to participating in the survey (i.e. communication barriers) need other measures and modes of research in order to understand their experiences of dignity and respect in healthcare.¹³⁴

¹²⁹ See also Allmark, P. *et al.* 2010. Chapter 5. Pages 59-61.

¹³⁰ Allmark, P. *et al.* 2010. Chapter 5. Page 54.

¹³¹ CLG 2009.

¹³² Allmark, P. *et al.* 2010. Chapter 4. Page 82.

¹³³ Allmark, P. *et al.* 2010. Chapter 6. Page 28.

¹³⁴ Allmark, P. *et al.* 2010. Chapter 6. Page 56.

Ethnicity

The sample numbers are small for some ethnic minority groups in the Citizenship Survey, making it more difficult to detect differences between them. Nevertheless, for England, Chinese, Bangladeshi and Black African people stand out as being least likely to report being treated with respect all of the time or most of the time when using health services, although these results should be regarded as indicative rather than significant.¹³⁵

The National Patient Survey Programme led by the Care Quality Commission shows that people of Asian and Chinese origin report less positive experiences than the White British majority across a range of care settings, but that differences are particularly noticeable in primary care.¹³⁶

The Living in Wales 2008 survey examines perceptions of treatment with dignity and respect by ethnic minority groups but the numbers of ethnic minority individuals included in the survey are too small for analysis.¹³⁷

While poor communication is a commonly cited problem and there are widespread inadequacies in interpretation and translation facilities, this is not merely an issue for those who cannot speak English. Poor listening, dismissiveness, rushed consultations and disrespectful attitudes are factors that have been found to undermine patient–provider communication for ethnic minority people, even where they speak English.¹³⁸

Evidence suggests that Gypsies and Travellers have extremely poor experiences of primary care and may face significant obstacles to registering with a GP.¹³⁹

Religion or belief

The Citizenship Survey shows that the groups most likely to report being treated with respect when using health services ‘some of the time or less’ were Buddhist, Muslim and ‘No religion’, though the differences were not large and did not reach statistical significance.

Qualitative studies have explored healthcare experiences among individuals of ethnic minority and religious minority identity. By-and-large these studies have suggested rather low levels of satisfaction with services for some groups and some significant concerns around feeling unwelcome and disrespected by healthcare professionals. Several studies have highlighted the ways in which

¹³⁵ CLG 2009.

¹³⁶ Allmark, P. *et al.* 2010 Chapter 7. Page 75.

¹³⁷ Allmark, P. *et al.* 2010 Chapter 7. Page 77.

¹³⁸ Allmark, P. *et al.* 2010 Chapter 7. Page 112.

¹³⁹ Allmark, P. *et al.* 2010 Chapter 7. Page 78.

certain religious identities – notably a Muslim identity – may result in particularly negative experiences in healthcare settings (as in other public service settings). For example, this may include Muslim women suffering severe humiliation when being forced to accept care from male health professionals, or opting not to take up recommended exercise programmes when those on offer were for both genders together.¹⁴⁰

Sexual orientation

The Citizenship Survey shows that gay and lesbian people are more likely to say that they have been treated with respect in health services some of the time or rarely, but due to small sample sizes, the difference from the average is not significant. It is suggested that this finding may be borne out in other literature.¹⁴¹

Transgender

The 'Patient Satisfaction with Transgender Services' which surveyed the opinions and experiences of 647 individuals at all stages of treatment/transition, found that 1 in 7 transgender people who responded to the healthcare section of the satisfaction survey felt that they had been treated adversely by healthcare professionals because of their transgender status.¹⁴²

In the same survey, a third of respondents said that their GP was 'always' supportive of their decision to seek gender reassignment, compared to 17% who responded 'never' and 23% 'sometimes'.

¹⁴⁰ Allmark, P. *et al.* 2010. Chapter 9. Pages 60-64.

¹⁴¹ Allmark, P. *et al.* 2010. Chapter 10. Page 26.

¹⁴² Allmark, P. *et al.* 2010. Chapter 10. Page 19.

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