

**HEALTH AND WELLBEING SURVEY
HULL IN 2003**

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INTRODUCTION

This report is based on a Health and Wellbeing Survey of the residents of Hull, conducted by the Public Health Development Team on behalf of Eastern and West Hull Primary Care Trusts (PCTs) during 2003. The aim of the survey was to provide information on the health, lifestyle and service use of the population served by the PCTs which could be used in the planning and evaluation of current and future services, particularly those services aimed at improving public health. In addition the survey aims to provide information to a much wider range of organisations and individuals who have an interest in the health and health-related lifestyle activities of the population.

A similar Survey of the population of East Yorkshire PCT was conducted in 2002, and of Yorkshire Wolds & Coast in 2003. Although this report focuses on Hull, results for the other PCTs will also be reported occasionally.

METHOD

The Questionnaire

A self-completion questionnaire was developed, based on that used in the 1994 Health and Lifestyle Survey conducted by East Riding Health. A copy of the questionnaire is in Appendix 1.

Survey Sample

A random sample of 6,500 adults (aged 16 years or above) was selected from those residents of Kingston upon Hull who were registered with a GP on the Exeter System. This practice-based sample means that some individuals who live beyond the PCT boundaries were included in the sample.

Survey Response

A confidential, self-completion questionnaire and explanatory letter were sent out to these people by post during April 2003. Twenty eight percent of the sample had returned their completed questionnaires after 3 weeks, using the Freepost envelopes provided. A reminder postcard was then sent out to those who had not returned their questionnaire or contacted the administrators to be removed from the database, 4,684 reminders were sent out. A further 8% returned their questionnaire after this first reminder.

Seven weeks after the original mailing, a second, identical questionnaire and explanatory letter were sent to the non-respondents. A further 14% then returned completed questionnaires giving a final response rate of 50%. Those who were no longer eligible to be included in the survey (had moved or died) were not removed from the database before the response rate was calculated. A total of 1,716 responses were received from the residents of the Eastern Hull PCT area and 1,560 from the West Hull PCT area.

Survey Administration

The Survey was developed and managed by the Public Health Development Team, and led by single member of the team. Mailing and data entry were carried out by Trent Data Services Ltd. The report was produced by members of the Public Health Development Team.

Further information can be obtained from the Public Health Intelligence Team at Hull City Council via publichealthintelligence@hullcc.gov.uk and further survey reports are available at www.hulljsna.com

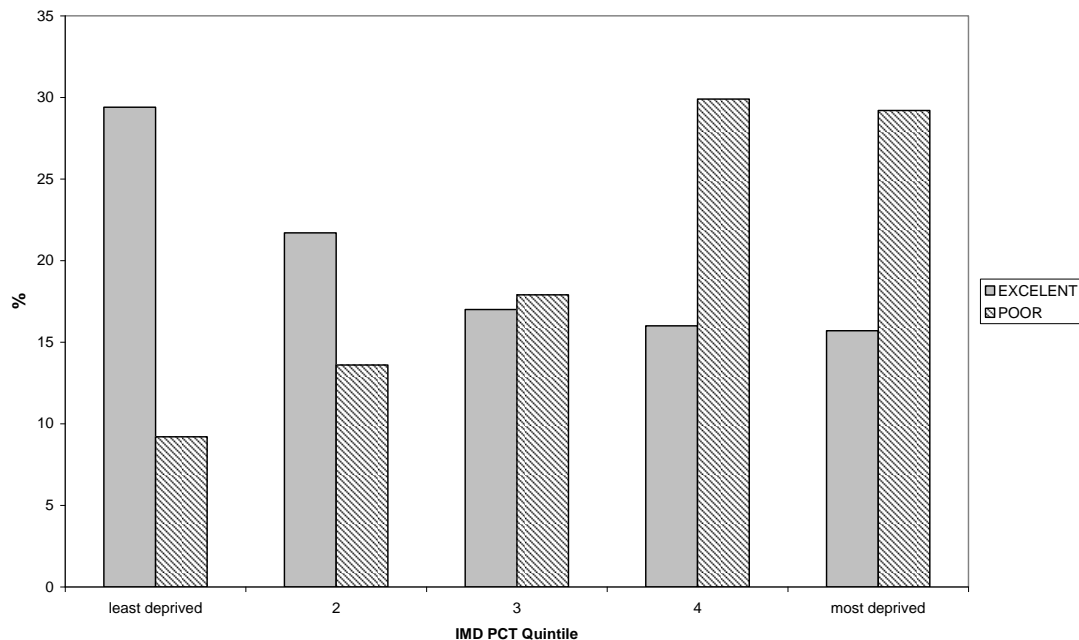
GENERAL HEALTH

Self reported general health status (Q3)

Younger males and females in Hull reported increasingly better health than older age groups, the younger the individual, the more likely they were to report having better health. The opposite pattern was recorded in the four age groups from 45+ where increasingly more poor health was reported. Compared to national rates recorded in the Health Survey for England 2002 where 75% of males and 74% of females said their health was 'very good' or 'good', 62% of males and 65% females in Hull said this of their health. Also, 8% of males and 7% of females in England said their health was 'very bad' or 'bad' compared to 9% of males and 6% of females in Hull who said their health was 'poor'.

The following graph shows a comparison between 'excellent' and 'poor' self-reported health across 5 levels of deprivation in Hull. Where around 30% of people in the least deprived areas considered their health was excellent, only 15% in the most deprived areas described their health as excellent. There was a marked difference in ratings of poor health between the least deprived and the 4th and 5th most deprived areas where people were three times more likely to rate their health as poor.

Figure 1: Comparison between excellent and poor self-reported health by deprivation quintile



Further analysis of survey variables, in relation to deprivation are included in the inequalities section of this report.

12 month health comparison (Q4)

Generally, people reported that their health was about the same as 12 months ago. Those in younger age groups were less likely to report their health was worse than 12 months ago and were more likely to report their health was better than 12 months ago. This pattern was reversed in the 45-54 age bands in which a larger proportion of people considered they had somewhat worse health than a year ago.

Baby Expected (Q5)

Only males and females in the youngest three age groups reported expecting a baby. The highest proportion of females expecting a baby was recorded in 25-34 year olds where 22 out of 264 women (8%) were expecting a baby.

Limiting long term illness/disability (Q6/7)

Older age groups were more likely to report long term illness or disability; with more than two thirds of over 75s reporting a problem. Rates of long term illness or disability were slightly lower in females than males. Compared to national rates recorded in the Health Survey for England 2003 where 44% of males and 46% of females reported at least one longstanding illness, 44% of males and 39% of females in Hull reported long term illness/disability. Nationally, 23% of males and 26% of females have a limiting long term illness this compares to 35% of men and 27% of women in Eastern Hull and 45% of males and 41% of females in West Hull reporting limiting long term illness.

Last BP measure (Q8)

Overall, 59% of males and 69% of females had their BP measured in the last 12 months, with more recent measurements being associated with older age groups. In the 16-24 age band the largest proportions of people had never had their BP measured (average for males 35% and for females 13%). Of the two youngest age groups, a larger proportion of females had their BP taken in the last 12 months; this proportion evened out across males and females as age increased.

High/raised BP (Q9/10)

Reporting of high blood pressure increased with increasing age. There were significant differences between males and females in the youngest two age groups where females reported much higher rates of raised BP than males. Overall, 31% of males and 34% of females reported they had high BP, this compares to national rates recorded in the Health Survey for England 2002 in which 27% of males and 33% of females reported high BP. Roughly half of the people with high BP reported it was still high. In Hull, high BP was maintained more with increased age, peaking at ages 65-74 in both male and female groups reporting their BP was still raised.

DENTAL HEALTH

Number of teeth (Q13)

Most people in the younger age groups had 20 or more of their teeth and older age groups tended to have fewer. The oldest two age groups most reported having 'no teeth' with around 65-70% of those 75+ having no teeth. Generally, slightly more females than males in the older age groups reported having fewer teeth.

Registered with Dentist & NHS/private/both dentist (Q14/15)

There were no highly significant variations across male and female age groups; registration peaked around the middle age groups with the lowest rates of registration in the oldest age group. Again, registration rates with a dentist in all three categories were highest in the middle age groups and lowest in the oldest age group. Registration with NHS dentists peaked in the 35-44 age band and registration with private dentists peaked in the 45-54 year age band. Registration choices were fairly consistent across age groups.

When dentist was last visited (Q16/17/18)

More recent visits to the dentist were observed in the younger age groups. For those in the 75+ age band, 40% of males and 25% of females reported never having visited a dentist. The most common reason for both males and females for not visiting a dentist in the last 12 months was that they had 'no need' to. The main reasons why the dentist was last visited for females and males were for a 'check up' and they had 'trouble with teeth or gums'.

How soon an appointment was available (Q19)

The experience of males and females was similar, with 10% getting an appointment immediately, and a further 25% within one week. Between one and two and a half percent were unable to get an appointment.

Distance to dentist (Q20)

Around 80% of males and females lived within 6 miles of their dentist. At the 7 mile boundary, the percentage dropped to 3% and again the further away they had to travel. Less than one percent of females and males lived further than 25 miles from their dentist.

EATING

Type of fat for frying food (Q21)

Most people reported they fried their food in vegetable oil. More females than males reported they did not eat fried food at all; therefore females scored healthier than males in the overall fat score.

Type of milk drunk most often (Q22)

Most people reported they drank semi-skimmed milk, around 30% of males in the three younger age groups drank whole milk.

Usual type of spread (Q24)

The three types of spread most used were polyunsaturated margarine, low fat spreads and butter.

Dietary score

Most people fell into the 'fairly healthy' range. No significant variations were observed across age groups or between males and females within this category.

Dietary classification

Most people fell into the 'fairly healthy' category. More females than males were 'healthy' and more males than females were 'unhealthy'.

Weight and Height

Survey respondents were asked to give their height and weight. From this information a Body Mass Index (BMI) was calculated for each person. The calculation is:

BMI = weight (kilograms) divided by height (in metres) squared

Individuals with a BMI of under 20 are classified as underweight, although this is generally not in itself a medical problem; a BMI of over 30 is classified as Obese, and over 40 (where there are severe risks of consequent health problems) morbidly obese. The recent House of Commons Health Committee report on Obesity¹ highlighted the growing risks to Public Health from Obesity and particularly urged the Government to increase its preventative actions.

A report by Experian International which analysed expected rates of Diabetes in Local Authorities gave Hull Britain's highest obesity index rating. Despite the figures being ill-founded the mass media widely reported that Hull was top of the fat league and "Britain's top obesity hot-spot"²

¹ House of Commons Health Committee Report on Obesity. HMSO 2004.

² Daily Mail: March 1 2004 p25

The main finding, shown in table 1, is that the percentage of adults who are obese in Hull is BELOW the national average.

Table 1. Percentage of adults classified obese (BMI>30) 2003

Primary Care Trust	Male	Female
E YORKSHIRE	14	14
EASTERN HULL	13	20
WEST HULL	14	19
Y W & C	16	17
England*	22	23

Other findings are that:

- The highest levels of obesity locally are among women in Hull
- The more materially deprived an area, then the higher the levels of both obesity and underweight
- The highest levels of obesity are in the 45-64 year old age groups
- There has been roughly a 60% rise in the obesity level in the last decade both locally and nationally

***Data Considerations**

The local data presented in this survey comes from “self-reported” height and weight data, whereas the England data is from actual measurements. Research has shown that overweight individuals, particularly the elderly, tend to under-report their weight and hence their BMI too³. Recent estimates of the degree of underreporting in Western cultures indicate that levels of obesity may be underestimated by the survey by 1 to 7 percentage points^{4,5}. This particularly needs to be borne in mind when comparing local and national figures.

Gender and Obesity

Figure 2 compares the BMI categories of males and females for Hull and East Riding. The pattern was similar for both areas. Females were more likely to be underweight and of a desirable weight but also three times more likely than males to be morbidly obese. 43% of males were overweight compared to 28% of females.

³ Rowland ML. (1990). Self-reported weight and height. *AM J Clin Nutr*; **52(6)**:1125-33

⁴ Nieto-Garcia FJ, Bush TL, Keyl PM. (1990). Body mass definitions of obesity: sensitivity and specificity using self-reported weight and height. *Epidemiology*; **1(2)**:146-152

⁵ Kuskowska-Wolk A, Karlsson P, Stolt M, Rossner S. (1989). The predictive validity of BMI based on self-reported weight and height. *Int J Obes*; **13(4)**:441-453

Figure 2. Hull and East Riding Male and Female BMI categories

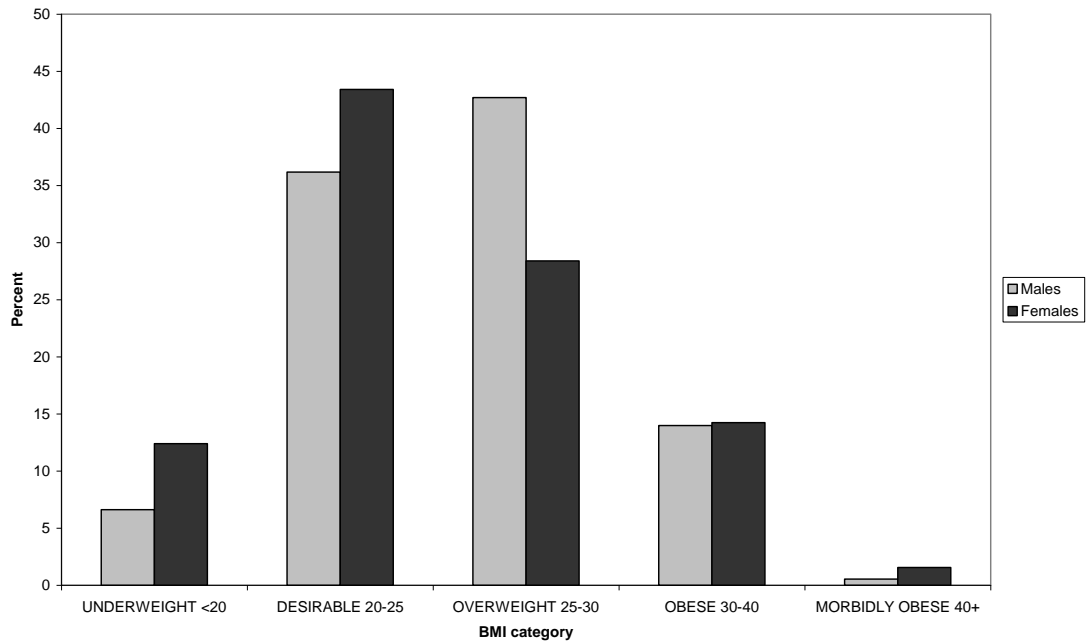


Figure 3 compares female BMI categories for PCTs to national levels. When the tendency to under-report obesity in the local survey, discussed above, is taken into account, the PCTs are broadly similar to one another and to the national picture, although with generally higher proportions of underweight people (although this too may be an “over-reporting” feature).

Figure 3. Female BMI categories by PCT

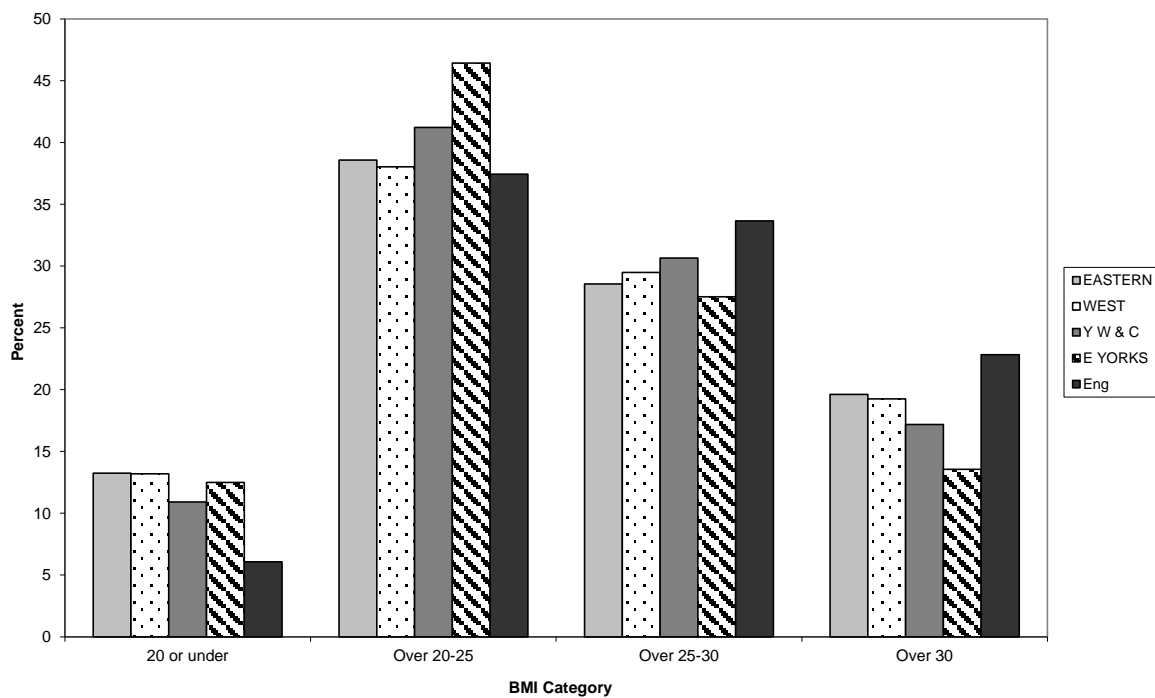
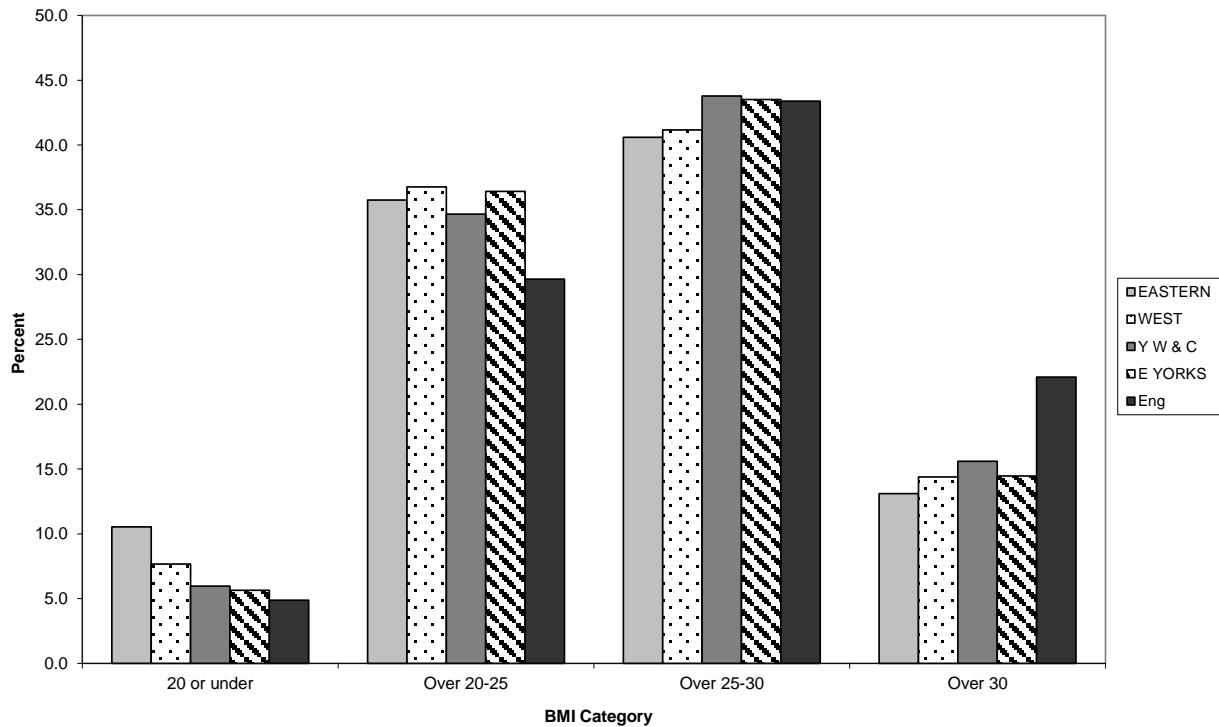


Figure 4 shows that for males, all four local PCTs show very similar BMI levels both to one another and the national pattern (taking account of the previously discussed under-reporting of obesity).

Figure 4. Male BMI categories by PCT

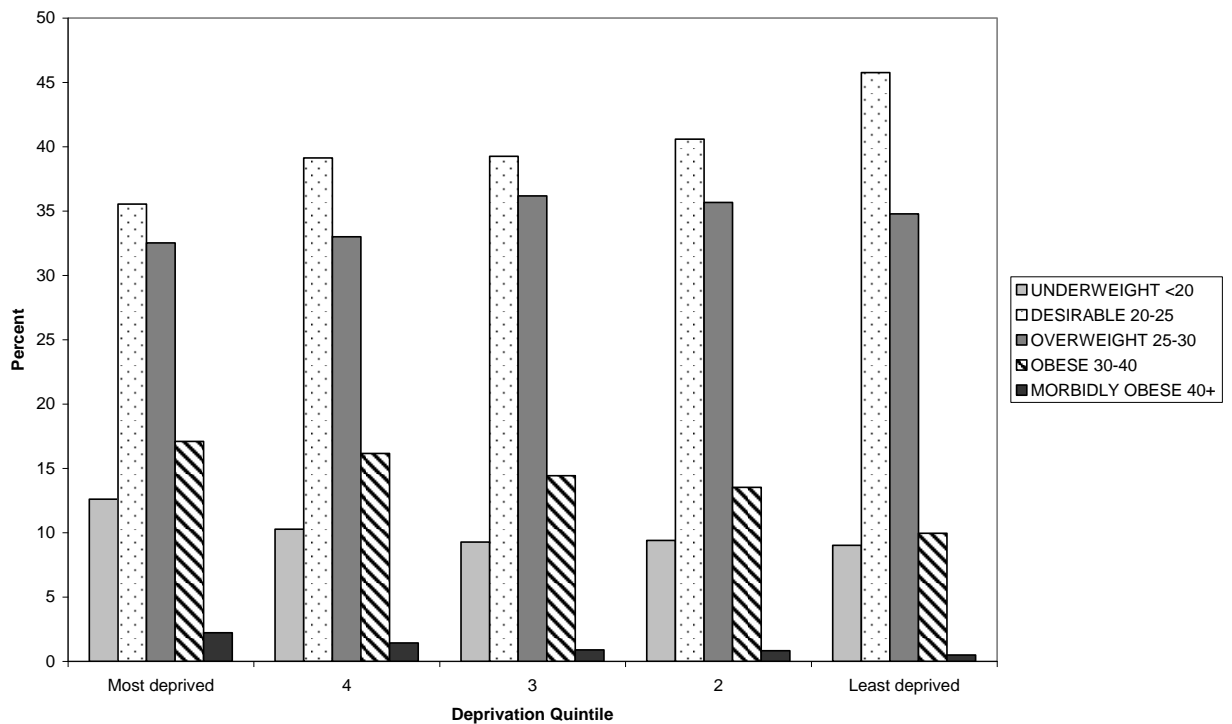


Deprivation and BMI

Obesity is a known risk factor involved in CHD and many other diseases. Figure 5 shows self-reported body mass index (BMI) scores for Hull and East Riding, split by deprivation quintile. It is better to use data from both authorities here in this figure to give a wider spread of people across the deprivation categories. Deprivation quintiles involve ranking geographical areas of around 1,000 people according to a range of material and social deprivation measures, and then dividing the areas into 5 groups (the quintiles). There is a clear trend for more deprived areas to have higher proportions of people who are obese, morbidly obese and underweight. Correspondingly the more deprived an area then the lower the percentages of people who have a (medically) desirable weight or are overweight.

However although this trend is clear, the absolute difference in proportions between the areas is not great – an increase of 1.7 % points for BMI>40 (from 0.5 for the least deprived areas to 2.2 in the most deprived), and of 7.1 % points for the obese (BMI 30-40) rising from 10 to 17.1.

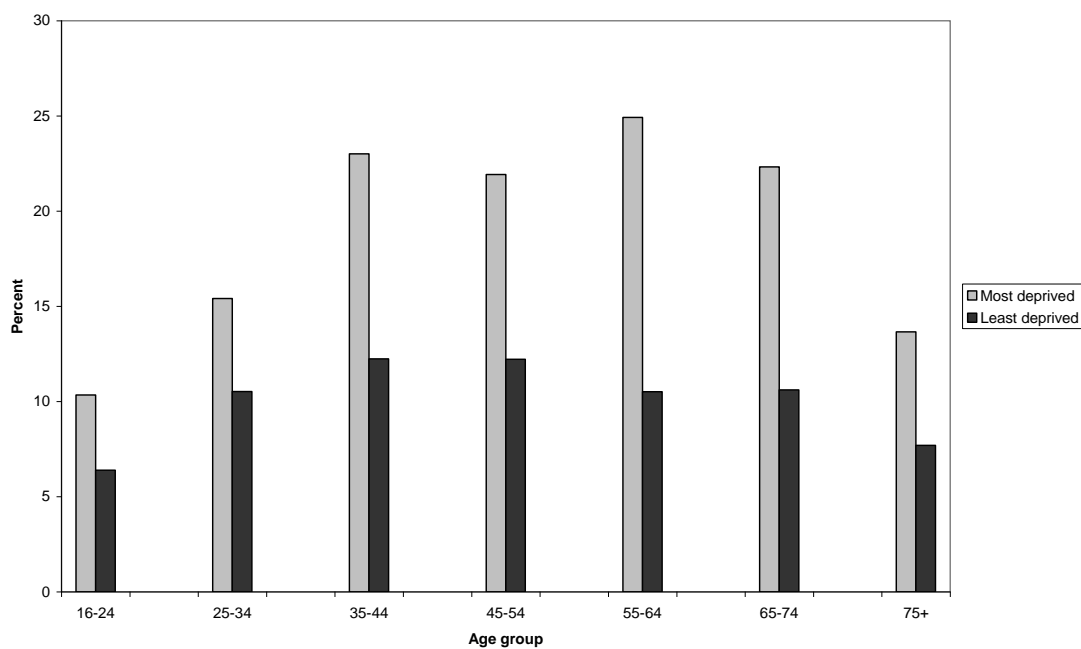
Figure 5. Percentage of people by BMI category and deprivation quintile



Obesity and age

As Figure 6 shows, there is a trend for Obesity levels (defined as BMI > 30) to rise through the age ranges of the 20's and 30's. This pattern occurs in both the most and least deprived areas, and across all four PCTs represented here, including both the Hull PCTs.

Figure 6. Percentage of people with BMI > 30 (Obese) by age group



ALCOHOL IN HULL 2003

A series of questions about people's drinking in the previous 7 days were asked in the survey. Amounts consumed were then calculated as "units" to standardise and compare different drinks.

Units of alcohol consumed were derived as follows:

- Ordinary beer, lager or cider (1 pint) = 2 units
- Strong beer, lager or cider (1 pint) = 3 units
- Wine (1 small glass) = 1 unit
- Sherry (1 small glass) = 1 unit
- Spirits (1 measure) = 1 unit
- Low alcohol beer/wine (1 pint) = 1 unit

Levels of drinking per week were defined as follows⁶:

	None	Safe	Excessive	Dangerous
Males	0-1	1-21	22-50	51+
Females	0-1	1-14	15-35	36+

Results

Most people who reported drinking drank safe levels of alcohol during the week and over 50% of females did not report drinking at all (Table 2 and figures 7 & 8). Overall, males drank more excessively and dangerously than females but those drinking excessively in the youngest age band were comparable. For females in the excessive drinking category, the youngest females (16-24) had the highest rates although excessive drinking rates were also high in the 45-54 year age band.

Table 2. Hull: Levels of drinking in the week

GENDER	Age band	Weekly drinking levels (%)				All levels	
		None	Safe	Excessive	Dangerous	%	N
MALE	16-24	40.5	40.4	13.4	5.7	100	147
	25-34	28.2	47.2	19.5	5.1	100	188
	35-44	25.3	50.9	20.7	3.1	100	135
	45-54	29.4	55.0	12.5	3.1	100	237
	55-64	29.2	50.5	18.3	2.0	100	246
	65-74	41.2	49.7	8.6	0.5	100	199
	75+	48.7	48.4	2.9	0.0	100	125
	Total		34.6	48.9	13.7	2.8	100
FEMALE	16-24	38.3	47.8	12.7	1.2	100	252
	25-34	45.3	47.9	6.0	0.8	100	265
	35-44	42.2	50.4	5.9	1.5	100	323
	45-54	40.1	48.3	10.6	0.9	100	285
	55-64	57.0	39.6	3.4	0.0	100	284
	65-74	70.4	27.7	1.2	0.8	100	251
	75+	79.1	20.9	0.0	0.0	100	158
	Total		53.2	40.4	5.7	0.7	100

⁶ These levels are different for males and females because of different average body mass and composition.

Figure 7. Hull: Male drinking level categories (Percentage by age group)

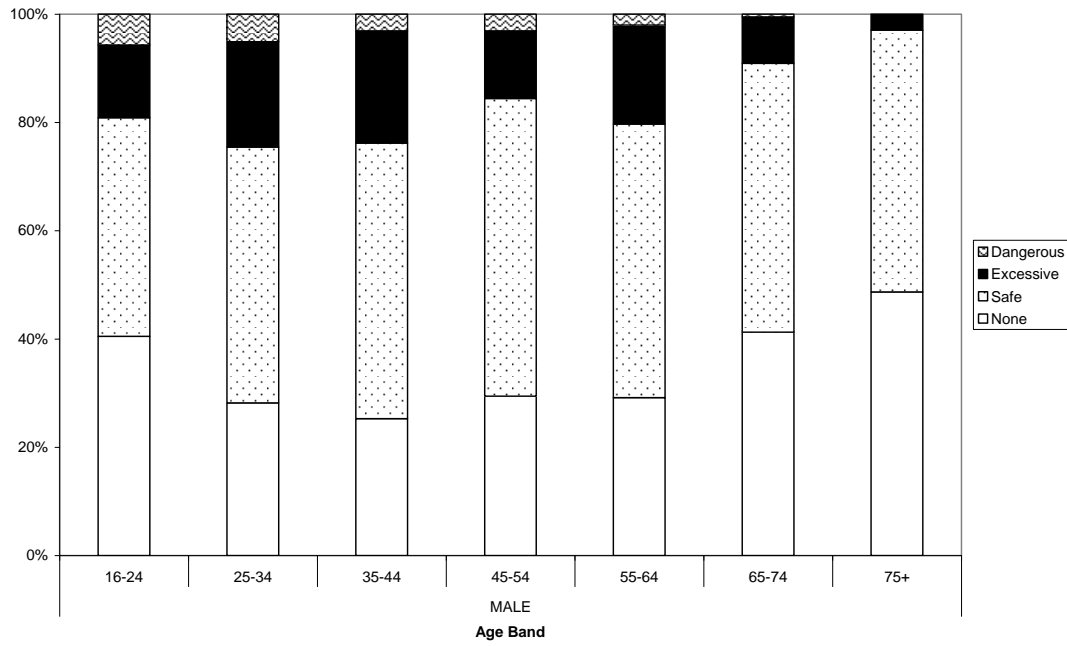


Figure 8. Hull: Female drinking level categories (Percentage by age group)

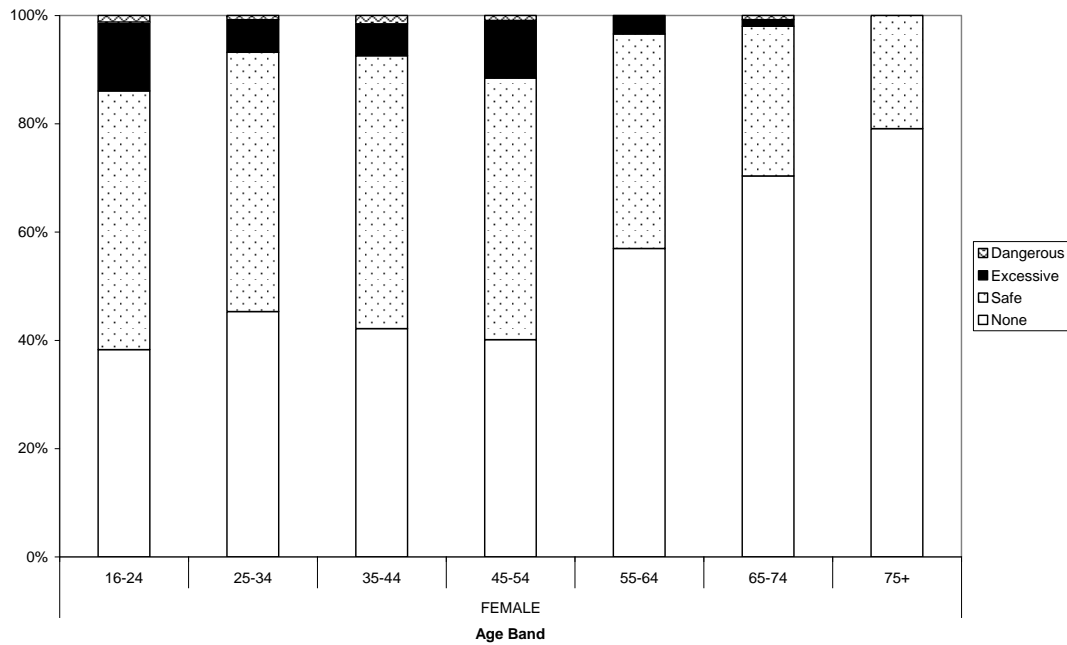
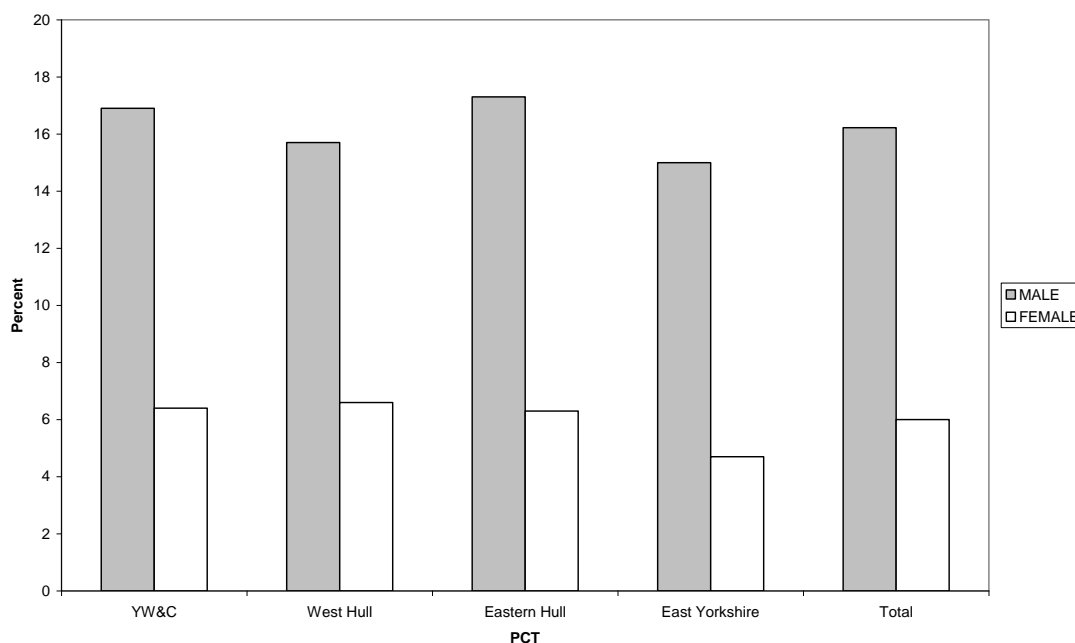


Table 3 shows only the percentage of heavy drinkers (i.e. excessive and dangerous drinkers). Males were far more likely to be heavy drinkers than females. Younger males showed higher levels of excessive and dangerous drinking than older males and again, rates of heavy drinking increased in 45-54 year old females. Figure 9 shows Hull's levels of excessive drinking to be similar across Hull & East Riding.

Table 3. Hull: Heavy drinkers (percentage by age)

Gender	Age band	Excessive & Dangerous (%)	Dangerous (%)	All persons (Number)
MALE	16-24	19.1	5.7	28
	25-34	24.6	5.1	46
	35-44	23.8	3.1	56
	45-54	15.6	3.1	37
	55-64	20.3	2.0	50
	65-74	9.1	0.5	18
	75+	2.9	0.0	4
	Total		16.5	2.8
FEMALE	16-24	13.9	1.2	35
	25-34	6.8	0.8	19
	35-44	7.4	1.5	24
	45-54	11.5	0.9	32
	55-64	3.4	0.0	10
	65-74	2.0	0.8	5
	75+	0.0	0.0	0
	Total		6.4	0.7

Figure 9. Percentage of people drinking excessively (over 21 units for males & over 14 units for females) by PCT



Figures 10-13 show the proportions of types of alcohol drunk by males and females in Eastern and West Hull. Males tend to drink more beer, lager and cider than females who drank more wine and spirits. Types of alcohol drunk by males and young females were similar in Eastern and West Hull.

Figure 10. Types of alcohol drunk by males in Eastern Hull

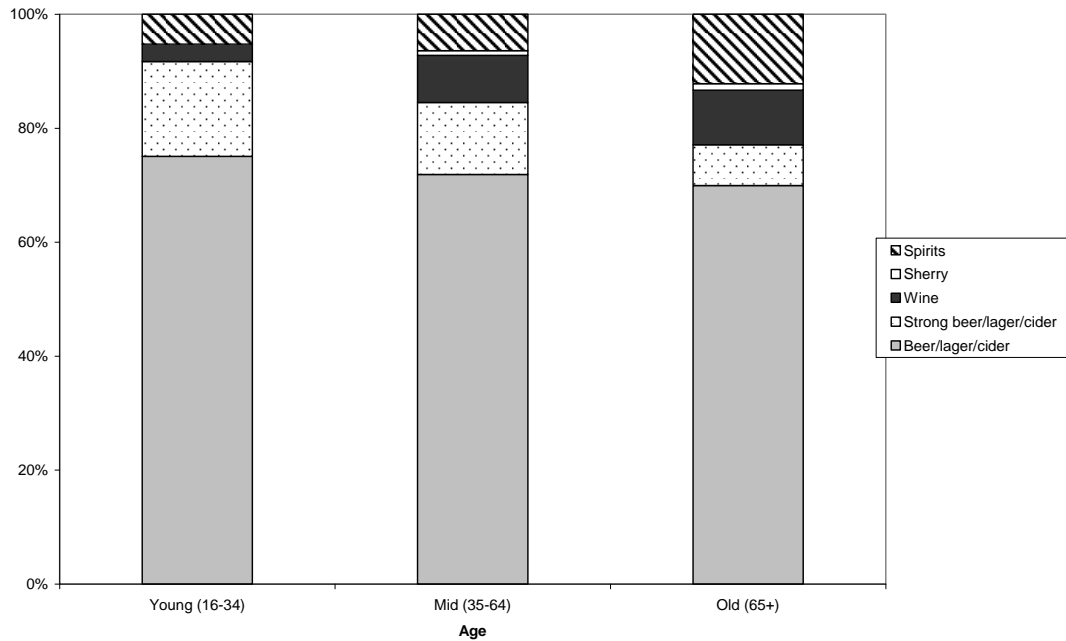


Figure 11. Types of alcohol drunk by males in West Hull

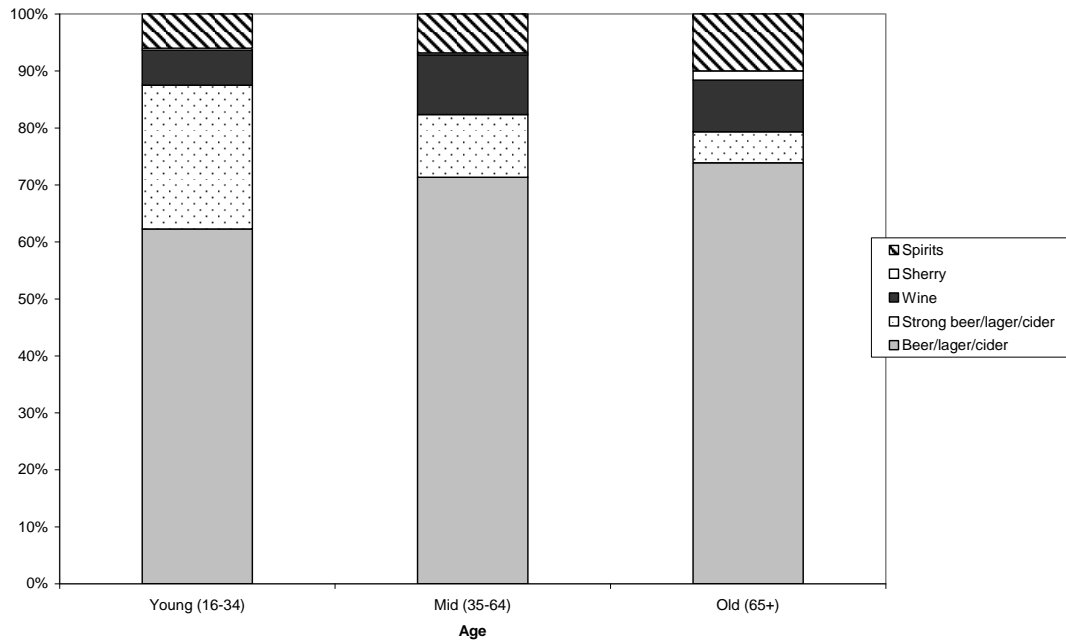


Figure 12. Types of alcohol drunk by females in Eastern Hull

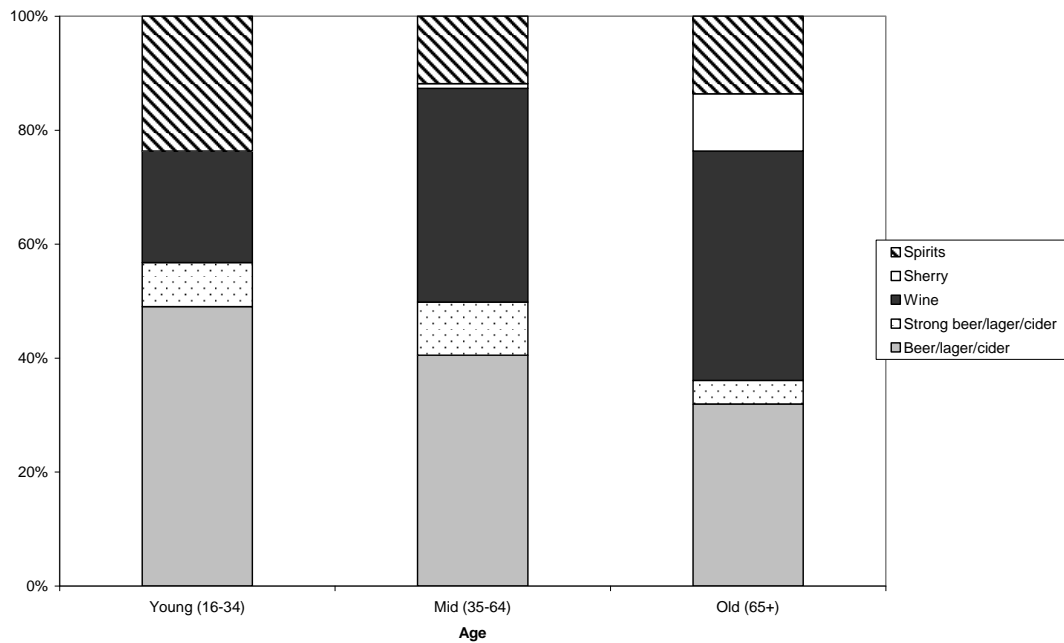
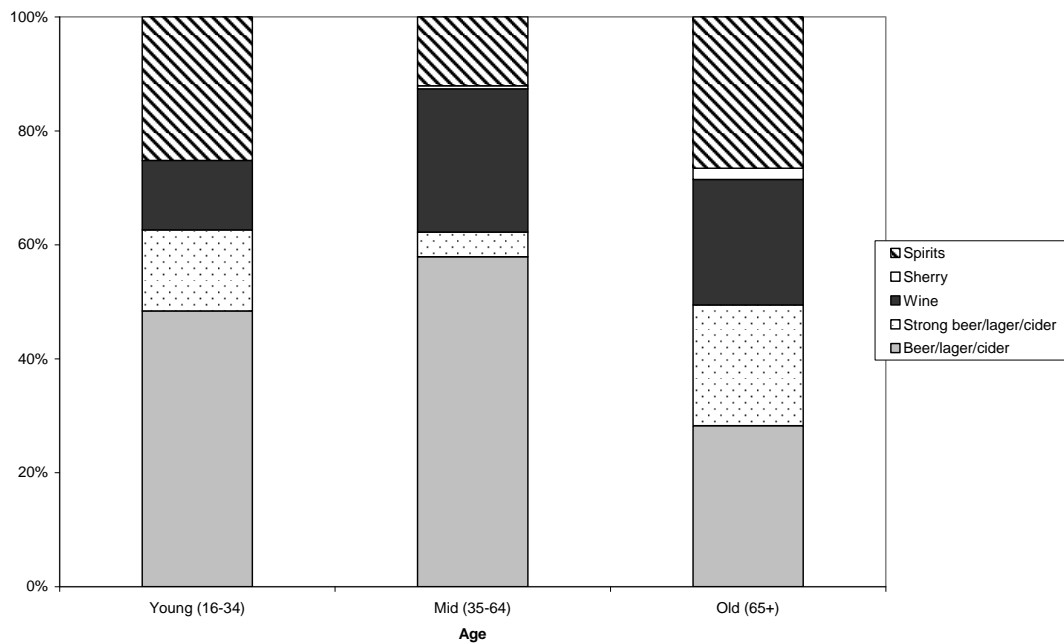


Figure 13. Types of alcohol drunk by females in West Hull



Figures 14-17 illustrate in the same way the types of alcohol drunk by heavy drinkers (i.e. excessive and dangerous drinkers). Again, males drank very high percentages of beer, lager and cider – a pattern similar to the types of alcohol drunk by all male drinkers (see figures 10 & 11). Compared to all drinkers, excessive female drinkers in Eastern Hull generally drank more spirits and the young age group drank more beer, lager and cider and less wine. Female excessive drinkers in West Hull drank less spirits than all drinkers. Female excessive drinkers in Eastern Hull generally tended to drink beer and those in West Hull drank more wine and in the middle age band, females in Eastern

Hull drank more beer, lager and cider than their counterparts in West Hull who drank more wine. In the older age band, where all female drinkers showed fairly even patterns of drinking different alcohol types, excessive drinkers in Eastern Hull drank a large proportion of strong beer, lager and cider where those in West Hull replaced this with wine.

Figure 14. Types of alcohol drunk by excessive male drinkers in Eastern Hull

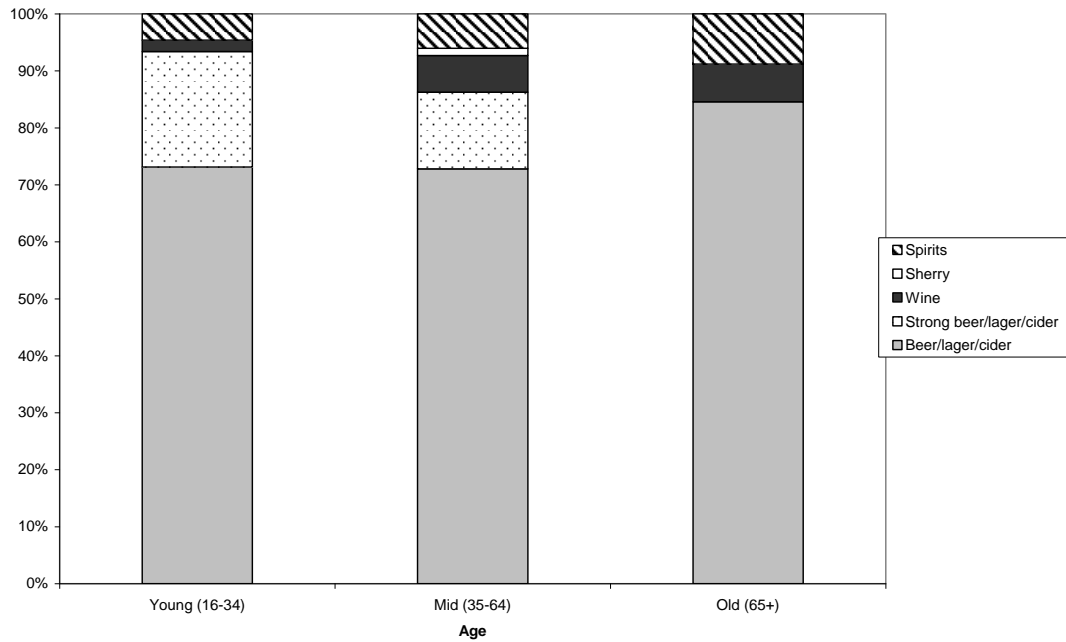


Figure 15. Types of alcohol drunk by excessive male drinkers in West Hull

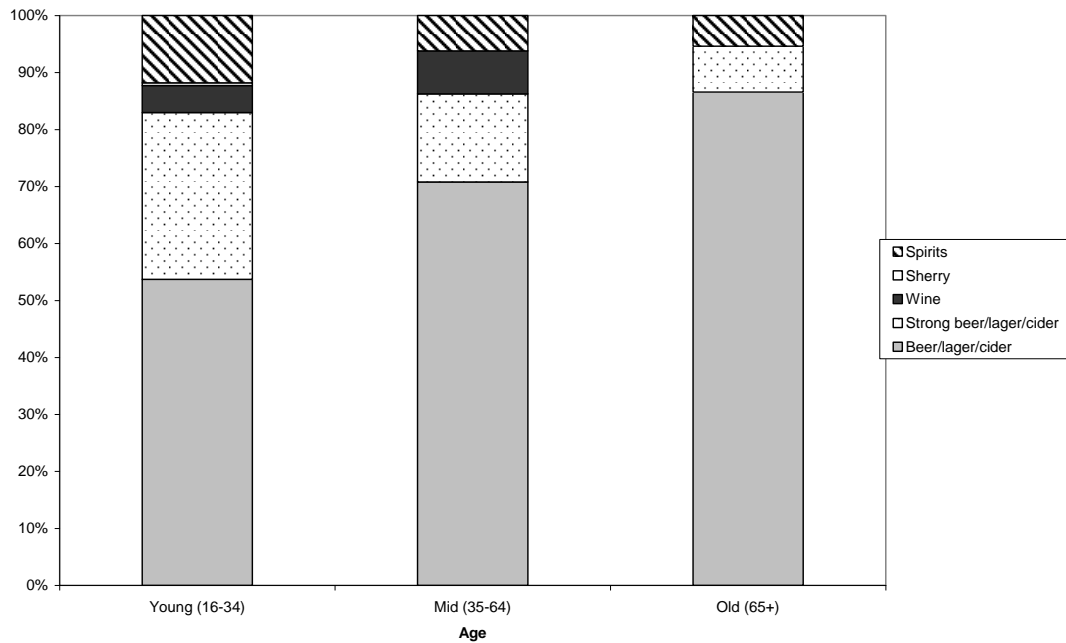


Figure 16. Types of alcohol drunk by excessive female drinkers in Eastern Hull

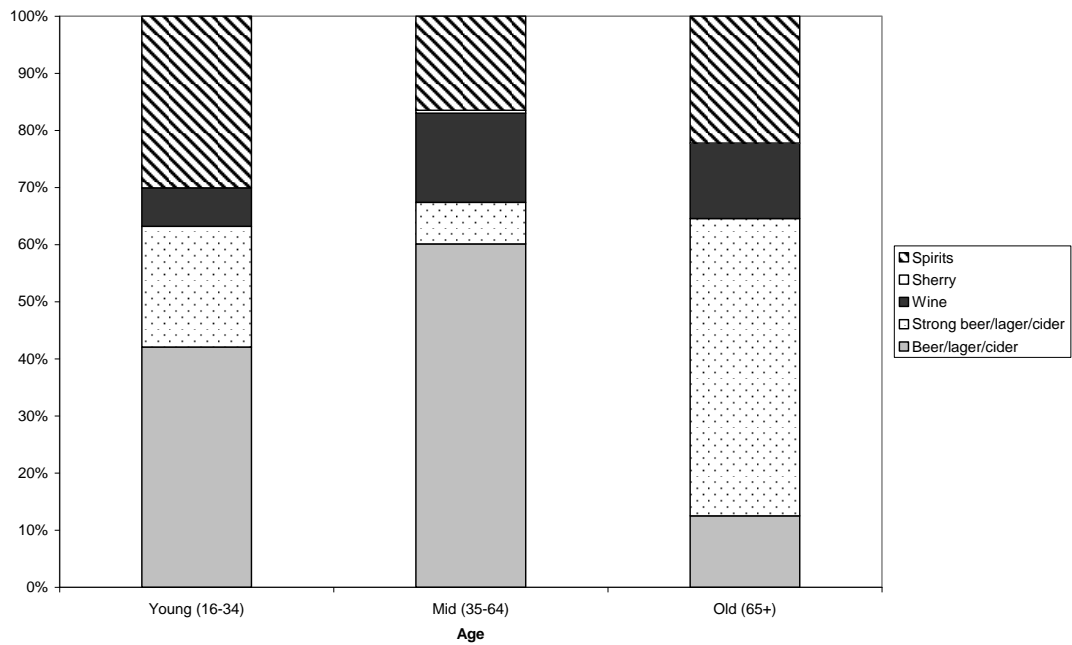


Figure 17. Types of alcohol drunk by excessive female drinkers in West Hull

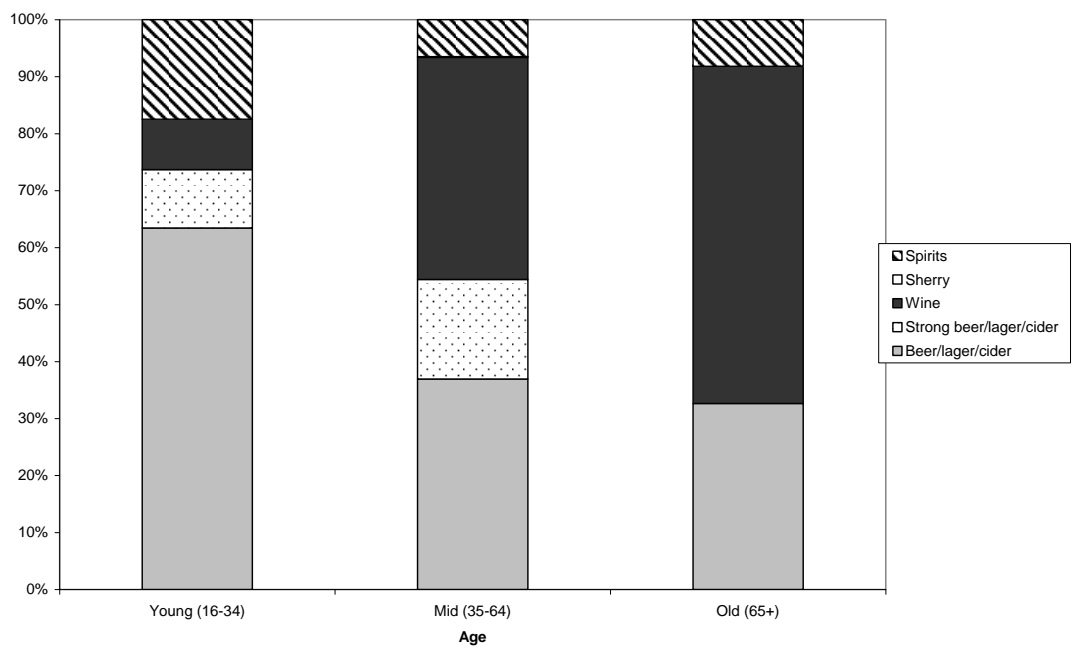
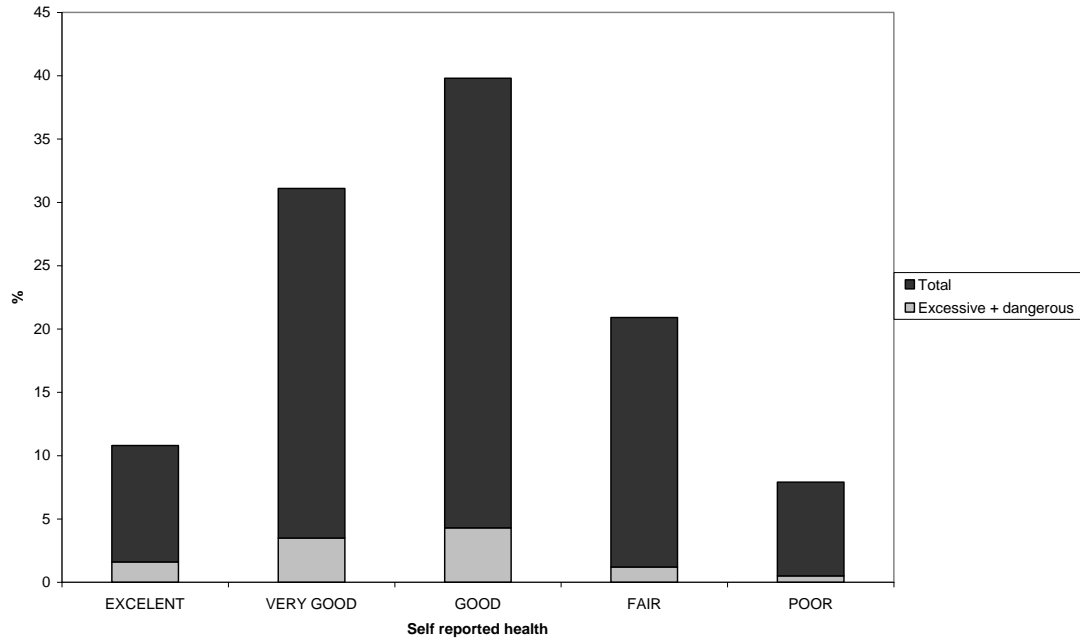


Figure 18 shows how excessive drinkers reported their health. Ratings followed the pattern of all drinkers, showing that people drinking at levels which may damage their health have similar perceptions of their current health to the rest of the population.

Figure 18. Self reported health of excessive drinkers in Hull



SMOKING

Have cigarettes been smoked in last 7 days (Q29)

One third of people reported having smoked in the last 7 days and higher percentages of the younger age groups, more females than males – in fact, 43% of females aged 16-24 in West Hull had smoked in the last 7 days. As age increased, so did the numbers of people reporting not having smoked in the last 7 days. 72% of males aged 16-24 had not smoked in the last 7 days.

Current smoking status (Q30)

Higher percentages of people in the younger age groups reported smoking daily. More people in the younger age groups reported never having smoked, and more males than females had never smoked. In the ‘ex-smoking’ category, the oldest three age groups, and more males, reported the highest rates peaking at 75+ where an average of 61% of males and 36% of females were ex-smokers. Refer to the graphs below.

Use of no smoking areas (Q31)

There were few variations across age groups here; more females than males used no smoking areas. More people in the two youngest age groups reported not using ‘no smoking’ areas, a percentage which decreased as age increased.

Number of years smoked and given up (Q33/34)

As expected, results varied according to people’s ages. Older smokers had smoked for longer. An average of 80% male and 55% female smokers aged 75+ had smoked for over 56 years. Younger ex-smokers had given up more recently than older ex-smokers. There were most ex-smokers in the 16-24 year age band where most male and female smokers had given up in the last 5 years.

Figure 19. Male smoking patterns across age groups

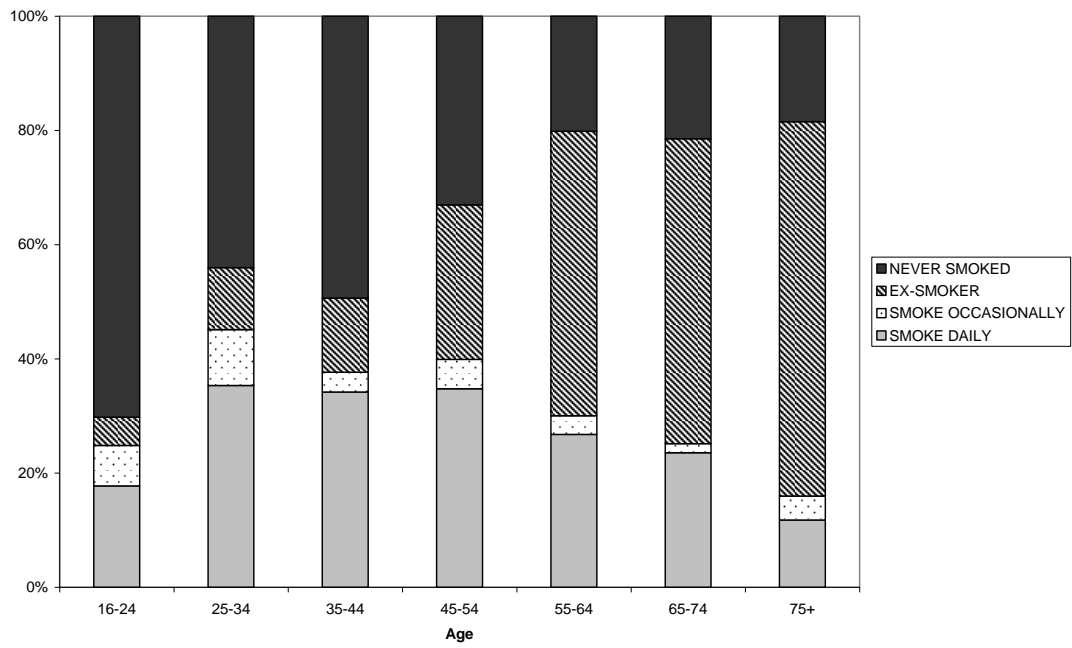
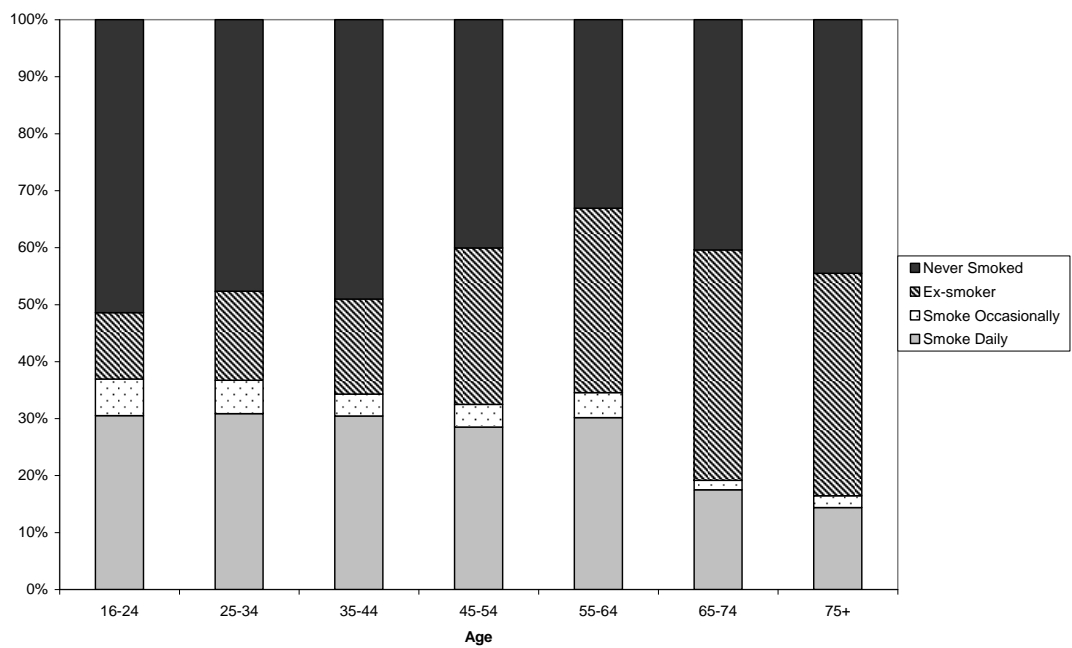


Figure 20. Female smoking patterns across age groups



EXERCISE

Normal day exercise (Q35)

About half of each sex considered themselves fairly active and around one quarter of each sex said they were 'not very active'. More males reported being 'very active' than females.

Frequency of exercise in the last 7 days (Q36)

Around 30% of each sex reported never doing vigorous exercise. Males in the two youngest age groups reported having vigorously exercised 3 times or more in the last 7 days compared to females in this age band reporting vigorously exercising 1-2 times. Most people reported exercising moderately and lightly in the last 7 days, again 16-24 year old males reported more instances. More females than males reported exercising lightly 3 times or more in the last 7 days. An average of 24% of males and 21% of females aged 75+ reported never exercising lightly.

Is enough exercise taken (Q37/38)

Younger people were more likely to report they did not take enough exercise where older people were more likely to think they did do enough exercise. For example, an average of 36% females aged 75+ compared to 71% females aged 16-24 considered that they did not take enough exercise. For around half of males and females, the main reason preventing them taking enough exercise was lack of time, and for one third, no will power and illness/disability. Around 20% of females said they didn't exercise because it was too expensive.

HOUSEHOLD & PERSONAL INFORMATION

Who people live with (Q39)

In the youngest age band, on average, 56% of females and 75% of males lived with their parents. A large proportion of people from 25-64 years old lived with their partner and children, and those who were 65-75 years old mostly lived with just their partner. At 75+, more males than females lived with their partner while more females than males lived alone.

Responsible for long term care (Q40)

Only a small percentage of people (6%) reported being responsible for the long term care of anyone. Of those that did care, most reported being responsible for the care of a partner or parents. Overall, 9% of people reported being responsible for their disabled partner with older age groups reporting higher rates. Around 10% of females and 12% of males reported being responsible for the long term care of their elderly or disabled parents; these rates peaked in the 45-54 year age band.

Hours per week spent in unpaid care (Q41)

90% of males and 87% of females did not spend any hours caring for someone. Overall, hours spent in unpaid care for females were consistent and peaked at 8 hours (3%) the time males spent in unpaid care were fewer than females and peaked at 2 and 8 hours.

Children (Q42/43)

Around two thirds of households in Hull had children living in them. Around 40% of households had one or two children under 16 and 20% of households had 1 child over 16.

Housing tenure (Q44)

Around 60% of males and females owned their house, and around 20% rented their property from the council.

Work (Q45/46/47)

52% of males and 45% of females in Hull were working. Generally, younger people were working, and older people were not working, although high rates of younger males and females reported they were not working. At age 65, only 4% of males and 2% of females were working; no females aged 75+ were working compared to 1.5% of males who were working part time. Of those who were working, 46% were males and 23% were females working full time along with 5% males and 23% females who were working part time. Of those who were not working, around 20% were retired males and 20% retired females, 9% were looking for work (mainly younger people), 16% were sick or disabled, 10% of females were full time carers and 9% were in full time education (mostly those in the 16-24 age band and more males than females).

Use of a car or van (Q48)

69% of males and 61% of females had the use of a car or van. Those in the middle age bands were more likely than other age groups to have this access; 27% of males and 35% of females aged 75+ did not have the use of a car or van.

Highest Qualification (Q49)

50% of males and 53% of females in Hull did not report having any academic qualifications. Of those that did, more females than males had GCSEs, A levels and degrees as their highest qualification, a similar amount of males and females had attained post graduate level. Three times more males than females had HNC & technical qualifications.

Ethnic group (Q50)

95% of males and 96% of females in Hull were white.

HEALTH SERVICES

Attendance as a patient in the last 12 months (Q51)

16% of females and 17% of males had attended A&E in the last 12 months; rates were highest in young males. Around one quarter of males and one quarter of females had attended outpatients in the last 12 months. Older people were more likely to make an outpatient visit. Most people had not used a counsellor in the last 12 months, of those that did, the highest rates were found in 35-44 year old males and in 25-34 year old females. Around 8% of males and 9% of females had been an in-patient in the last 12 months; again this was more likely in the older age groups. Females were more likely to use NHS direct and visit the Family Planning Clinic.

Use of General Practice services in the last 12 months (Q52)

72% of females and 67% of males had visited their family doctor in the last 12 months and 40% of females and 25% of males had visited their practice nurse. 16% of males and 9% of females had not used any General Practice services in the last 12 months.

Alternatives to General Practice services (Q53/54)

Over 82% of people did not report using any alternatives to services which might have been available at their General Practice. Of those that did use alternative services, 16% of people used A&E instead and females used NHS direct instead. 8% said the hours were more convenient, 2% said they got the service through private health insurance, 3% thought that better care was available this way, 7% said there was too long a wait at their GP, 4% that the location was more convenient, 9% that they did not think their GP could help, and 12% for other reasons.

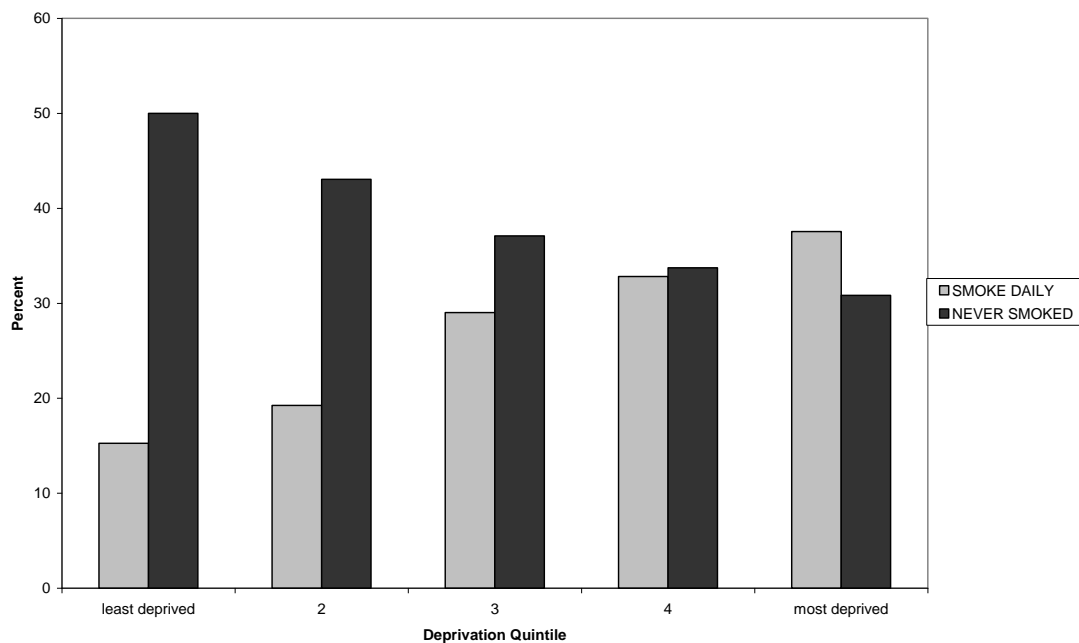
INEQUALITIES IN HEALTH

The following section presents variables according to 5 levels of deprivation in Hull where 1 is the least deprived and 5 the most deprived.

Smoking

The graph below shows a gradient across deprivation areas; as deprivation increases, the likelihood of smoking increases and the likelihood of never having smoked decreases compared to the least deprived areas. Differences in smokers and non-smokers are more pronounced in the less deprived areas. A similar health and lifestyle survey in 1994 reported that in more deprived areas; around 35% of people smoked daily and 45% had never smoked.

Figure 21. Comparing daily smokers and non-smokers across deprivation quintile within Hull



Drinking

Figure 22 shows that more people in the least deprived areas drink up to an excessive level (22-50 units per week for males and 15-35 units per week for females). Those in the most deprived areas are more likely not to drink and to drink dangerous levels (51+ units per week for males and 36+ units per week for females).

Figure 23 illustrates the percentage of heavy drinking by deprivation quintile within Hull. In each quintile, at least twice as many males drink heavily than females. Heavy drinking levels are similar across all quintiles. Heavy drinking levels are slightly elevated in less deprived areas.

Figure 22. Weekly drinking levels in the least and most deprived quintiles of Hull

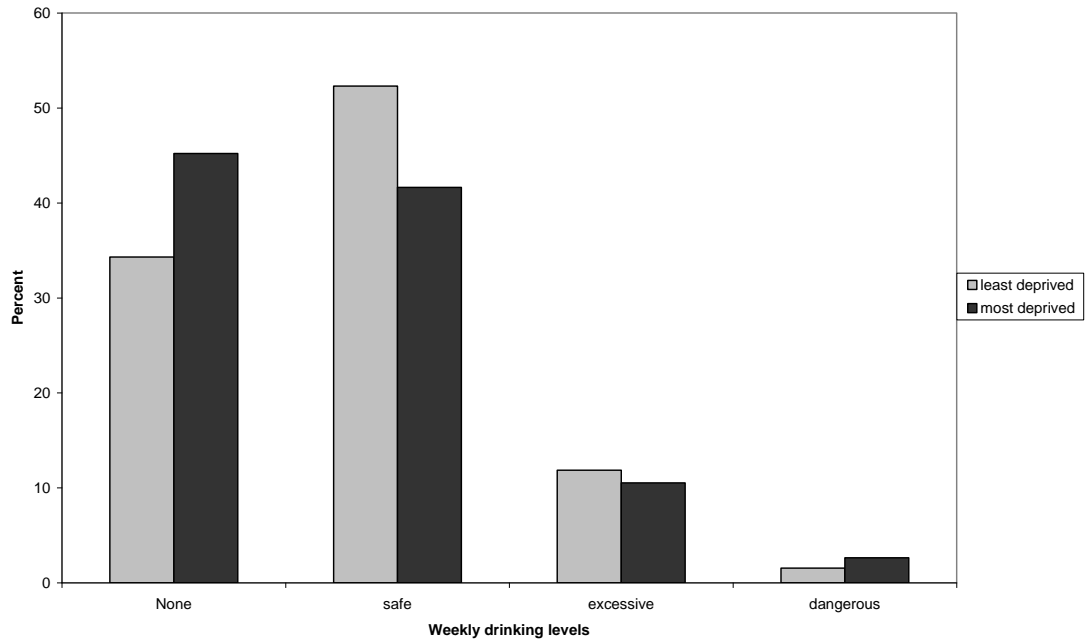
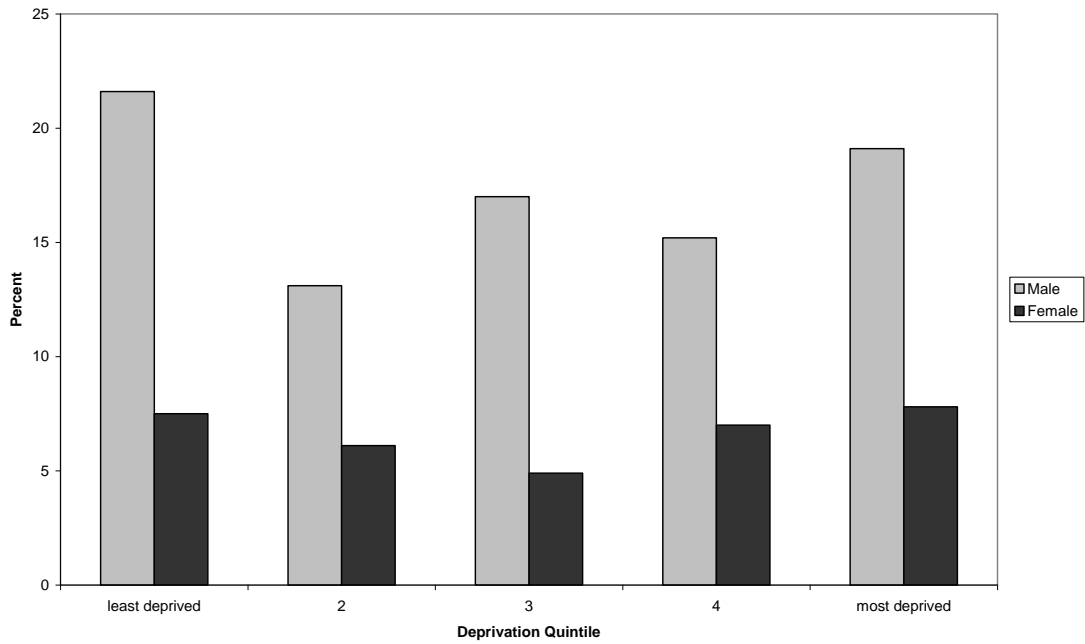


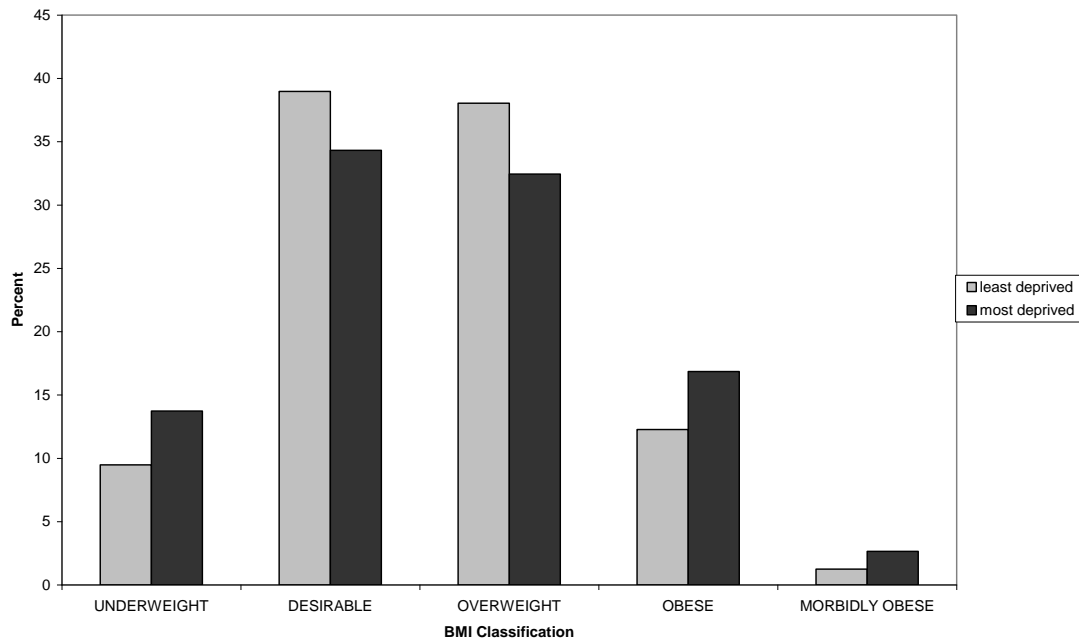
Figure 23. Excessive/dangerous drinking during week by Deprivation quintile



Body Mass Index (BMI)

Figure 24 compares the BMI classifications of those in the most and least deprived areas of Hull. Those in the most deprived areas were more likely to be underweight, obese and morbidly obese. Those in the least deprived areas were more likely to be of a desirable weight and overweight. A similar health and lifestyle survey in 1994 reported that obesity was more common in more deprived areas, especially among females.

Figure 24. Comparing the most and least deprived quintiles of Hull in relation to BMI classification



Education

Figure 25 shows the highest qualification attained in each deprivation quintile. It can be observed that as deprivation increases, it is more likely that people will have lower qualifications and as deprivation decreases, people are more likely to achieve more advanced qualifications.

Figure 25. Comparing the highest qualifications of each deprivation quintile

