

5 HEALTH AND SOCIAL WELLBEING

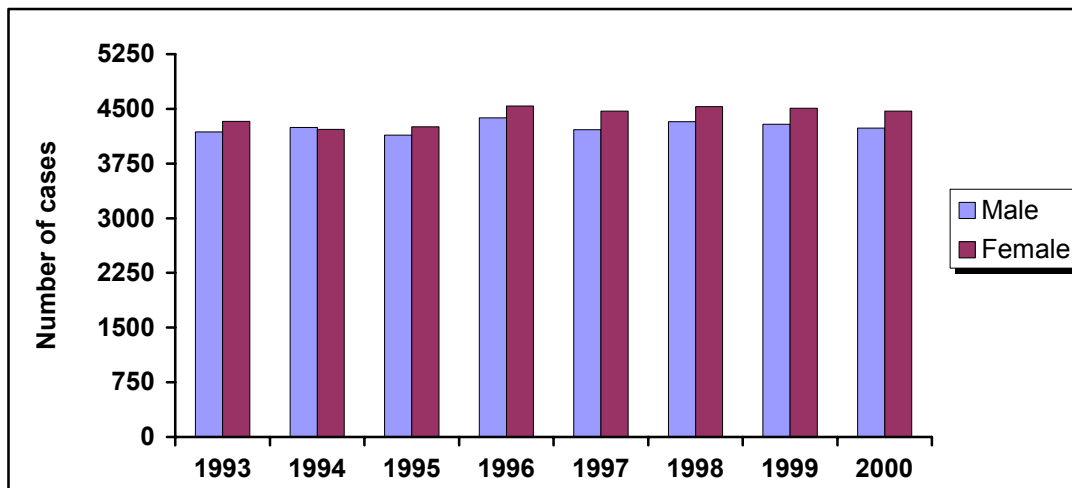
LIFE EXPECTANCY AND PREMATURE MORTALITY (SMR U75)

- 5.1 Life Expectancy and Standardised Mortality Rates for people aged under 75 (SMR U75) provide broad indicators of the overall health of a population. Results for these indicators are presented in Chapter 8 for different geographical groupings. Life expectancy at birth of men and women has increased significantly since the late 1800s. Whereas males and females born in 1890-92 could expect to live for 47 and 46 years respectively, males born in 2000-02 could expect to live for 75 years and females for 80 years. Over the last decade, male life expectancy has increased by 3 years and female life expectancy by 2 years.

CANCER

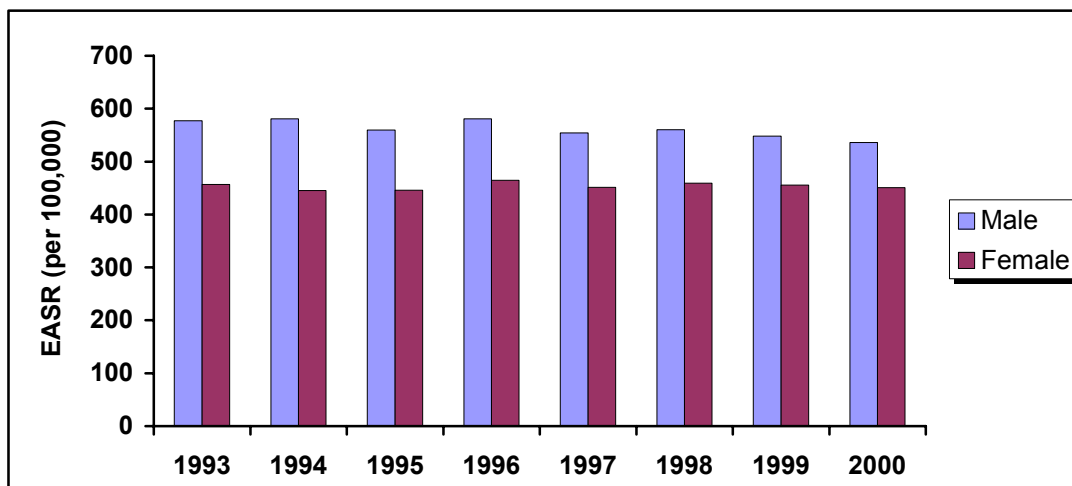
- 5.2 The Northern Ireland Cancer Registry (NICR) provides information on all cancers diagnosed in Northern Ireland since 1993. In Northern Ireland just under a quarter (23%) of all deaths are cancer related. Figure 5.1 shows the incidence of cancer among males and females over the period 1993 to 2000. In 2000 4,237 males and 4,470 females were diagnosed with cancer. In the same year, 1,762 males and 1,789 females died of cancer. In each year, with the exception of 1994, the incidence of cancer was higher among females than males. However, when the data is adjusted for the effects of age, the overall incidence rates for females were lower than those for males (Figure 5.2).
- 5.3 The Base Report of the new Inequalities Monitoring System (presented in chapter 8) includes analysis of standardised cancer incidence rates. That is, an assessment of how much more, or less likely a person is to develop either any cancer, or lung cancer, in a geographic area compared to someone in Northern Ireland of the same age and sex.

Figure 5.1 Incidence of cancer by gender in each year: 1993 – 2000



Source: Northern Ireland Cancer Registry

Figure 5.2 European age standardised rate (EASR) by gender: 1993 – 2000



Source: Northern Ireland Cancer Registry

5.4 The NICR data show that death rates are higher for males than for females. The most recent figures suggest that males have a one in seven chance of dying from cancer before the age of 75 compared with a one in eight chance for females. The NICR examined the trend in cancer mortality over the period 1984 to 2000. Their results show that the rate of cancer mortality is decreasing overall. The percentage change between 1984 and 2000 was 10% in males and 7% in females.

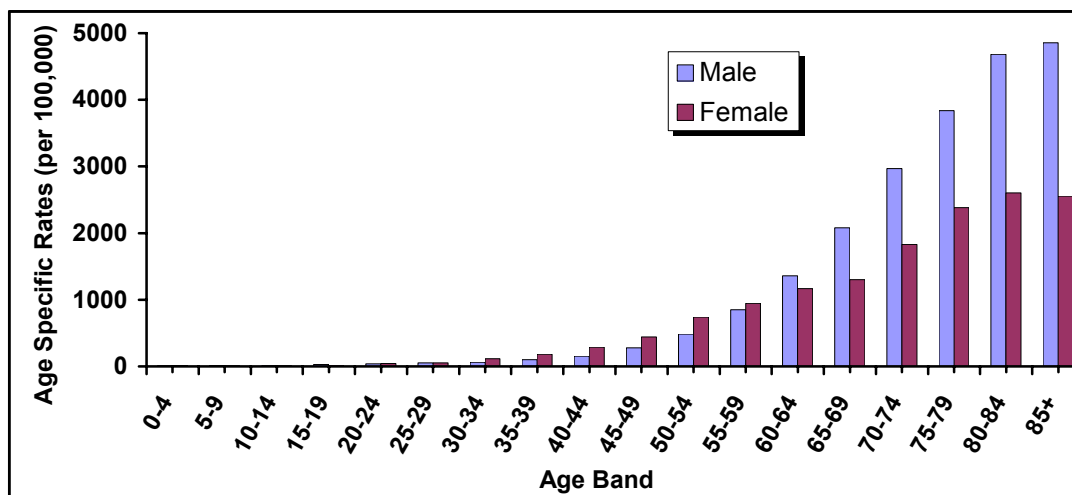
5.5 In terms of survival, for persons diagnosed between 1993 and 1996, this was significantly better in females than males. This gender difference may be explained by the higher levels of smoking and alcohol related cancers in men, with these cancers generally showing poor survival rates. On the other hand, the more common female cancers have higher survival rates

(breast cancer has a five-year relative survival rate of 78% compared with 8% for lung cancer).

5.6 There is a clear increase in the incidence rate of cancer with age (Figure 5.3). Half of all cancers in males in Northern Ireland occurred in those aged over 70 years, with half of those in females occurring in the 69 and over group. Although cancer is generally an older persons disease, cancer of the testis, cervix and malignant melanoma have a younger age of diagnosis compared with other cancers (Figure 5.4). Relative survival is lower for elderly patients than for younger patients for almost all cancers, even when the generally higher mortality among the elderly is taken into account. Breast cancer in women and prostate cancer however are two exceptions, with relative survival rates lower for younger people. Children diagnosed with cancer have about an 80% chance of surviving over 5 years.

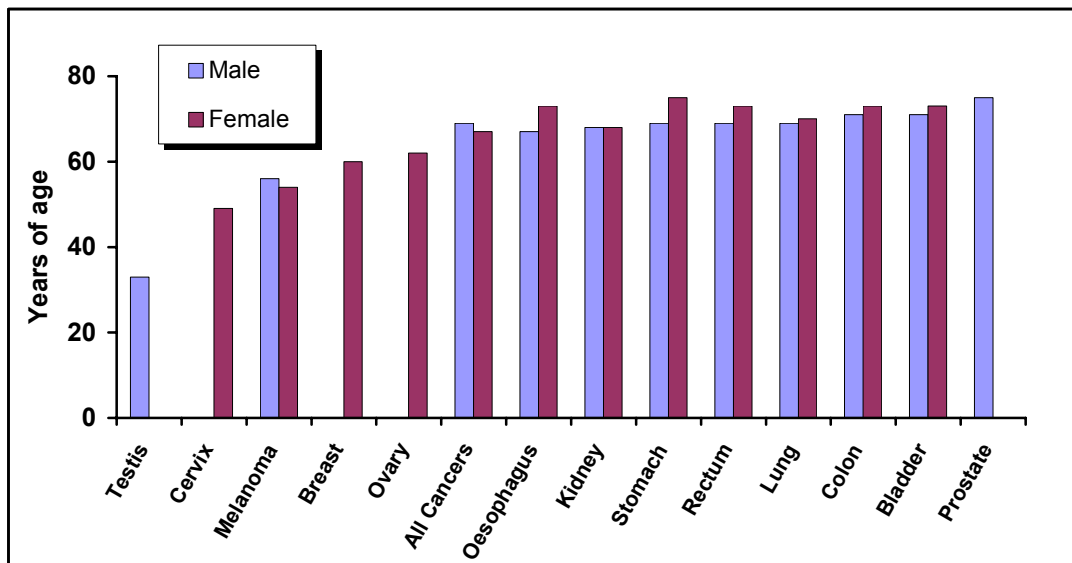
5.7 In general, people in lower socio-economic groups tend to have higher incidence of cancer and poorer cancer survival rates, when compared with those in higher groups. People in lower social classes experience greater incidence of lung, stomach, cervix and colorectal cancers than those in higher classes. In contrast, more cases of cancers of the breast, malignant melanoma, ovary and testis are diagnosed among individuals in the least deprived social groups. Figure 5.5 illustrates the incidence of lung cancer in Northern Ireland by deprivation quintile (using the income domain of the Noble Index). This shows that the highest lung cancer incidence rate was in the most deprived areas, in particular among males living in such areas. Analyses presented in Chapter 8 confirm this finding.

Figure 5.3 Age-specific incidence rates for all cancers: 1999



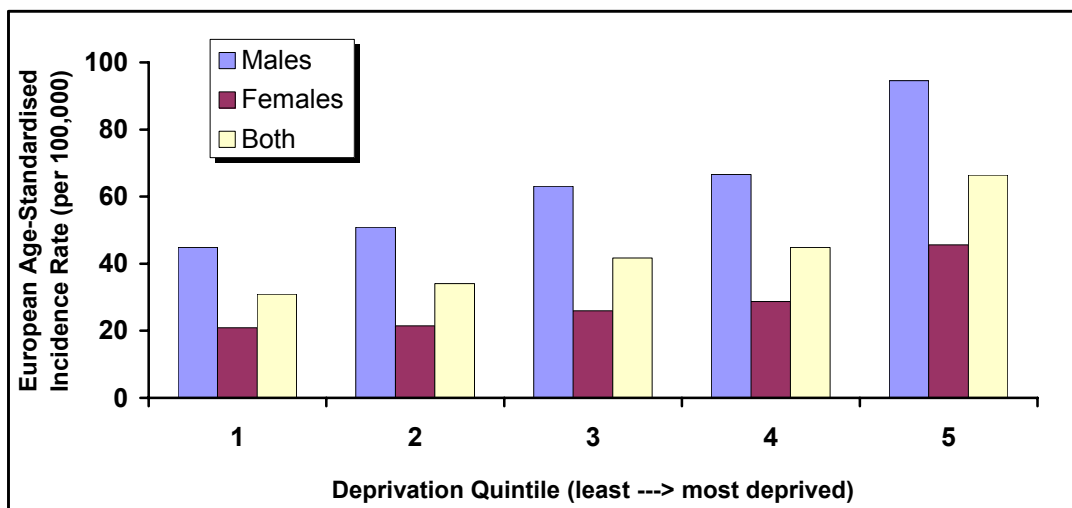
Source: Northern Ireland Cancer Registry

Figure 5.4 Median age at diagnosis by cancer type: 1999



Note: Half of the cases diagnosed were above and below the age incidence
 Source: Northern Ireland Cancer Registry

Figure 5.5 Incidence of lung cancer in NI by deprivation quintile: 1993 – 1999



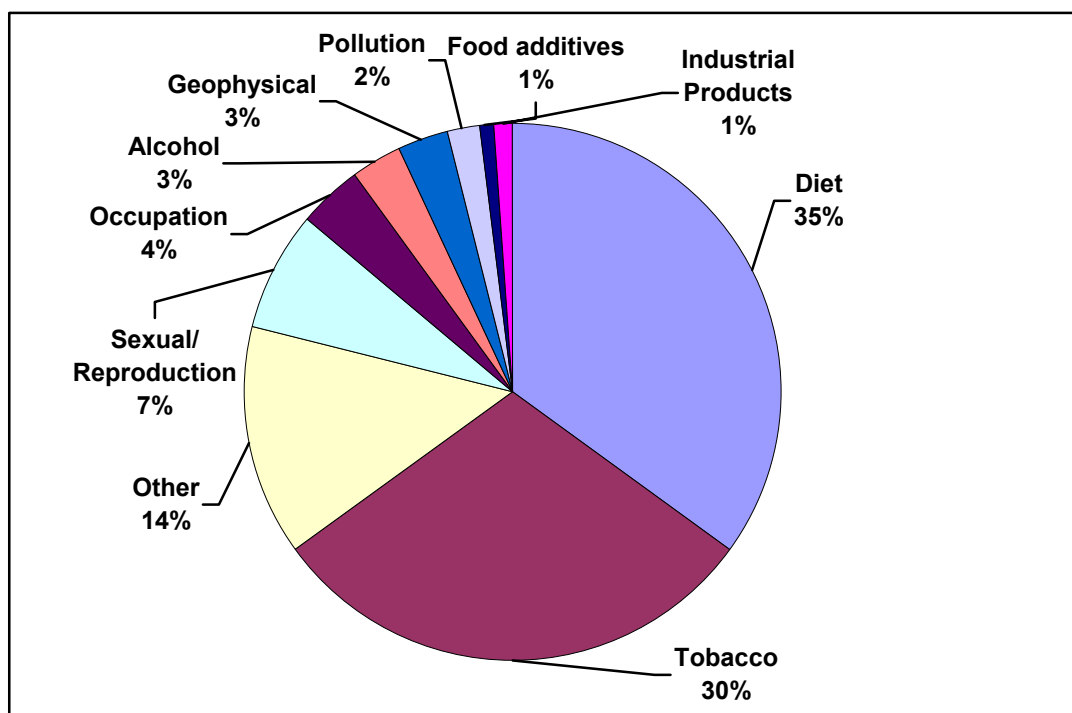
Source: Northern Ireland Cancer Registry

5.8 Research by the NICR on cancer incidence within HSS Boards/District Councils shows a higher incidence of lung cancer in the deprived areas of Belfast and Derry District Councils. Newry and Mourne also experienced higher levels of stomach cancer among males than was expected. Across Board areas, the Eastern HSS Board area experienced high numbers of cervical cancers, possibly due to low screening uptake rates. The Southern HSS Board area reported more cases of prostate cancers than expected which may have been attributable to the increased use of Prostatic Specific Antigen (PSA) testing in that area. There were no significant differences

between the survival rates across the four Board areas for each individual cancer site (1993 to 1996).

5.9 The differences in cancer incidence and mortality across the socio-economic groups can be partly explained by known risk factors such as tobacco smoking, diet and exposure to the sun. There is no data available for Northern Ireland or the UK on the factors attributing to cancer deaths but a study in America by Doll and Peto estimates that 30% of cancer deaths are attributed to tobacco smoking which, given the high prevalence of smoking among individuals in lower socio-economic groups (see Chapter 6), explains the observed differences in lung and other smoking related cancers (Figure 5.6). A further risk factor for cancer is diet; a higher daily intake of fruit and vegetables is known to offer protection against most cancers. People from lower socio-economic groups, adolescents and males are more likely than others to have a poor diet and are least able to change dietary habits (McGarrity and Knox, 1994).

Figure 5.6 Estimated percentage of cancer deaths attributed to various factors



Source: Doll and Peto, 1981

5.10 Variations in the incidence of cancer among people with diverse sexual orientations are difficult to identify due to the lack of data available. It is however believed that lesbians may have an increased risk of ovarian cancer due to lifestyle factors such as not bearing children (nulliparity), not

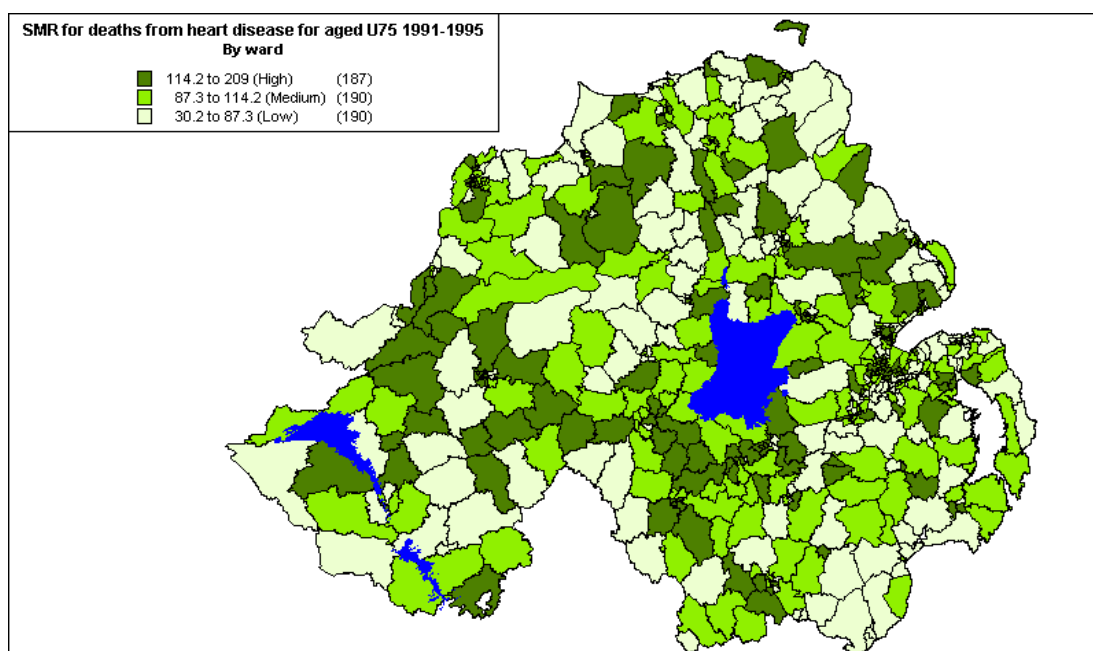
using oral contraceptives and possibly using fertility drugs. Furthermore, it has been suggested by researchers that there is a higher risk of breast cancer for lesbians as a result of nulliparity and lower uptake of breast screening.

5.11 Among gay men, high rates of Kaposi’s Sarcoma (a cancer-like disease which usually shows up in the skin, or in the mouth, nose, or eye, but can also spread to the lungs, liver, stomach, intestines, and lymph nodes) have been revealed in America. One American cohort study of records from cancer registries in New York and California found gay and bisexual men to be at excess risk of anal cancer, non-Hodgkin’s lymphoma and Hodgkin’s disease.

CORONARY HEART DISEASE

5.12 Coronary heart disease can result in angina, a heart attack and heart failure and is one of the main causes of death in Northern Ireland. It accounts for 1 in 3 deaths in males and 1 in 4 deaths in females and is also responsible for almost 20% of all potential years of life lost (CMO, 1999). McWhirter (2002) reports that electoral wards with the highest death rates from coronary heart disease are also those with the highest levels of deprivation (Figure 5.7).

Figure 5.7 Standardised mortality ratio for deaths from coronary heart disease for persons aged under 75

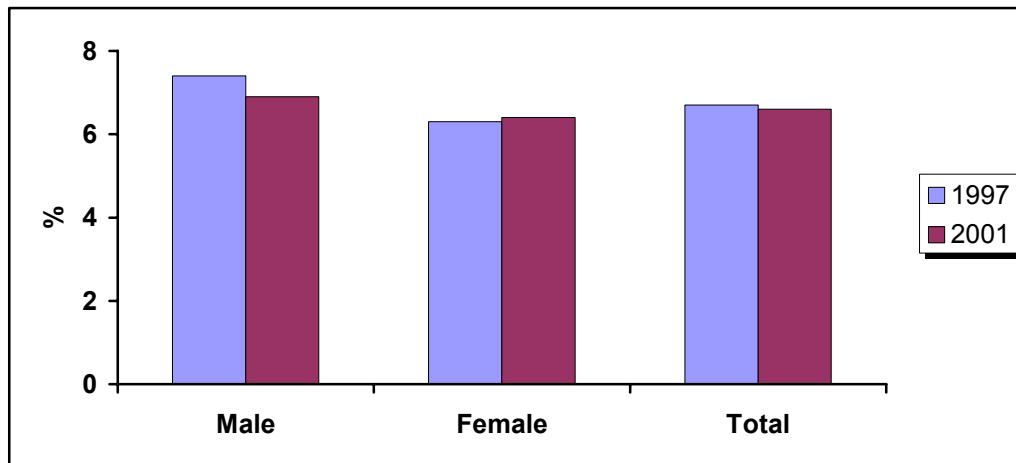


Source: General Register Office for Northern Ireland

Angina

5.13 In the 2001 Health and Social Wellbeing survey the most frequent condition mentioned was angina followed by heart attack. Figure 5.8 shows that the prevalence of angina was similar in both the 1997 and 2001 surveys (just under 7%). In 2001, 7% of males and 6% of females had been told by a doctor that they had angina.

Figure 5.8 Prevalence of angina by gender (aged 16+)

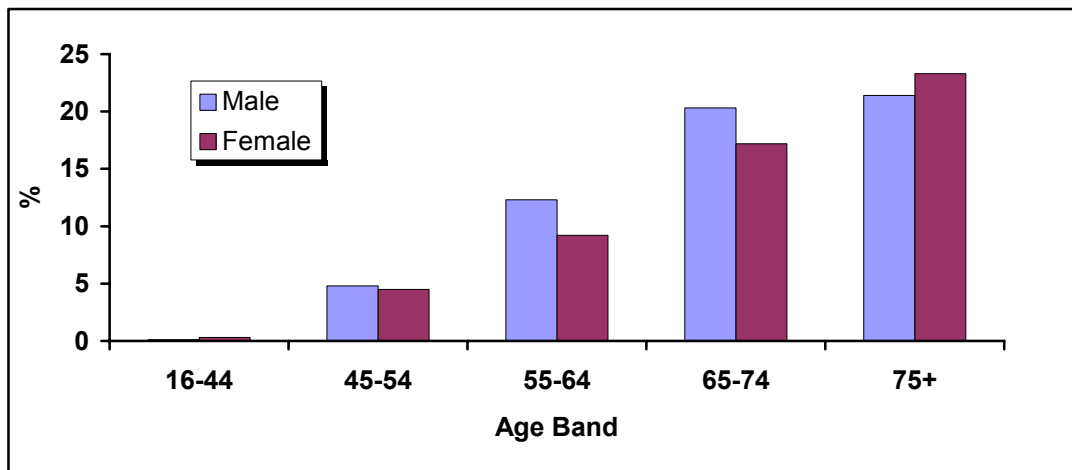


Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

5.14 The increasing trend in angina prevalence with age is illustrated in Figure 5.9. This suggests that angina is an older persons disease. Less than 5% of 45-54 year olds were diagnosed with angina compared with 23% of people over 75. Males aged 45-74 were more likely to experience angina than their female counterparts, while in the 75+ age band angina was more prevalent among females.

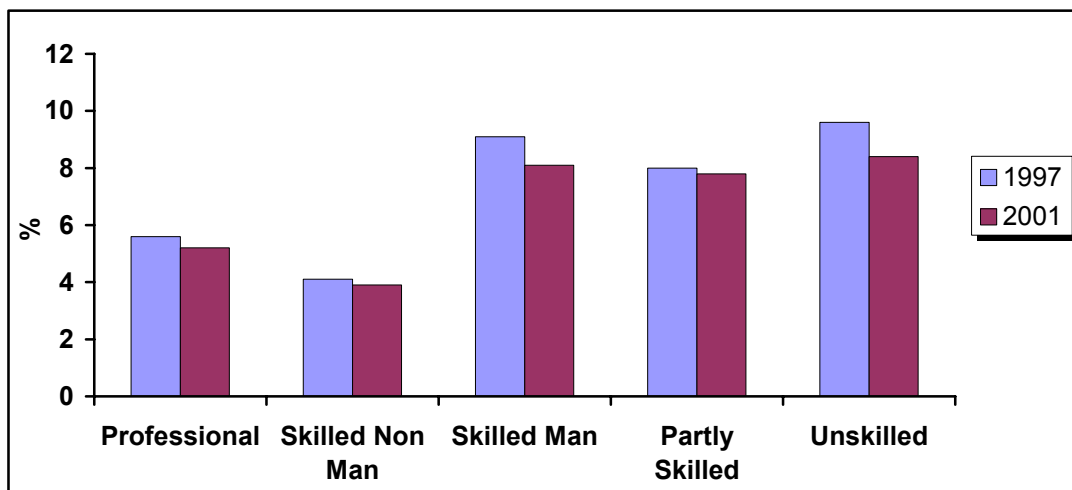
5.15 Skilled non-manual workers were least likely to indicate having angina in both years (1997 and 2001), while those in the least skilled occupations experienced the highest prevalence of angina (Figure 5.10). In 2001, 4% of skilled non-manual workers had been diagnosed with angina compared with 8% of the unskilled. There was no significant difference in the prevalence of angina across either the two main religious groups or four HSS Board areas.

Figure 5.9 Prevalence of angina by age and gender



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

Figure 5.10 Prevalence of angina by socio-economic group



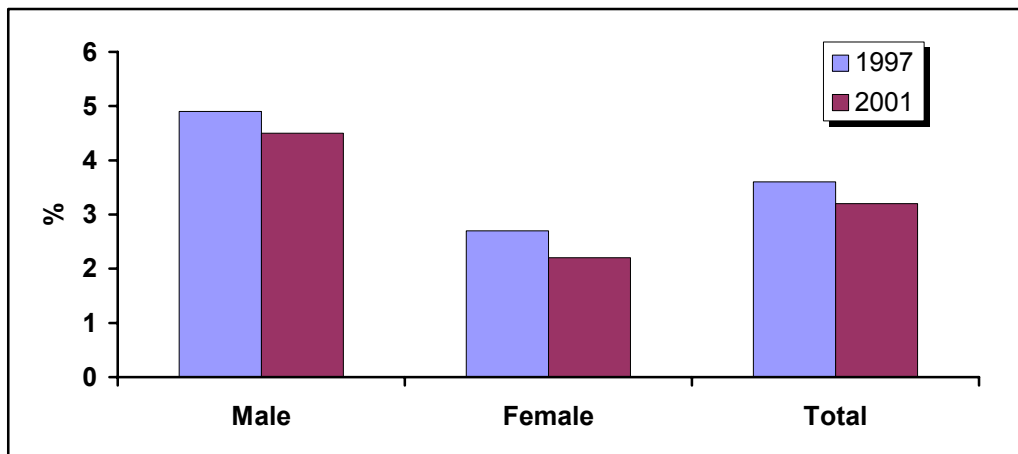
Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Heart Attack

5.16 In both 1997 and 2001, just over 3% of people reported having suffered a heart attack (Figure 5.11). However, in both years the prevalence of heart attack was significantly higher among males than females. In 2001, more than 4% of males had suffered a heart attack compared with 2% of females.

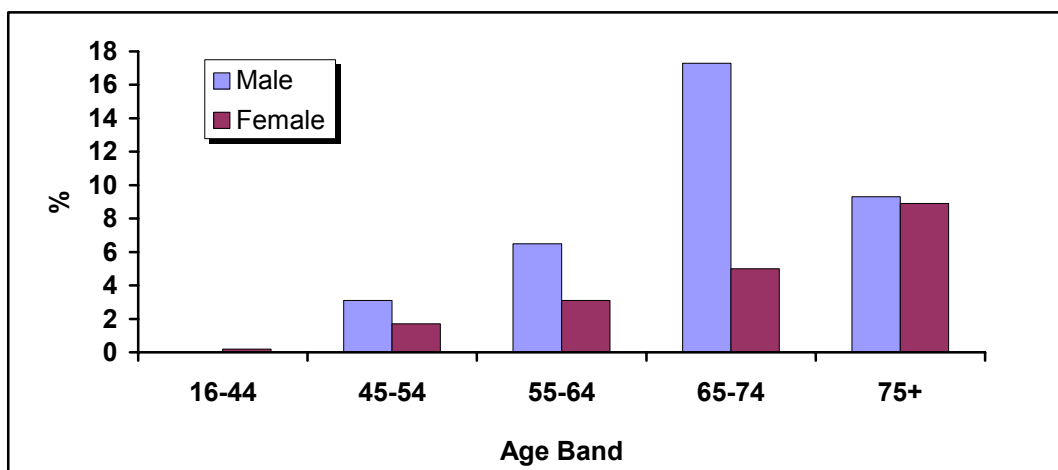
5.17 Figure 5.12 shows the prevalence of heart attacks across both sexes by age. People in the older age bands were more likely to experience a heart attack. Males in the 65-74 age group had the highest rate of heart attacks at 17%, while among females those over 75 were most at risk (9%).

Figure 5.11 Prevalence of heart attacks by gender (aged 16+)



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

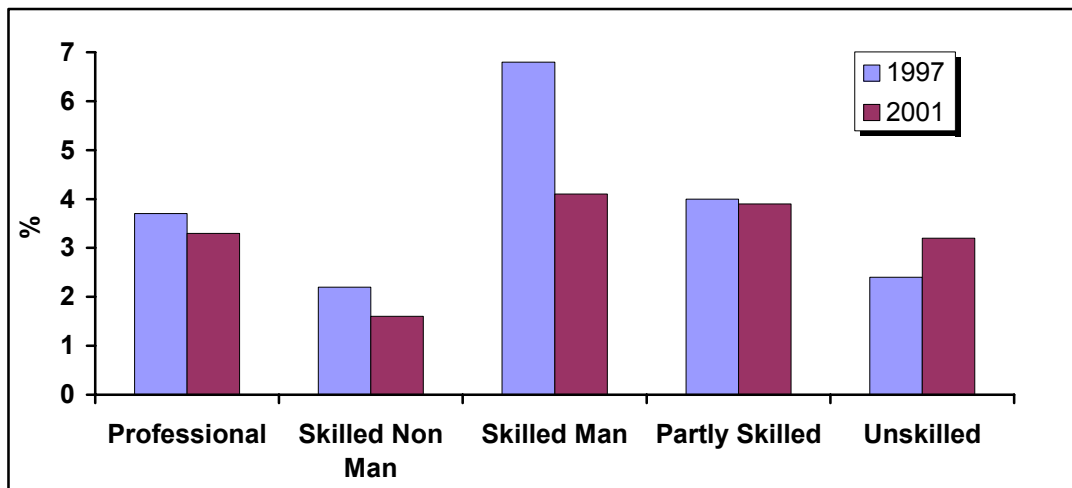
Figure 5.12 Prevalence of heart attacks by age



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.18 Skilled non-manual workers were least likely to indicate having suffered a heart attack in both years (1997 and 2001), while skilled manual workers experienced the highest prevalence of heart attacks (Figure 5.13). In 1997, just less than 7% of skilled manual workers had been diagnosed with a heart attack. There was no difference in the prevalence of heart attacks across the two main religious groups with 3% of both Catholics and Protestants having had a heart attack. Similarly, there was no significant difference in the level of heart attacks across HSS Boards.

Figure 5.13 Prevalence of heart attacks by socio-economic group

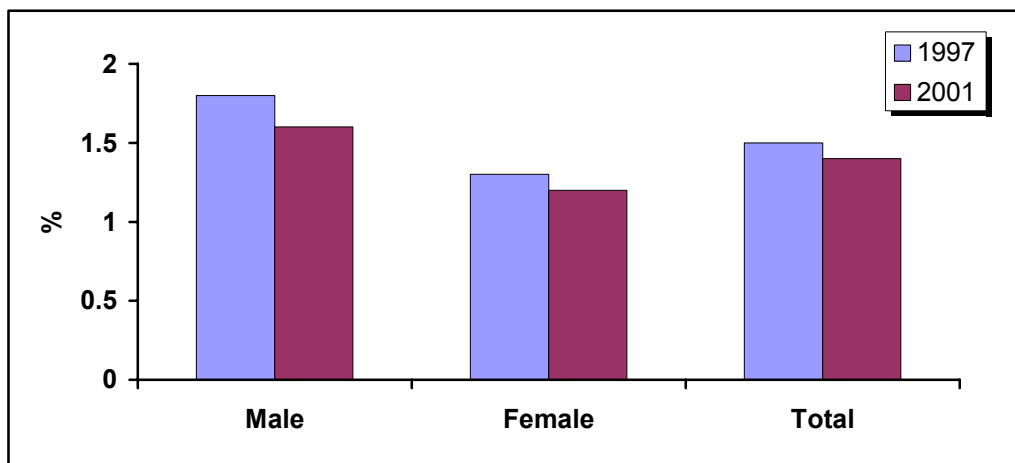


Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

STROKE

5.19 Stroke is a leading cause of disability and in Northern Ireland is one of the most common causes of death. In 2001, just over 1% of respondents in the Northern Ireland Health and Social Wellbeing Survey had been told by a doctor that they had had a stroke. Almost 2% of males had been diagnosed with a stroke compared with just over 1% of females (Figure 5.14).

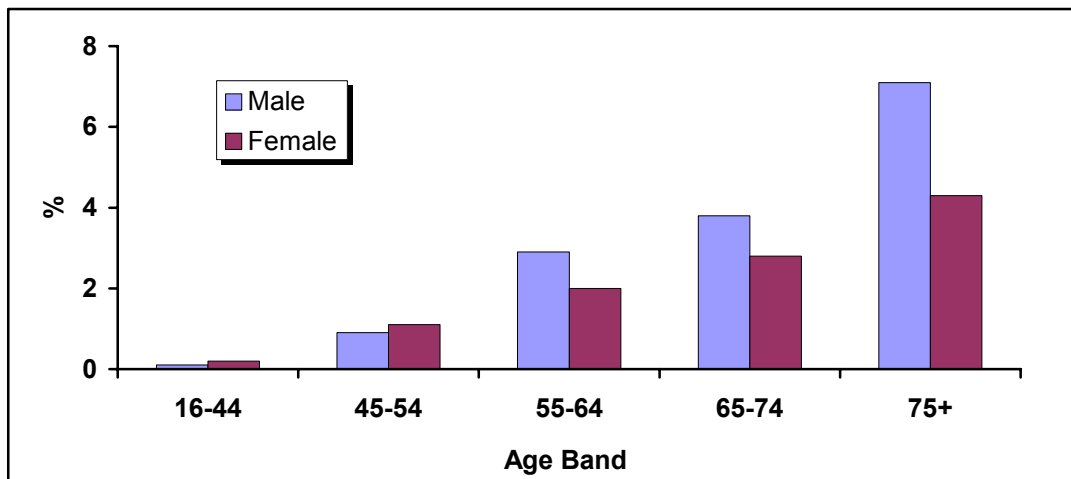
Figure 5.14 Prevalence of stroke by gender (aged 16+)



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

5.20 Figure 5.15 shows that strokes were more prevalent among the older population. In the older age groups males were more likely to have been diagnosed with a stroke than their female counterparts. Just over 7% of males over the age of 75 had suffered a stroke compared with 4% of females in the same age band.

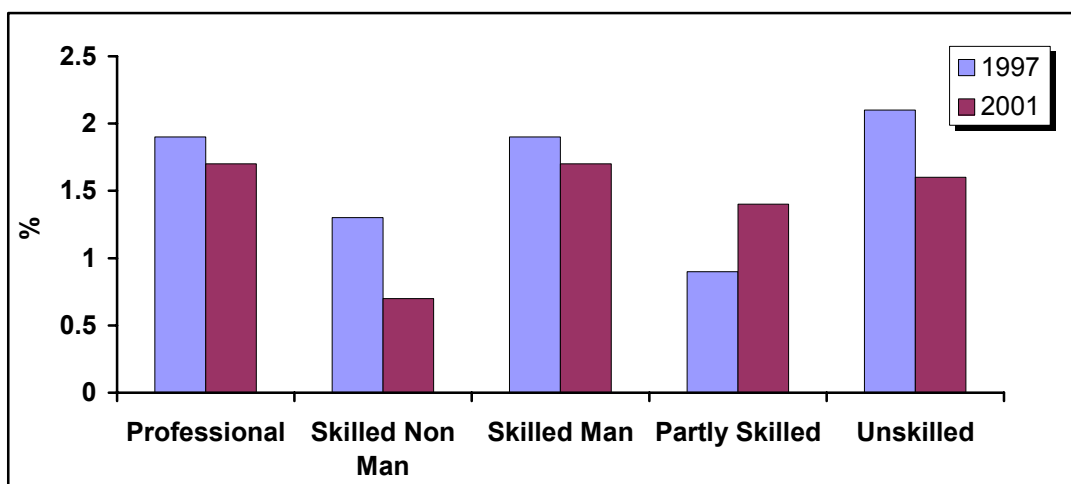
Figure 5.15 Prevalence of stroke by age



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.21 Figure 5.16 shows the relationship between the prevalence of strokes and socio-economic group. In both years, skilled non-manual and partly skilled workers were least likely to be diagnosed with stroke, while professionals, skilled manual workers and unskilled people experienced higher rates of stroke. There was no difference in the prevalence of strokes among professionals and skilled manual workers in both years.

Figure 5.16 Prevalence of stroke by socio-economic group



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

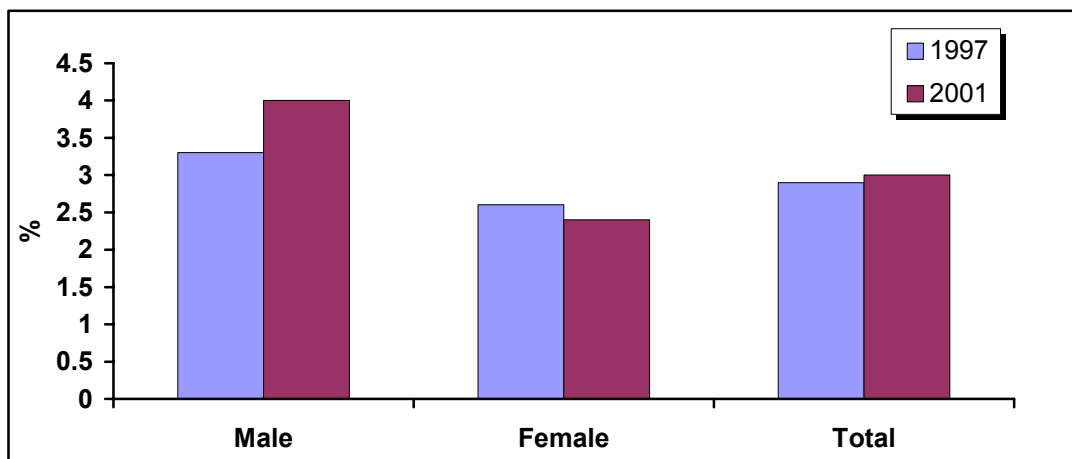
DIABETES

5.22 Diabetes is a condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. There are two main types of diabetes. Type 1 diabetes is known as insulin dependent diabetes and Type 2 diabetes is referred to as non-insulin dependent. It is estimated

that 40,000 people in Northern Ireland have been diagnosed with diabetes, while another 25,000 have the condition but do not know it (Diabetes UK). This figure is broadly in line with that in the Report of the Chief Medical Officer, which estimated that around 2% of the Northern Ireland population (over 30,000 people) have been diagnosed with diabetes (CMO, 2000). In 2001/02 just under 1% of deaths and discharges in acute hospitals in Northern Ireland were as a result of diabetes. When this acute activity is broken down into age groups, the majority of activity (59%) was among the 15-64 years age band, while children (0-14 years) and the older population (65+ years) accounted for 9% and 32% of diabetes activity respectively (McWhirter, 2002).

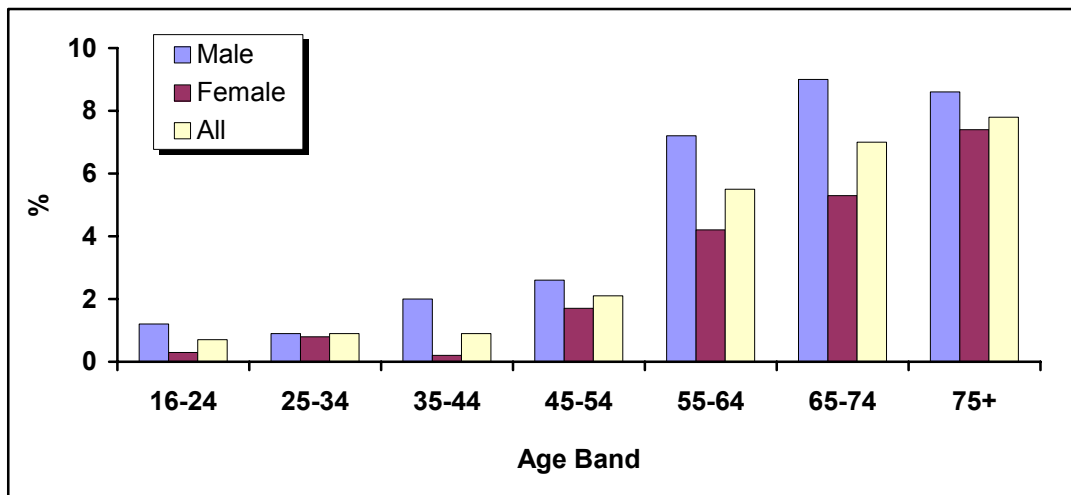
5.23 The 2001 Health and Social Wellbeing Survey indicated that 3% of the overall population aged 16+ had been told by a doctor that they had diabetes. This figure also stood at 3% in the 1997 survey. In 2001, 4% of males and 2% of females aged 16+ had been diagnosed with diabetes (Figure 5.17). The risk of developing diabetes increased with age (Figure 5.18). Less than one percent of 16-24 year olds had been diagnosed with diabetes compared with 8% of those over 75.

Figure 5.17 Prevalence of diabetes by gender (aged 16+)



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

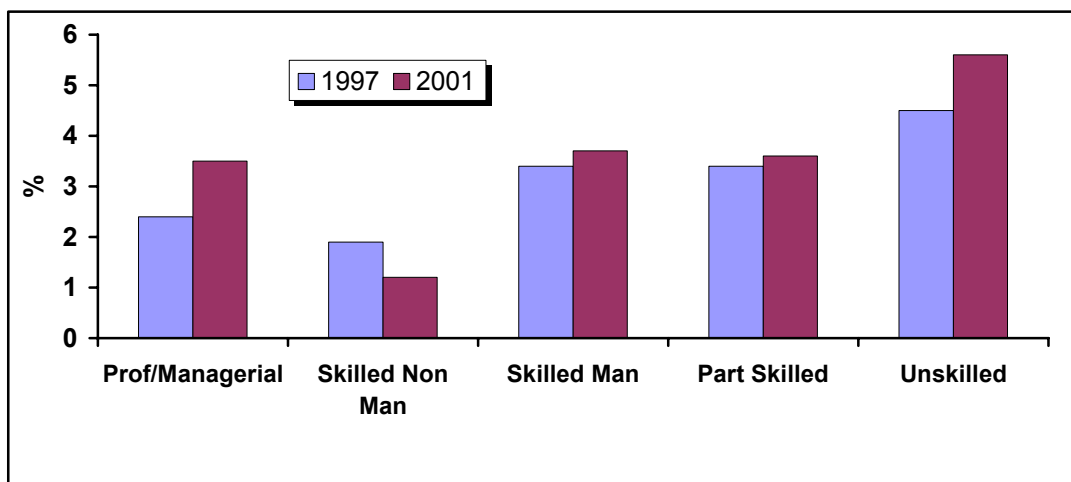
Figure 5.18 Prevalence of diabetes by age group and gender



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.24 Figure 5.19 shows the proportion of people who were diagnosed with diabetes for each separate socio-economic group. In 2001, the highest level of diabetes was among the unskilled (6%) while skilled non-manual workers were the least likely to be diagnosed with diabetes (1%). The prevalence of diabetes increased from 1997 to 2001 in all classes except for the skilled non-manual group.

Figure 5.19 Prevalence of diabetes by socio-economic group

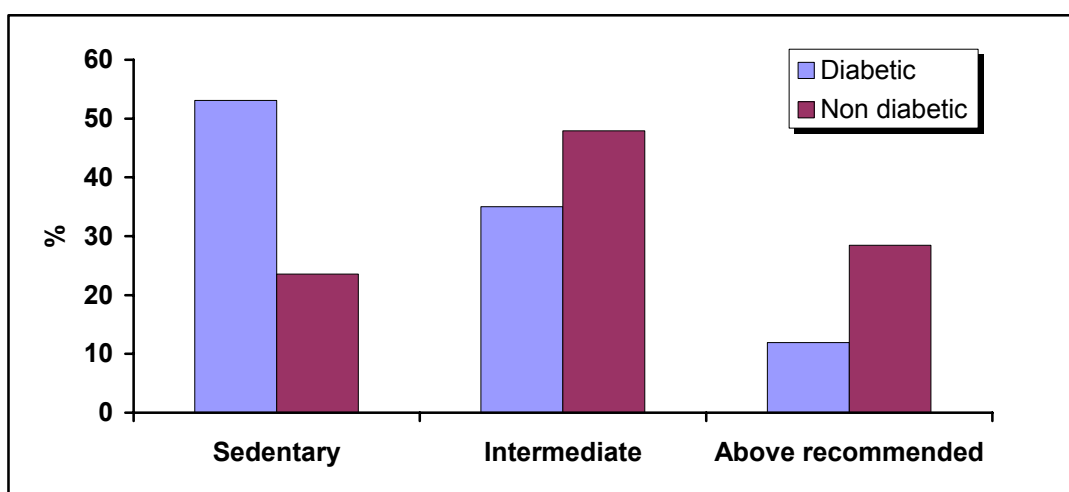


Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

5.25 The NI Health Promotion Agency has reported that increasing levels of obesity in the population is associated with an increase in Type 2 diabetes in younger people. Type 2 diabetes, a preventable condition, accounts for approximately 85% of diabetes (HPA Journal, Issue 20). Physical activity is recommended as a way of preventing and managing Type 2 diabetes. According to Diabetes UK, physical activity helps to reduce the risk of

complications such as heart disease and circulatory problems. The 2001 Health and Social Wellbeing Survey found that more than half (53%) of those diagnosed with diabetes were sedentary (i.e. they had not taken any activity of at least a moderate level, lasting twenty minutes, on one or more occasion in the previous seven days). This compared with less than one quarter of people who were not diabetic (Figure 5.20). Almost 30% of people who were not diagnosed with diabetes took above the recommended level of physical activity (at least thirty minutes per day on five days a week), while this figure was less than 12% for diabetics.

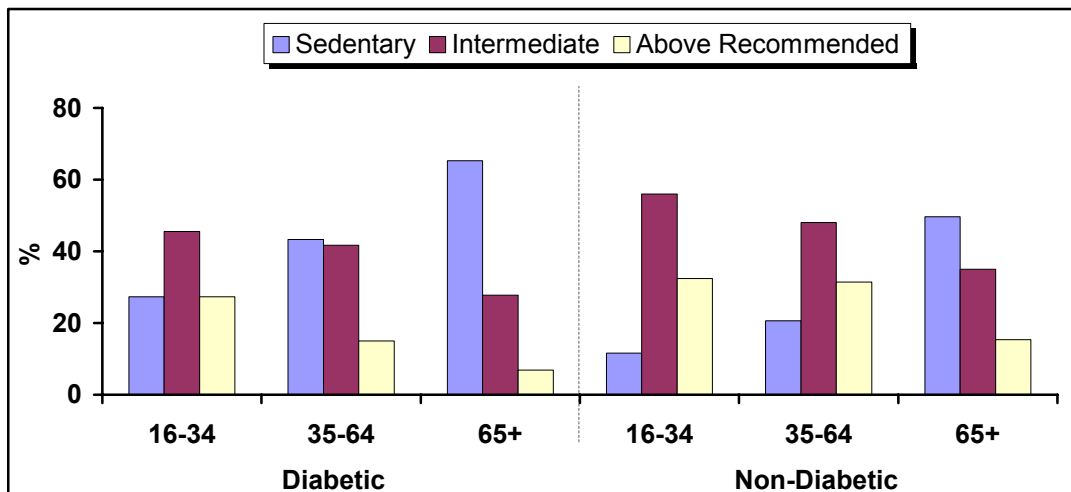
Figure 5.20 Physical activity level by diabetic status



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.26 Figure 5.21 shows that diabetics in all age groups were more likely to be sedentary than those who were not diabetic. Over 40% of diabetics aged 35-64 were sedentary compared with 21% of non-diabetics in the same age band. Furthermore, people diagnosed with diabetes were less likely to take above the recommended level of exercise than their non-diabetic counterparts.

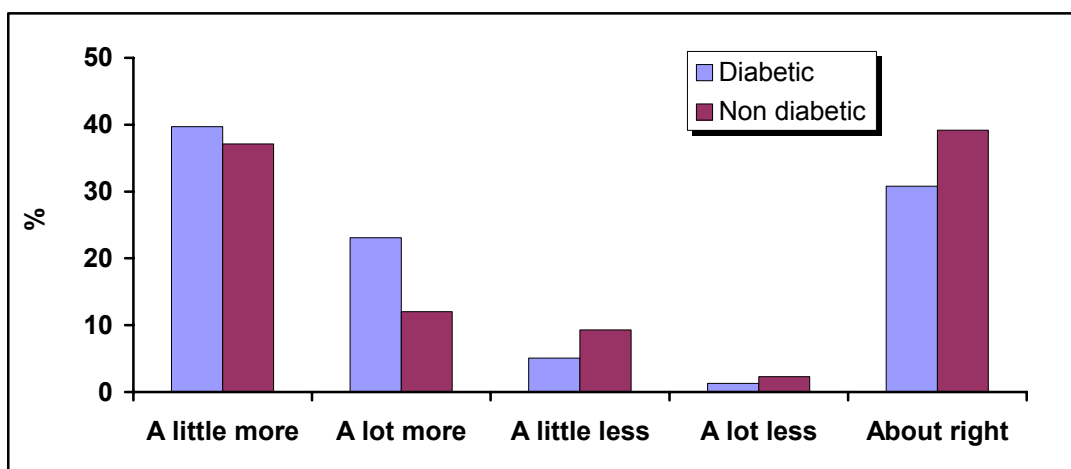
Figure 5.21 Physical activity level of diabetics and non-diabetics by age group



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.27 People who are overweight are more likely to develop Type 2 diabetes (Diabetes UK). Over one third (36%) of people suffering from diabetes believed that they weighed a little more than they should, while a further 30% thought they weighed a lot more than they should. Figure 5.22 shows the perception of weight to height for males. Almost 40% of males who were not diabetic thought they weighed the right amount compared with just fewer than 31% of those who were diagnosed with diabetes. A larger proportion of diabetic males thought they were overweight compared to those who did not suffer from diabetes. More than 60% of males diagnosed with diabetes thought they weighed a little or a lot more than they should compared with less than 50% of those who were not diabetic.

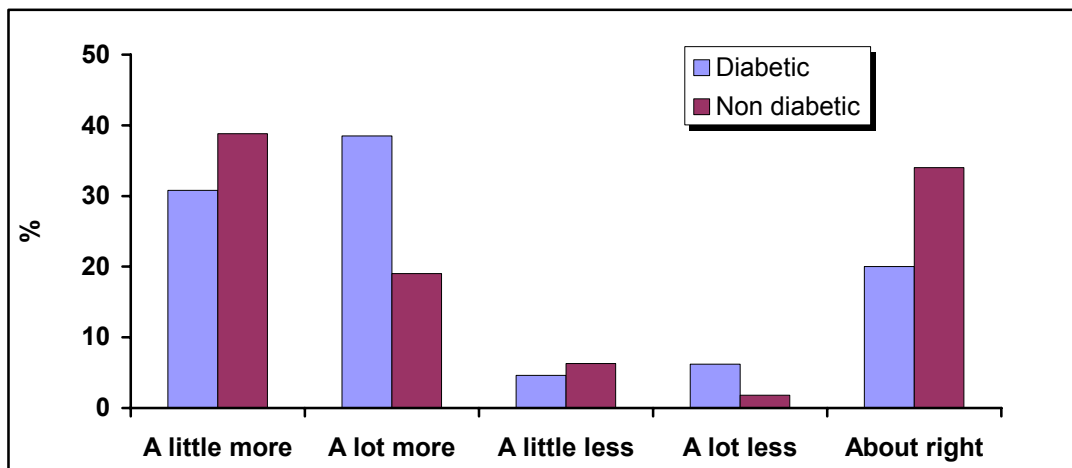
Figure 5.22 Perception of weight to height by diabetic status: males



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.28 Figure 5.23 shows that a similar picture emerged for females, with 69% of diabetic females and 58% of those who were not diabetic perceiving themselves to be overweight. One in three females who were not diabetic reported that they were about the right weight. This compared with just one in five diabetic females.

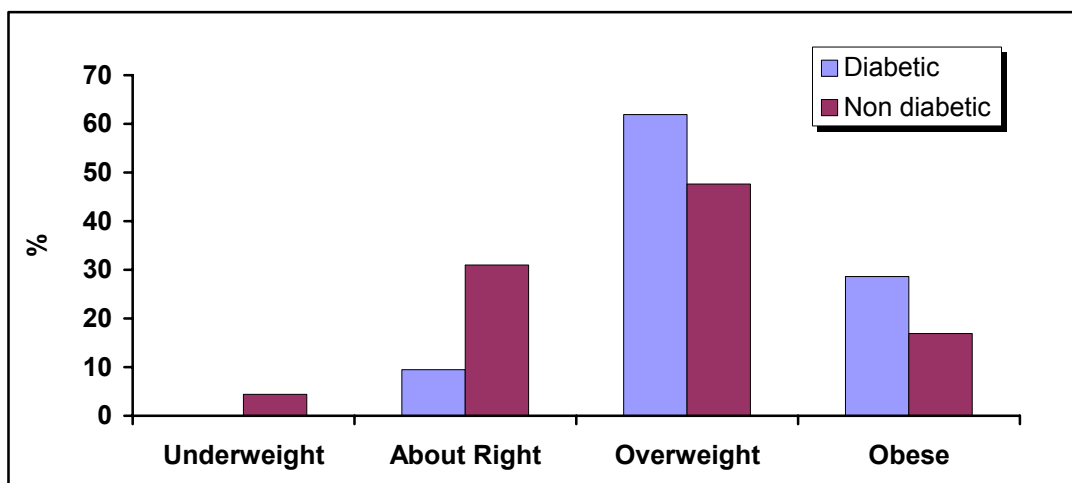
Figure 5.23 Perception of weight to height by diabetic status: females



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.29 The 1997 Health and Social Wellbeing Survey calculated the Body Mass Index (BMI) of selected respondents. From Figure 5.24 it is clear that the majority (90%) of diabetic males were overweight/obese. Almost one third (31%) of non-diabetic males were about the right weight compared with less than 10% of diabetic males.

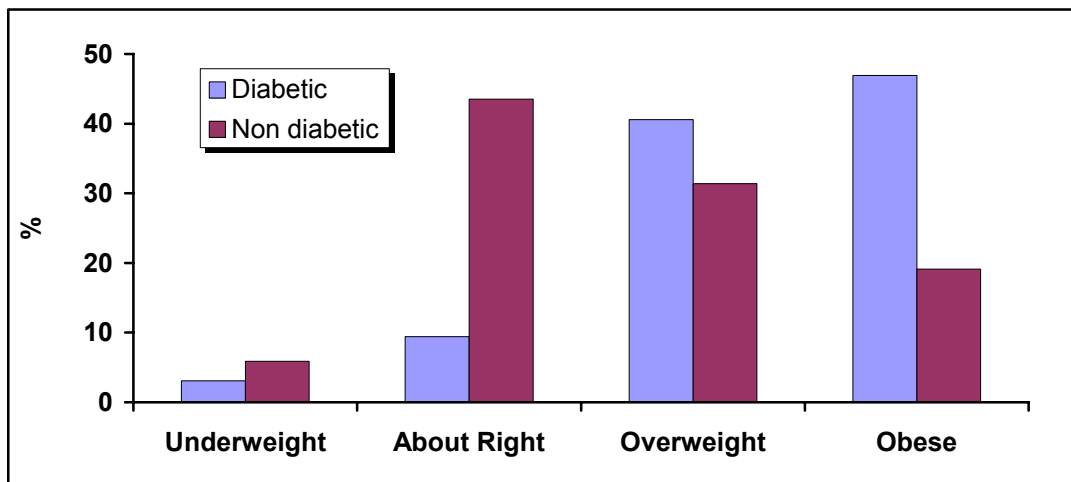
Figure 5.24 Body Mass Index by diabetic status: males



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.30 Similarly, 88% of females who had been diagnosed with diabetes were overweight/obese, while only 9% were about the right weight. Among non-diabetic females 44% were the correct weight for their height (Figure 5.25).

Figure 5.25 Body Mass Index by diabetic status: females

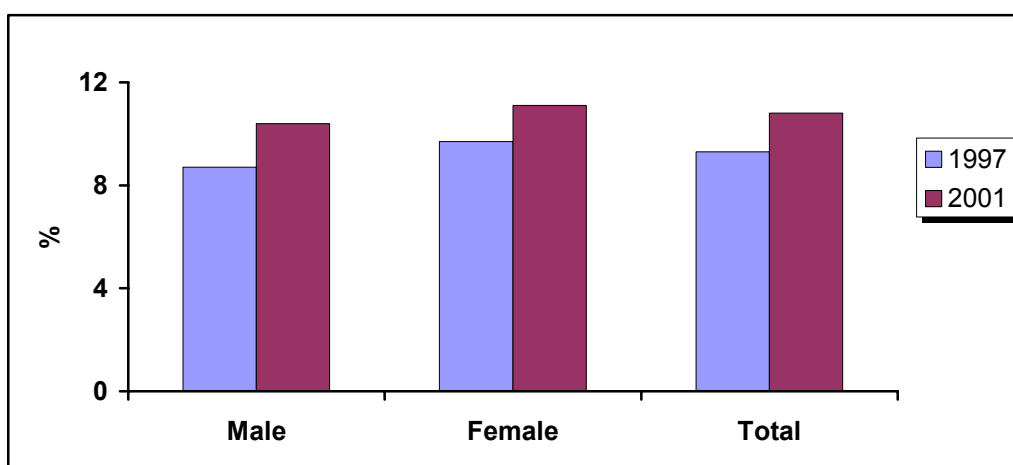


Source: Northern Ireland Health and Social Wellbeing Survey, 1997

ASTHMA

5.31 In both the 1997 and 2001 Northern Ireland Health and Social Wellbeing Surveys respondents were asked if they had ever been diagnosed by a doctor as having the respiratory condition asthma. Figure 5.26 shows that in 2001 10% of males and 11% of females had been told by a doctor that they had asthma.

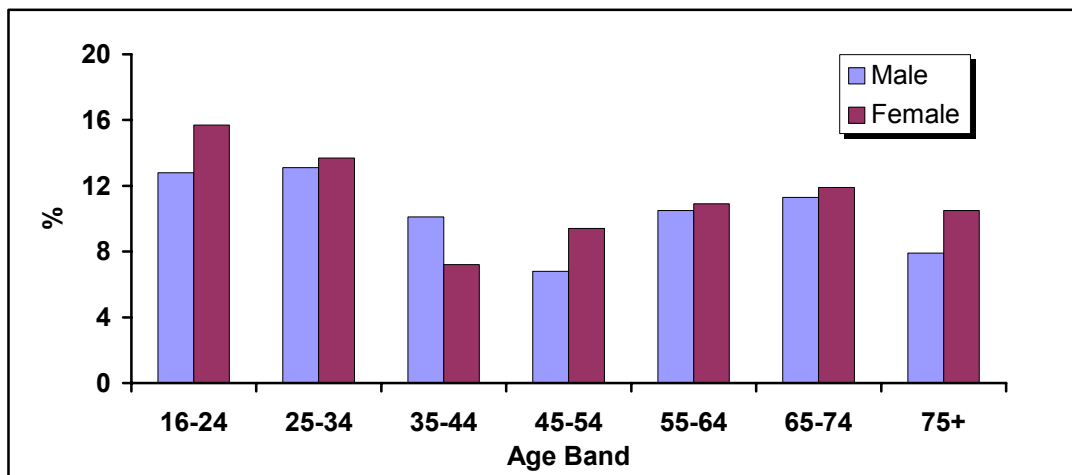
Figure 5.26 Prevalence of asthma by gender (aged 16+)



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

5.32 Asthma rates tended to dip among middle-aged people, before rising again for older people (Figure 5.27). The highest prevalence of asthma was among young females aged 16-24 (16%). Young males also experienced high rates of asthma, with 13% of 16-24 and 25-34 year olds having been diagnosed with the disorder.

Figure 5.27 Prevalence of asthma by age



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

5.33 Professionals were the least likely to indicate having asthma in both 1997 and 2001 surveys. This contrasted with the least skilled occupations who experienced a higher prevalence of asthma. The prevalence of asthma increased among skilled manual workers from 8% in 1997 to 11% in 2001 (Figure 5.28). There was no significant difference in the prevalence of asthma between the two main community backgrounds.

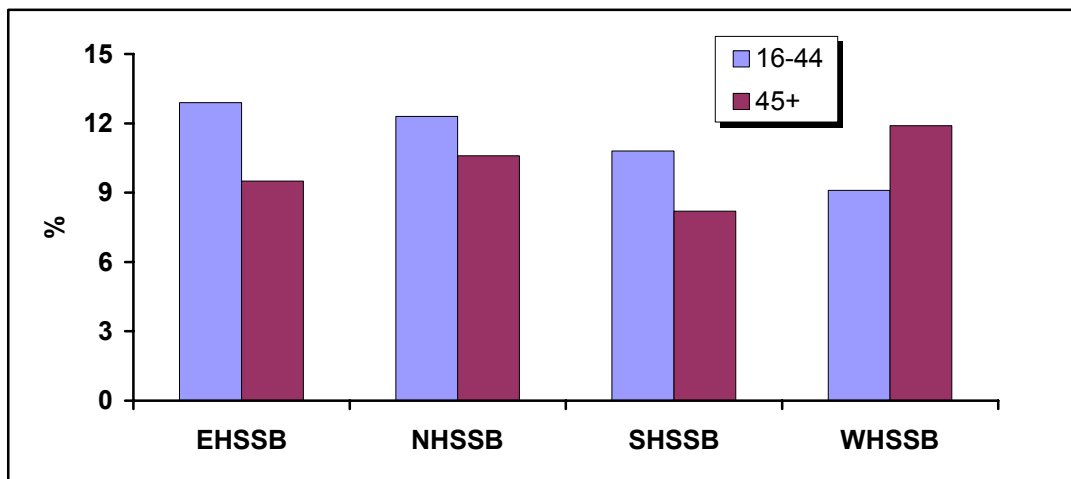
Figure 5.28 Prevalence of asthma by socio-economic group



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

5.34 Almost thirteen percent of 16-44 year olds living in the Eastern HSSB have been diagnosed with asthma (Figure 5.29). When compared with other HSS Board areas, the Western HSSB experienced the highest prevalence of asthma among older people and the lowest prevalence of asthma among people under 45.

Figure 5.29 Prevalence of asthma by HSS Board area and age group

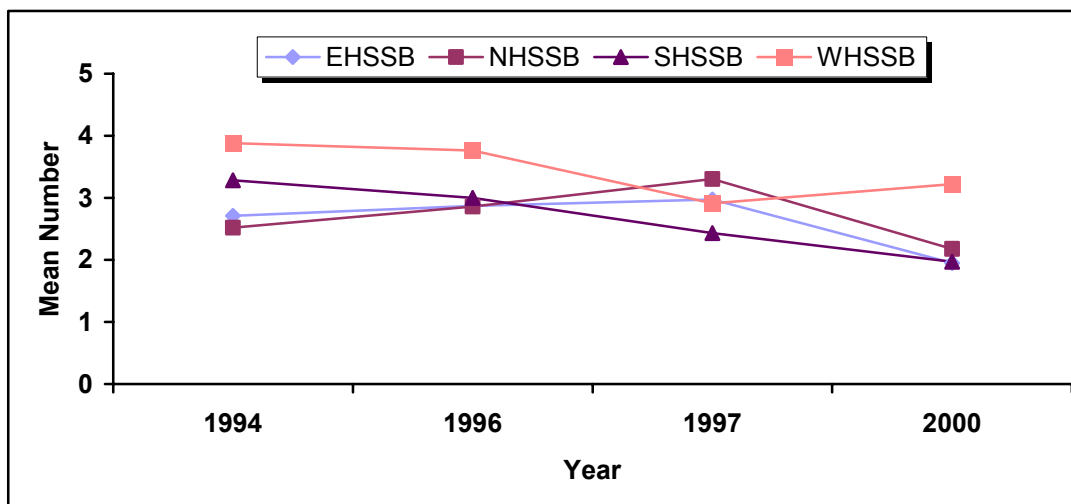


Source: Northern Ireland Health and Social Wellbeing Survey, 2001

DENTAL HEALTH

5.35 Surveys conducted by the British Association for the Study of Community Dentistry indicate variations within Northern Ireland. In 2000, five-year olds living in the Western Health and Social Services Board Area had the worst dental health (Figure 5.30).

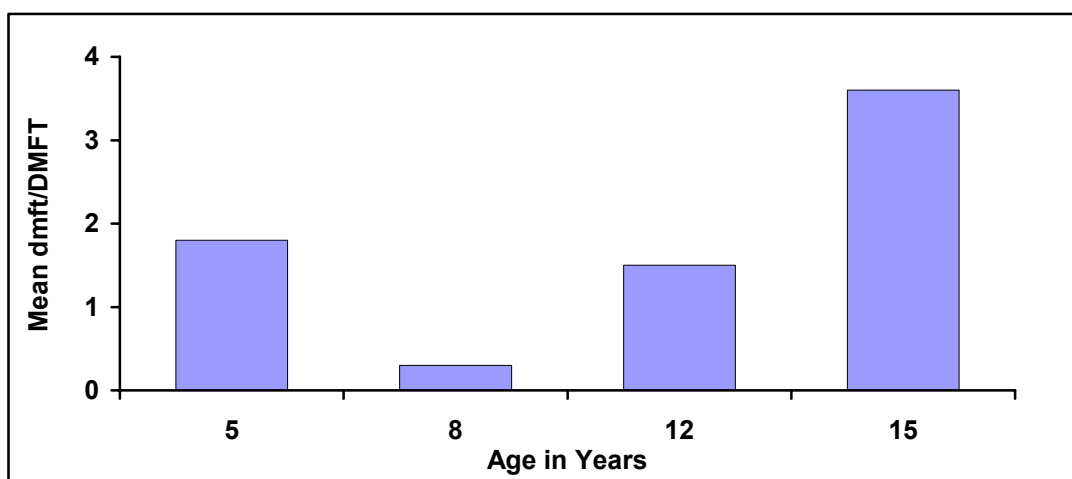
Figure 5.30 Average number of decayed, missing and filled teeth in 5 year olds: 1994 – 2000



Source: British Association for the Study of Community Dentistry Surveys

- 5.36 The Children’s Oral Health in Ireland Report (2002) presents the results of the first contemporaneous study of the oral health of children and adolescents in both Northern Ireland and the Republic of Ireland. It explores the relationship between disadvantage and oral health using low-income benefits as a surrogate for disadvantage in Northern Ireland. Tooth decay levels are described using a measurement called the DMFT index. This measurement counts the number of teeth which are decayed (D), missing (M), or filled (F) due to decay. Data for five year-old children refer to primary teeth only, and by convention are referred to by lower case letters (dmft). The figures for 8, 12 and 15 year olds refer to permanent teeth only, and are referred to by upper case letters (DMFT).
- 5.37 The decay experience of children and adolescents in Northern Ireland is illustrated in Figure 5.31. As children grow older, their caries levels increase as the number of permanent teeth in the mouth increases and the teeth are exposed to decay producing foods over longer time periods. The mean DMFT scores for 8 year olds was 0.3 compared with 3.6 for 15 year olds. The mean dmft/DMFT scores in Northern Ireland were statistically significantly higher than those for children and adolescents resident in fluoridated communities in the Republic of Ireland, except in the case of 8 year olds.

Figure 5.31 Mean number of decayed, missing and filled teeth in 2002 by age

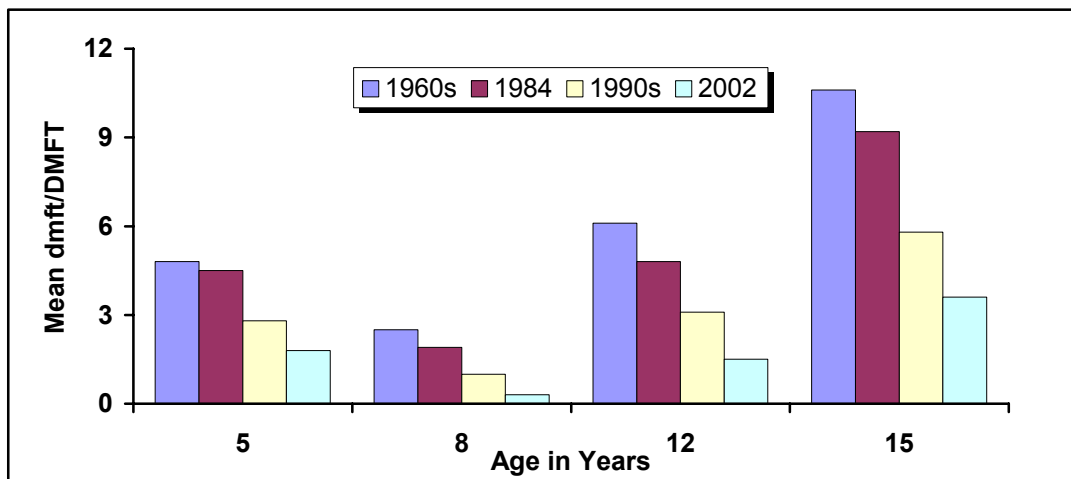


Source: Children’s Oral Health in Ireland, 2002

- 5.38 Caries levels in Northern Ireland have changed dramatically since the early 1960s. These changes are illustrated in Figure 5.32. Decay levels in all age groups were much lower in 2002 than they were in the 1960s. The mean DMFT among 15 year olds was 11 in the 1960s compared with less than 4

in 2002. Fluoride has contributed to this improvement in oral health with the use of fluoride toothpaste.

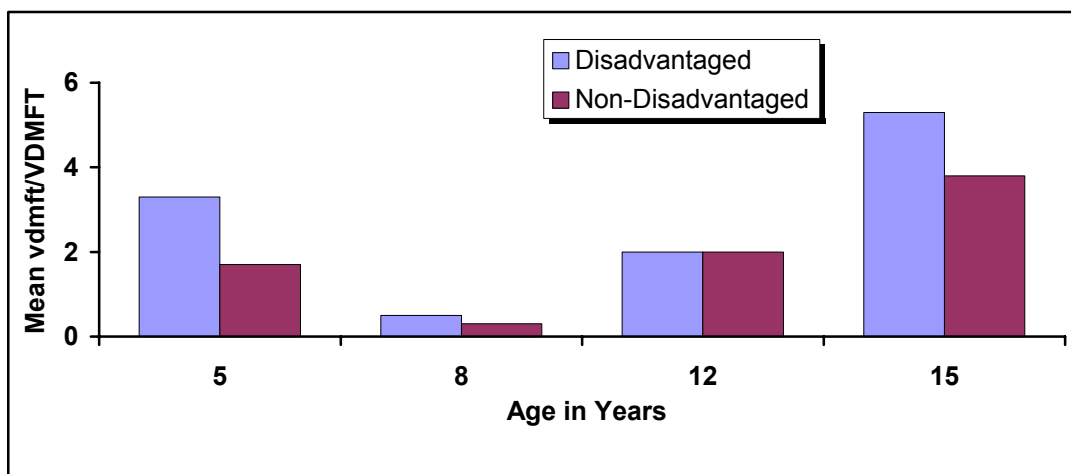
Figure 5.32 Mean number of decayed, missing and filled teeth by age in the 1960s, 1984, 1990s and 2002



Source: Children’s Oral Health in Ireland, 2002

5.39 The Children’s Oral Health report focuses on inequalities and oral health. In Northern Ireland children and adolescents were classed as disadvantaged if their family reported being in receipt of any state low-income benefits. The mean visual plus dentine caries of children and adolescents by disadvantage status are shown in Figure 5.33. Caries levels tend to be higher among the disadvantaged, except among 12 year olds where there is no difference in caries levels according to disadvantage.

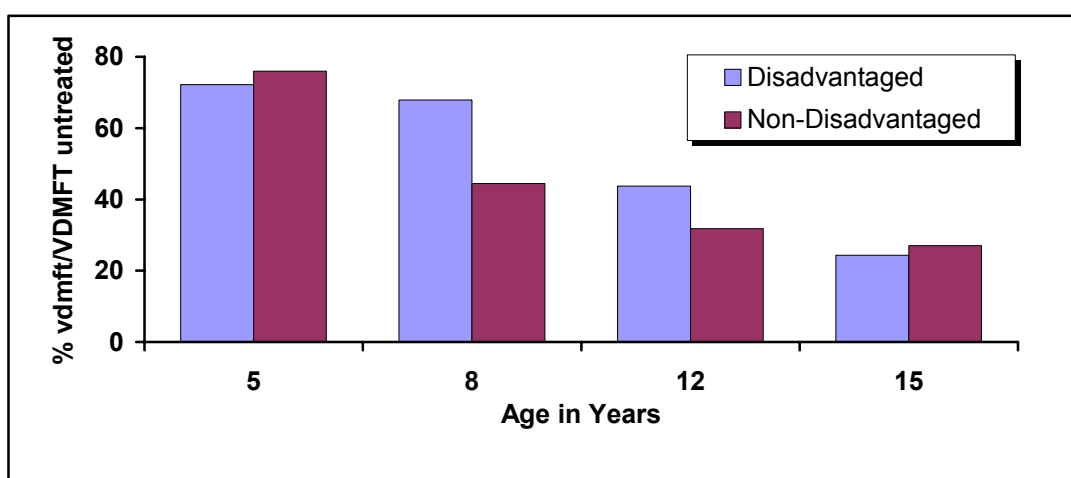
Figure 5.33 Mean number of decayed (visual and cavitated), missing and filled teeth in 2002 by age and disadvantage



Source: Children’s Oral Health in Ireland, 2002

5.40 The report also analysed data to determine whether the need for treatment for dental caries varied according to low-income benefits status. The proportion of untreated caries was higher among disadvantaged 8 and 12 year olds compared with those from more affluent backgrounds (Figure 5.34). However, the level of untreated caries was higher among non-disadvantaged 5 and 15 year olds compared with those from families receiving benefits. Over three quarters of caries were untreated among non-disadvantaged 5 year olds compared with 72% untreated in the low-income group.

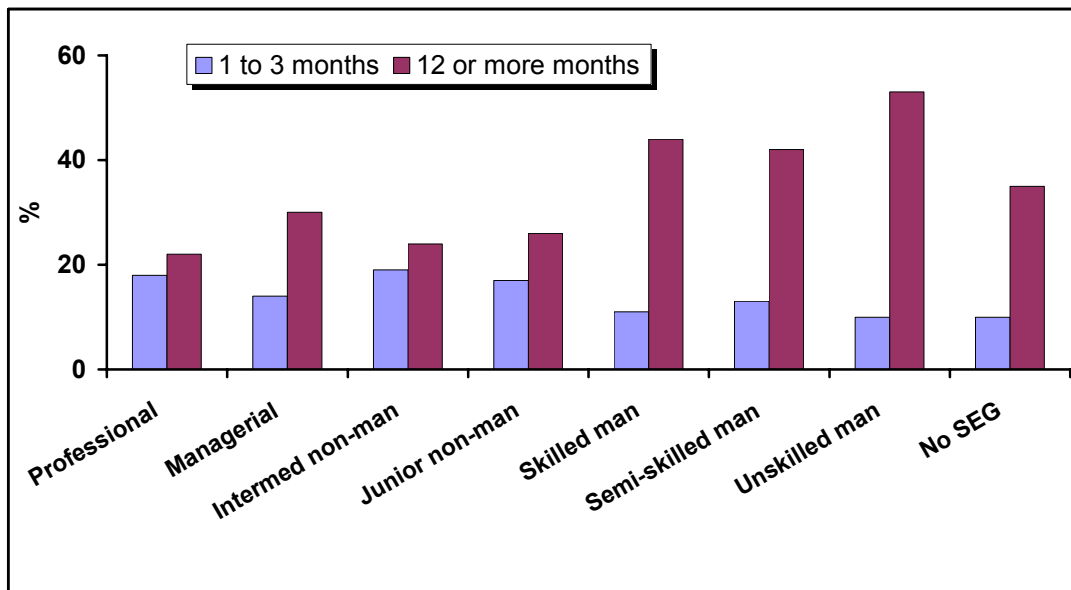
Figure 5.34 Untreated caries as a proportion of total caries experience by age and disadvantage



Source: Children’s Oral Health in Ireland, 2002

5.41 The Continuous Household Surveys (CHS) provide information on the dental health of people aged 16 and over. The CHS has found that those from professional occupations were less likely than those from unskilled manual occupations to wait for 12 months or more before visiting their dentist (22% compared with 53%). Professionals were also more likely than unskilled workers to have visited their dentist within the last 3 months (30% compared with 16%). A similar pattern of variation can also be observed between socio-economic groups. Figure 5.35 shows the decreasing likelihood of recent dental visits for less skilled occupations, and lower rates of 12 month plus visits for more skilled occupations.

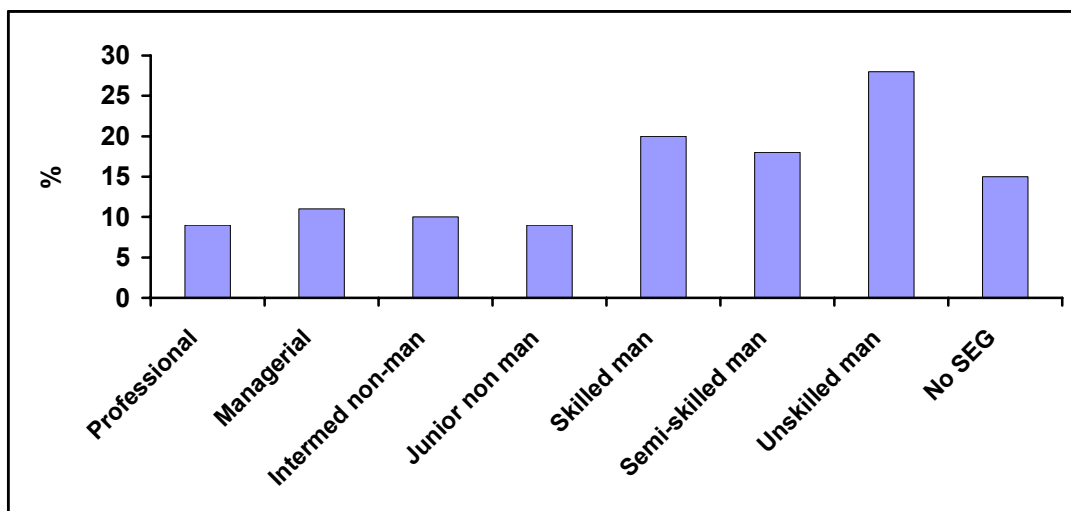
Figure 5.35 Time since last visit to the dentist by socio-economic group



Source: Continuous Household Survey, 2002/03

5.42 A larger proportion of those in the unskilled manual group (28%) compared with those in the professional SEG (9%) had failed to be registered with a dentist (Figure 5.36).

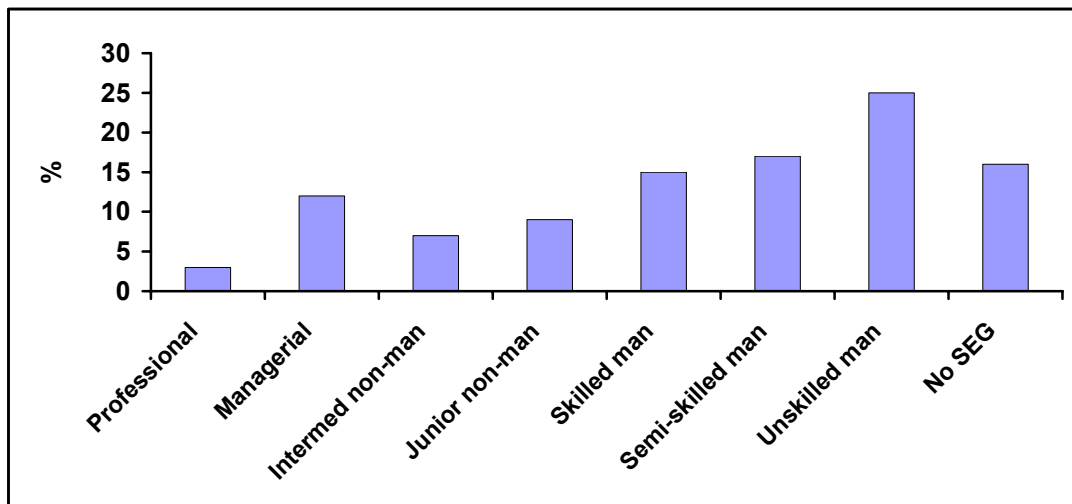
Figure 5.36 Persons not registered with a dentist by socio-economic group



Source: Continuous Household Survey, 2002/03

5.43 Social class differences were also observed in terms of persons with no natural teeth. Only a small number of professionals (3%) possessed no natural teeth, while a quarter (25%) of unskilled manual workers had lost all their teeth (Figure 5.37).

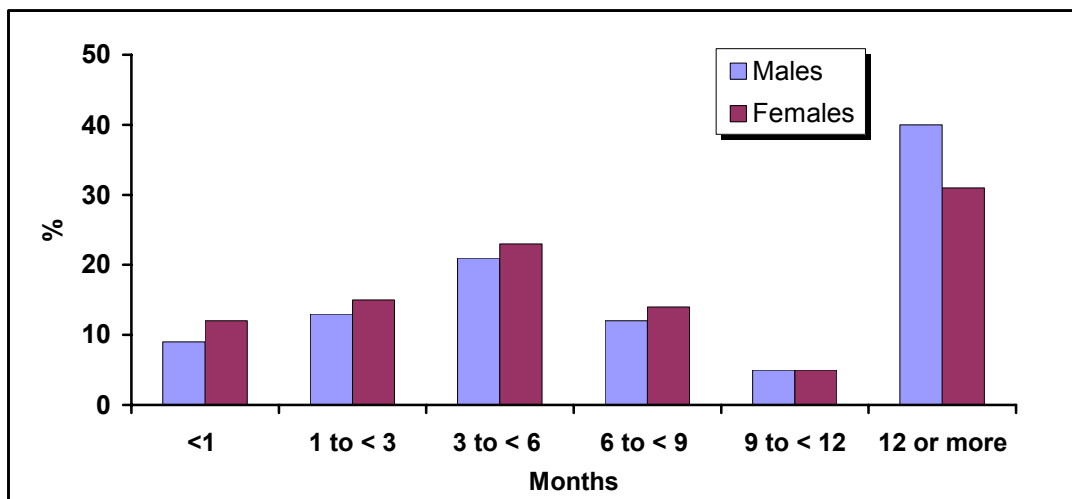
Figure 5.37 Persons with no natural teeth by socio-economic group



Source: Continuous Household Survey, 2002/03

5.44 Women tended to visit their dentist more recently than men. Figure 5.38 demonstrates that more males (40%) waited at least 12 months to visit their dentist compared with females (31%). Similarly, females were more likely than males to have visited the dentist in the last 3 to 6 months (23% compared with 21%).

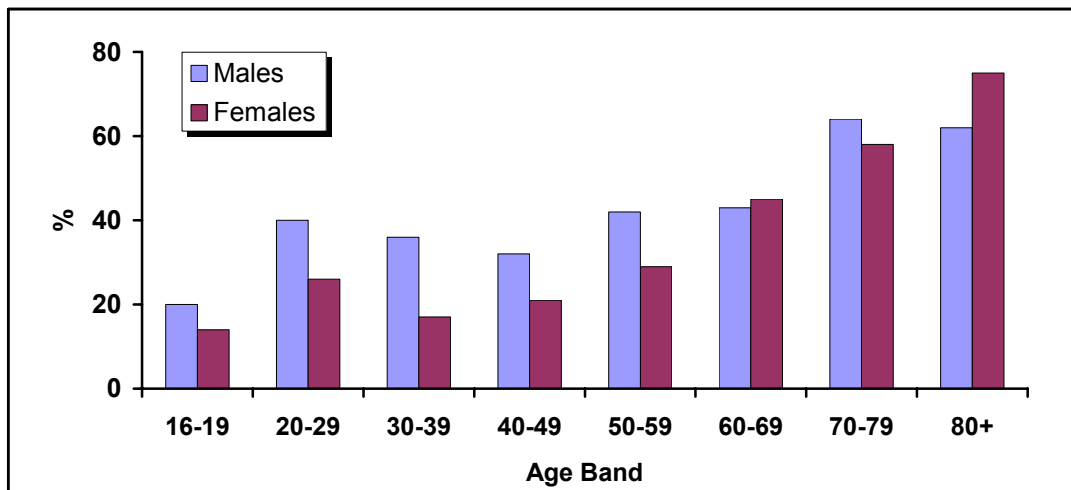
Figure 5.38 Length of time since last visit to the dentist by sex



Source: Continuous Household Survey, 2002/03

5.45 For all age groups between 16-59, more males than females waited 12 months or more before visiting the dentist (Figure 5.39). Men aged 30-39 were twice as likely to have waited 12 months or more before visiting the dentist as their female counterparts (36% and 17% respectively).

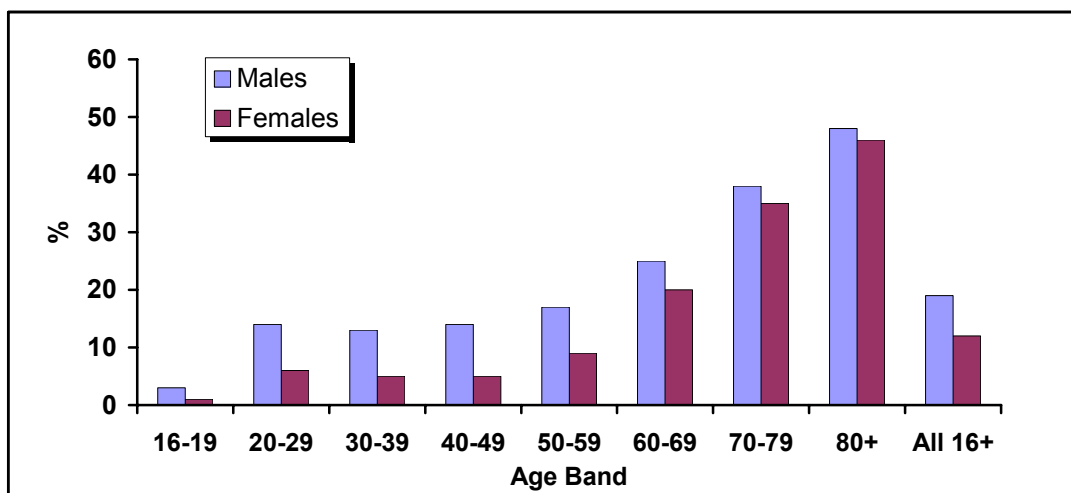
Figure 5.39 Persons waiting 12 months or more since last visit to the dentist by age and sex



Source: Continuous Household Survey, 2002/03

5.46 Overall, a larger proportion of males (19%) than females (12%) failed to be registered with a dentist. This pattern was also repeated across all age groups (see Figure 5.40).

Figure 5.40 Persons not registered with a dentist by sex and age



Source: Continuous Household Survey, 2002/03

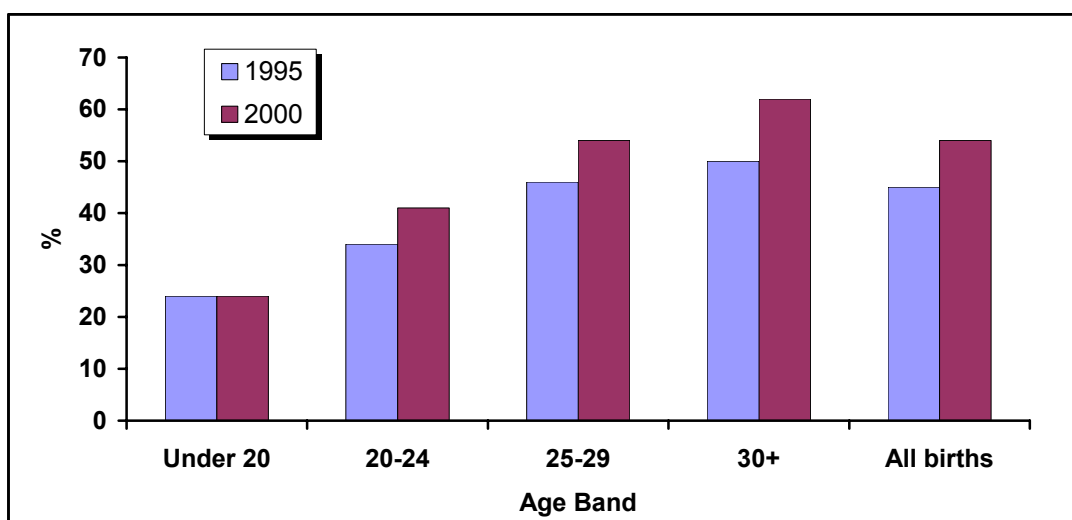
MOTHER AND CHILD HEALTH

5.47 This section examines aspects of the health of mothers and their children using data from the Infant Feeding Survey (1995 and 2000). This survey provided statistics on the incidence, prevalence, and duration of breastfeeding and other feeding practices adopted by mothers in the early weeks up to about nine months after birth. It also included information on

mothers' smoking and drinking behaviour before and during pregnancy, and after the birth.

5.48 There is a clear relationship between the incidence of breastfeeding and the mother's age (Figure 5.41). The level of breastfeeding increased with the mother's age, with mothers aged 30 or over showing the highest levels of breastfeeding in both 1995 and 2000 (50% and 62% respectively). However, females aged under 20 showed no difference between survey years, demonstrating the lowest breastfeeding incidence (24%) in both 1995 and 2000.

Figure 5.41 Incidence of breastfeeding by mothers' age

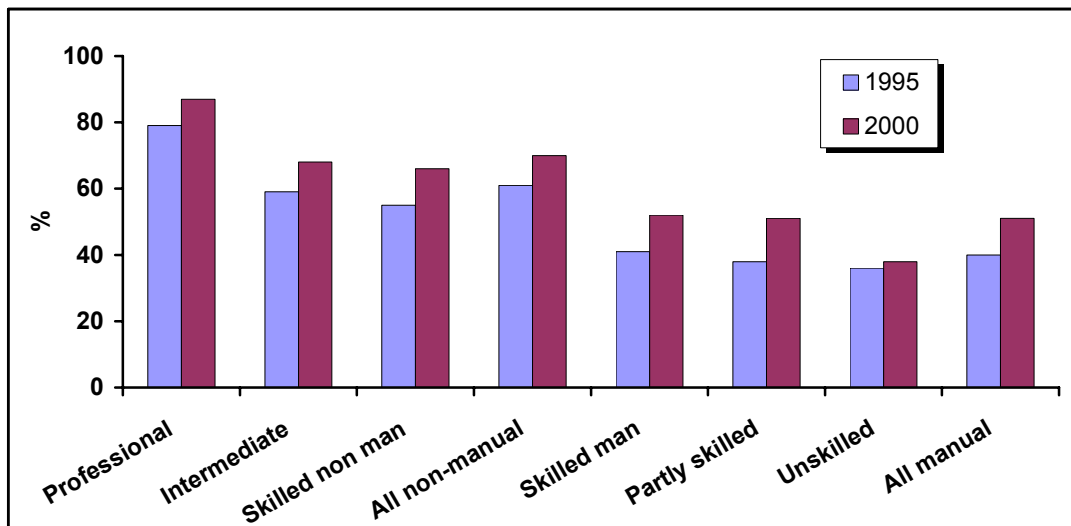


Source: Infant Feeding Survey, 1995 and 2000

5.49 The level of breastfeeding was higher for mothers with partners from more skilled occupations, and lowest for the least skilled (Figure 5.42). There was an increase between 1995 and 2000 in the percentage of mothers in non-manual classes who breastfed (61% and 70% respectively). There was also an increase over the same period in the percentage of mothers from manual classes who breastfed (40% in 1995 and 51% in 2000).

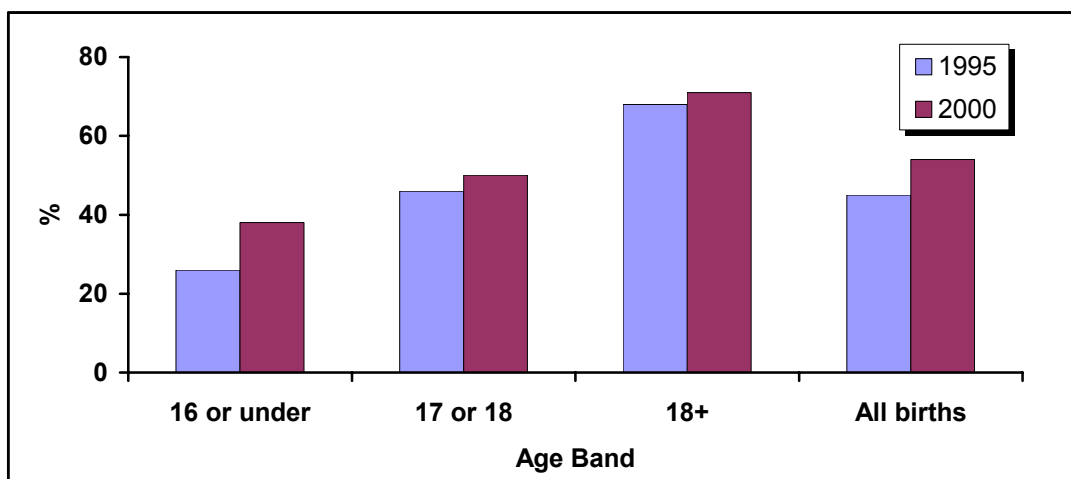
5.50 As seen in Figure 5.43, there is a clear relationship between breastfeeding and age at which mothers completed their education. However, between 1995 and 2000 there was a significant increase in the prevalence of mothers in the 16 or under category who breastfed (26% and 38% respectively). Increases in breastfeeding levels over the same period were less marked in the other two age categories.

Figure 5.42 Incidence of breastfeeding by social class



Source: Infant Feeding Survey, 1995 and 2000

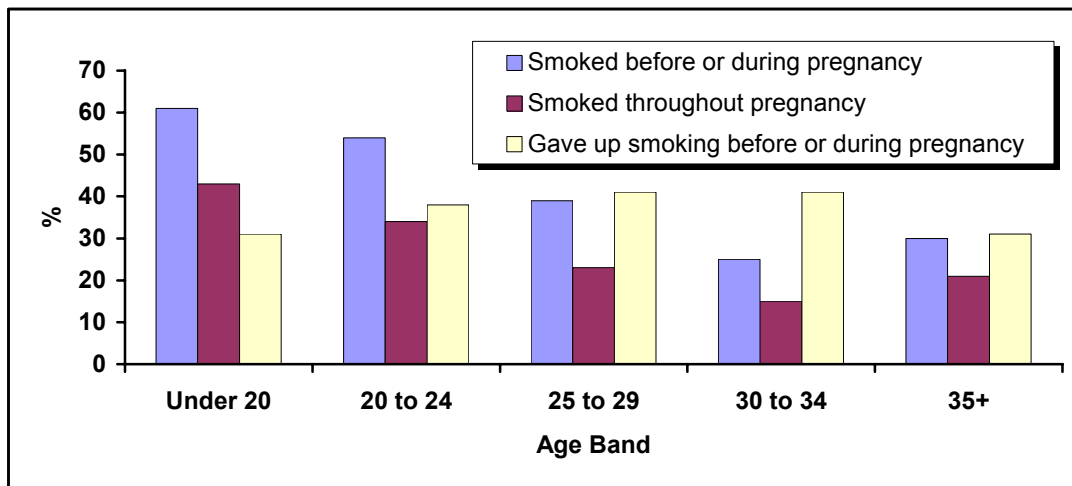
Figure 5.43 Incidence of breastfeeding by age mothers completed full-time education



Source: Infant Feeding Survey, 1995 and 2000

5.51 Figure 5.44 shows the relationship between the smoking habits of women during pregnancy and their age. Females aged 20 or under were more likely to smoke before or during pregnancy than females aged 35 and over, 61% and 30% respectively. They were also more likely to smoke throughout pregnancy (43%) than women aged 35 and over (21%). Fifteen percent of females aged 30 to 34, smoked throughout pregnancy. There were no significant differences in the proportions of women in any of the age bands who gave up smoking before or during pregnancy.

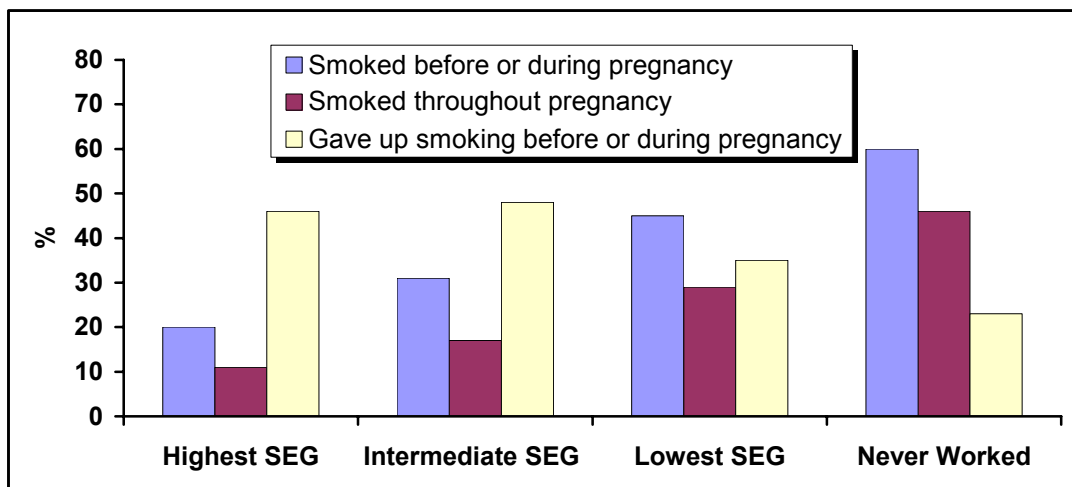
Figure 5.44 Smoking and pregnancy by mothers' age



Source: Infant Feeding Survey, 2000

5.52 Figure 5.45 illustrates the smoking behaviour of women by socio-economic group. There was a substantial difference between women who smoked before or during pregnancy who were in the highest and lowest socio-economic groups. One fifth of women in the highest social class smoked during this period compared with 45% of women in the lowest socio-economic group. Women in the least skilled occupations were substantially more likely to smoke throughout pregnancy (29%) than women in the highest social class (11%). Women in the most affluent social class were more likely to give up smoking before or during pregnancy (46%) than those who never worked (23%).

Figure 5.45 Smoking and pregnancy by mothers' socio-economic group

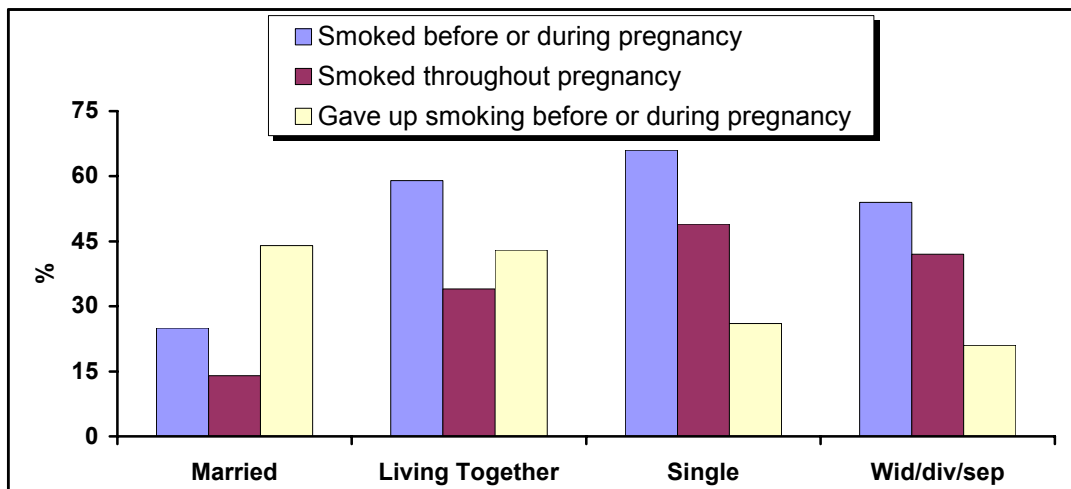


Source: Infant Feeding Survey, 2000

5.53 Two thirds of single women smoked before or during pregnancy compared with one quarter of married women (Figure 5.46). Just under half (49%) of

single women smoked throughout pregnancy compared with 14% of married women. Single women were less likely to give up smoking before or during pregnancy than married women, 26% and 44% respectively.

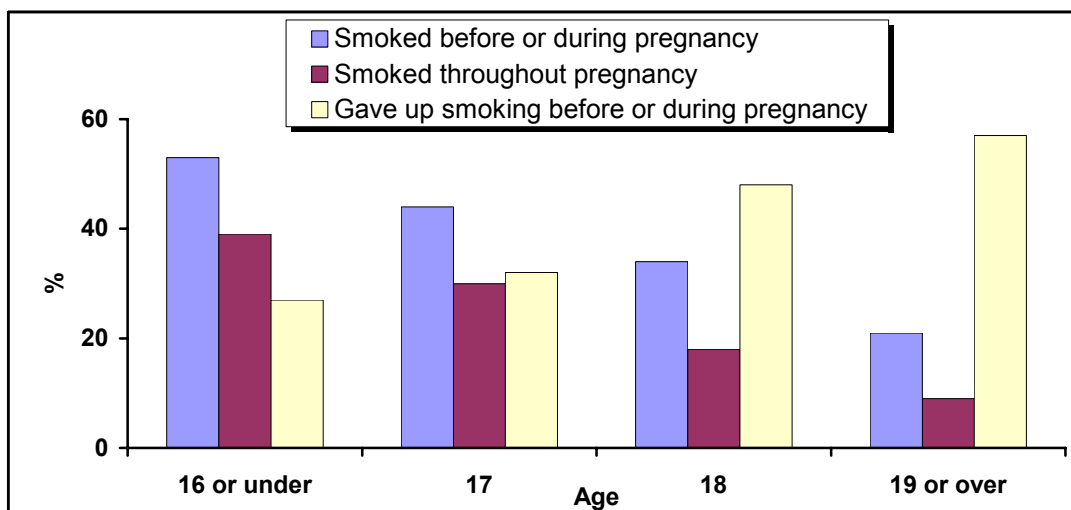
Figure 5.46 Smoking before or during pregnancy by marital status



Source: Infant Feeding Survey, 2000

5.54 There was a substantial difference in rates of smoking before or during pregnancy between women who completed their education aged 16 or under and those who were 19 or over, 53% and 21% respectively (Figure 5.47). Women who finished their education at 16 or under were more likely to smoke throughout pregnancy (39%) than those who finished when aged 19 or over (9%). Fifty-seven percent of women who left full-time education aged 19 or over gave up smoking just before or during pregnancy compared with 27% of those who finished their education aged 16 or under.

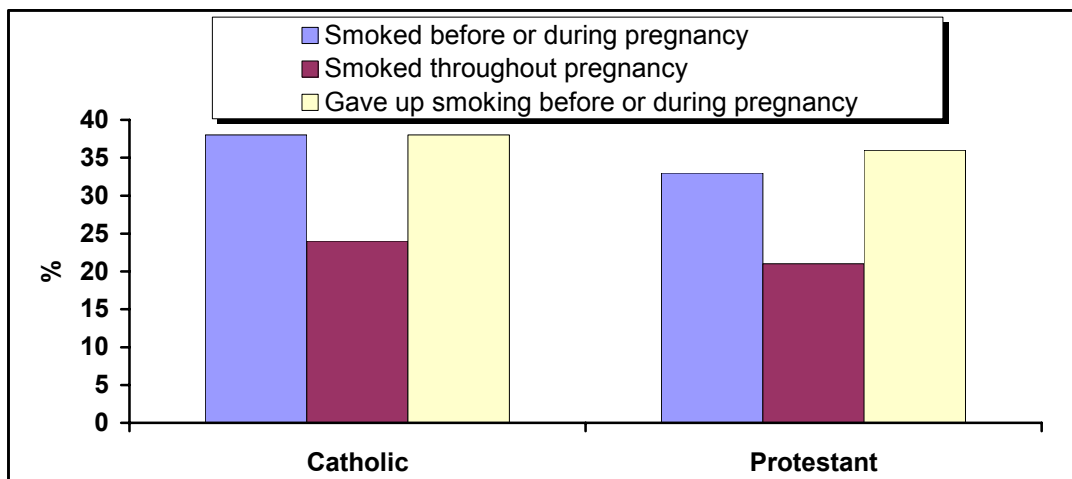
Figure 5.47 Smoking and pregnancy by age mother completed full-time education



Source: Infant Feeding Survey, 2000

5.55 The smoking behaviour of pregnant women across the two main religious groups is illustrated in Figure 5.48. Catholic females were more likely than Protestants to smoke before or during pregnancy (38% and 33% respectively). There were no significant differences between the two communities in terms of women smoking throughout pregnancy or giving up smoking before or during pregnancy.

Figure 5.48 Smoking and pregnancy by mothers' religion

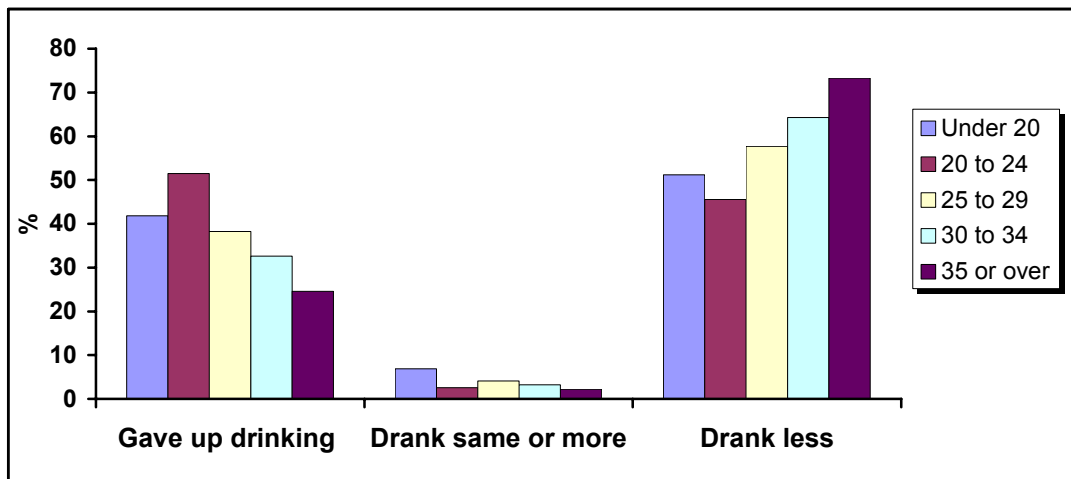


Source: Infant Feeding Survey, 2000

5.56 The Infant Feeding Survey also asked females about their drinking behaviour before and during pregnancy. Figure 5.49 shows that with the exception of the 20-24 age group the percentage of women who gave up drinking, or drank the same or more, decreased with age. The proportion of women who drank less increased with age. Over 40% of females aged 20 or under gave up drinking during pregnancy compared with one quarter of those aged 35 or over. Women aged 20 or under were more likely to drink at the same or at increased levels during pregnancy (7%) than those aged 35 or over (2%). Almost three quarters (73%) of women aged 35 or over, drank less during pregnancy compared with just over half (51%) of those aged 20 or under.

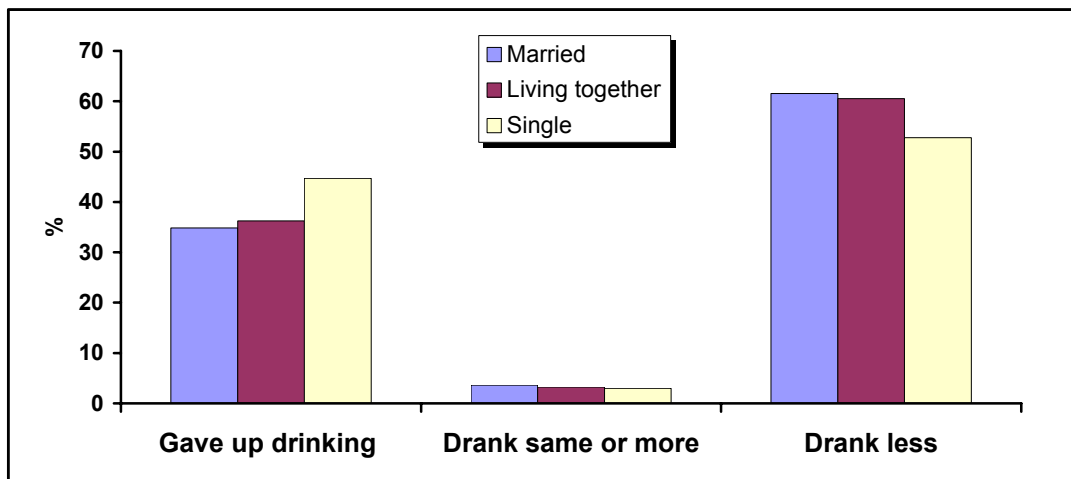
5.57 As seen in Figure 5.50, single females were more likely to give up drinking during pregnancy (45%) than married women (35%). The proportions of women drinking the same or more during pregnancy were similar in each marital status group. Over 60% of married women drank less during pregnancy compared with 53% of single women.

Figure 5.49 Drinking during pregnancy by mothers' age



Source: Infant Feeding Survey, 2000

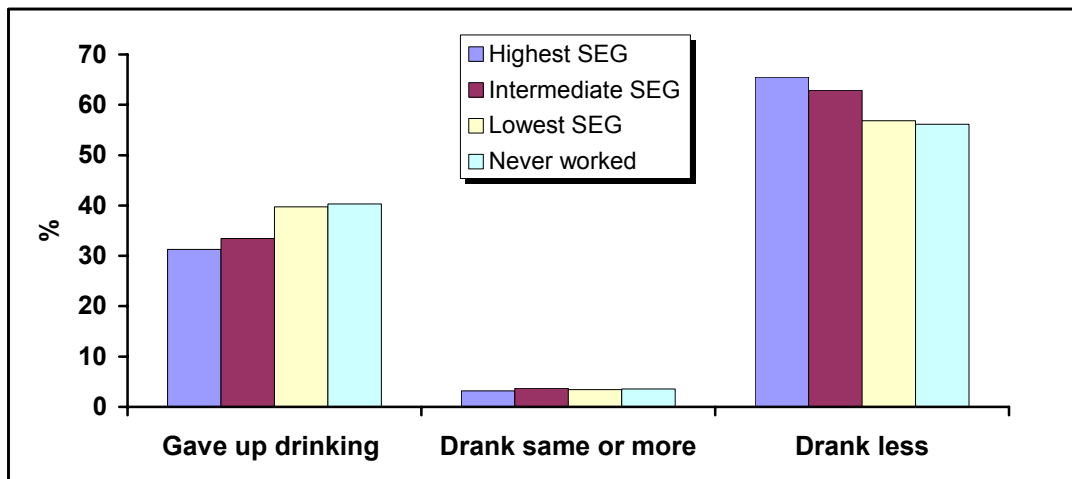
Figure 5.50 Drinking during pregnancy by mothers' marital status



Source: Infant Feeding Survey, 2000

5.58 There was a clear relationship between the proportion of women who gave up drinking or drank less and socio economic group (Figure 5.51). Women in the lowest socio-economic group were more likely to give up drinking during pregnancy (40%) than those in the highest group (31%). The percentage of women who drank less during pregnancy declined with a reduction in social class status. Two thirds of women in the highest social class drank less compared with 57% of those in the lowest.

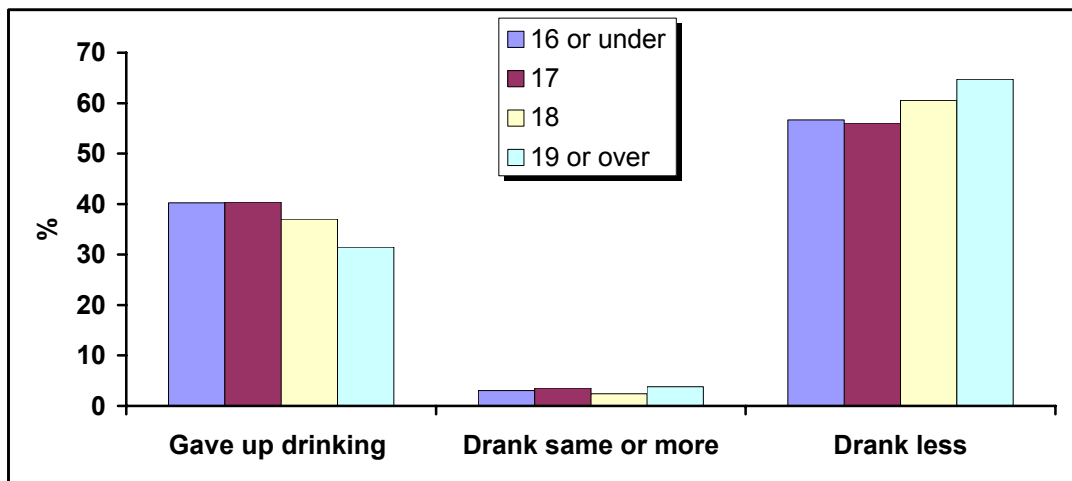
Figure 5.51 Drinking during pregnancy by mothers' socio-economic group



Source: Infant Feeding Survey, 2000

5.59 Women who completed their full time education at 16 or under were more likely than those who finished at 19 or over to give up drinking during pregnancy, 40% and 31% respectively (Figure 5.52). Among females who drank the same or more during pregnancy, there was little difference for each age of leaving full-time education. Just under two thirds (65%) of women who completed their education at the age of 19 or over drank less during pregnancy compared with 57% of those aged 16 or under.

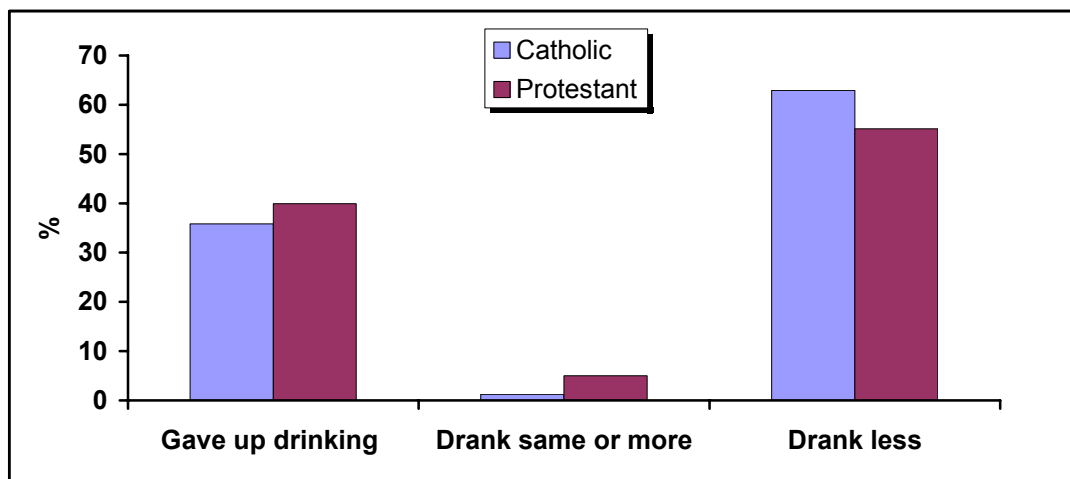
Figure 5.52 Drinking during pregnancy by age mothers completed full-time education



Source: Infant Feeding Survey, 2000

5.60 There was no significant difference in the percentage of Protestant and Catholic women giving up drinking during pregnancy (Figure 5.53). Protestants were more likely to drink more or the same during pregnancy (5%) than Catholics (1%). Catholics, on the other hand, were more likely to drink less during pregnancy (63%) than Protestants (55%)

Figure 5.53 Drinking during pregnancy by mothers' religion



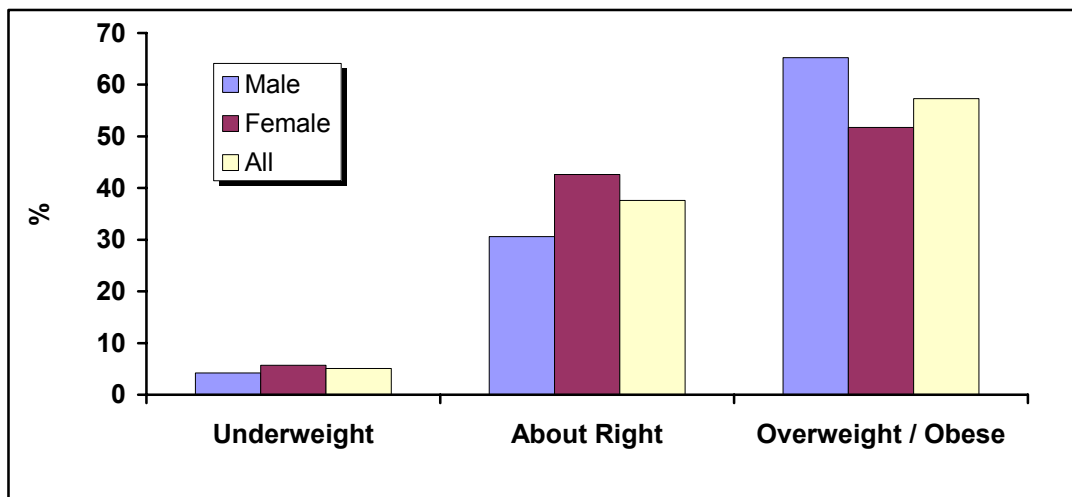
Source: Infant Feeding Survey, 2000

BODY WEIGHT

- 5.61 Body Mass Index (BMI) is the most widely used measure of obesity. It is calculated using a person's height and weight (weight (kg)/height squared (m^2)). A healthy BMI is considered to be between 20 and 25. A person with a BMI greater than or equal to 25 and less than 30 is considered to be pre-obese (overweight), while a BMI of 30 or more is defined as obese. Obesity can be further sub-divided into those who are severely obese (BMI>35) and those who are morbidly obese (BMI>40). A BMI under 20 kg/m² is used as an estimation of those who are underweight.
- 5.62 The Northern Ireland Health and Activity Survey (MacAuley *et al.*, 1994) found that 42% of males aged 16 and over were overweight, while a further 16% were obese. Over one third (35%) of females aged 16 and over were overweight and 21% were obese. More recently, the 1997 Northern Ireland Health and Social Wellbeing Survey found that almost two thirds of males (65%) and just over half of females (52%) aged 16+ weighed more than they should for their height (Figure 5.54). In contrast, 4% of males and 6% of females were underweight.
- 5.63 Figure 5.55 shows the distribution by gender across a wider range of BMI categories. Nearly half (48%) of males were slightly overweight (pre-obese), 14% were moderately obese and 3% were severely/morbidly obese. Females, however, were more likely than males to have the ideal BMI of 20<25 (43% compared with 31%) and they were also less likely to be slightly overweight (32% compared with 48%). However, females had

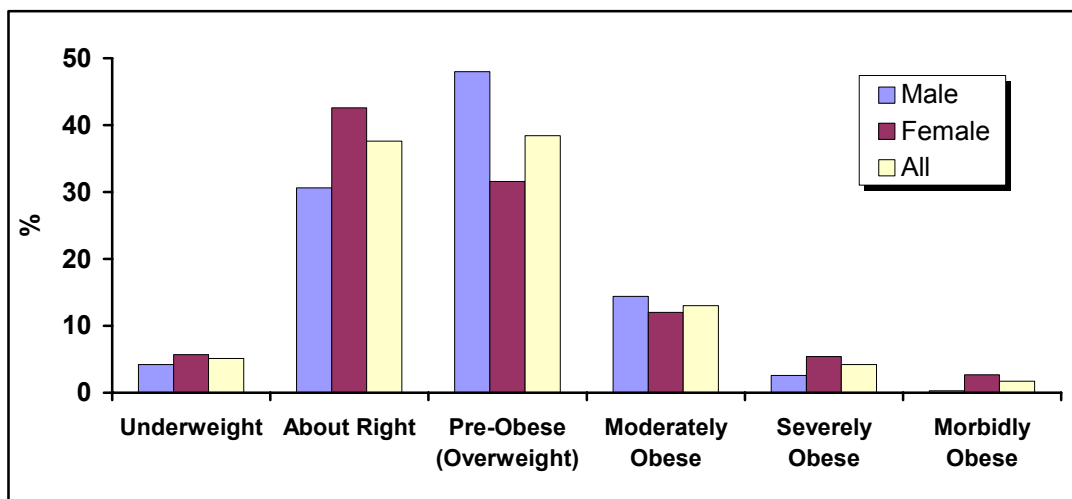
higher overall levels of obesity than males (20% compared with 17%), and also higher levels of severe obesity (5% compared with 3%) and morbid obesity (3% compared with less than half of 1%). Overall, 38% of people had a normal weight for their height, with 5% being underweight and 19% being obese. Due to the small numbers, severely and morbidly obese are combined into one category for the remainder of this section (severe obesity BMI 35+).

Figure 5.54 Body Mass Index by sex



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

Figure 5.55 Body Mass Index by sex

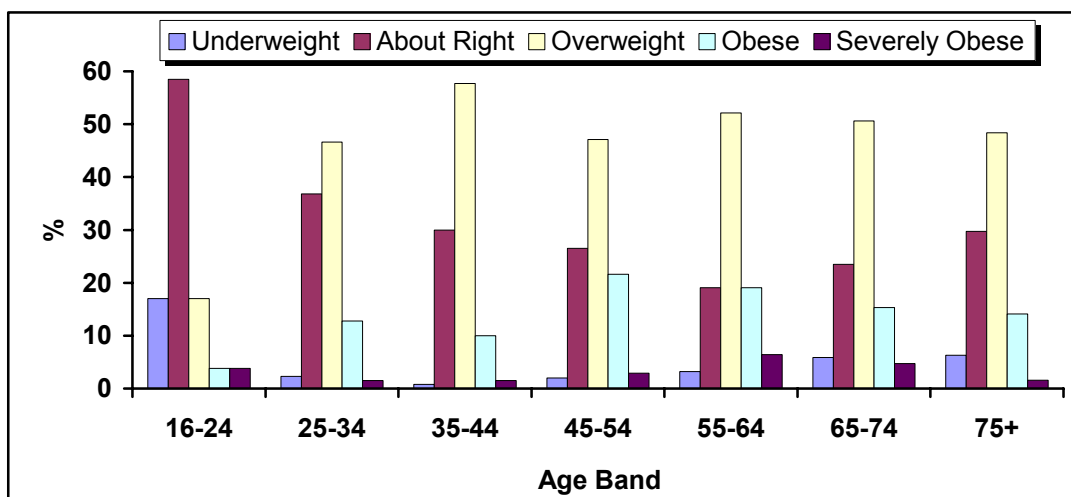


Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.64 The BMI of males within various age bands is illustrated in Figure 5.56. The proportion of males who were overweight increased from 17% of 16-24 year olds to 58% of those aged 35-44 and then decreased in the subsequent older age bands. Almost 60% of 16-24 year old males were

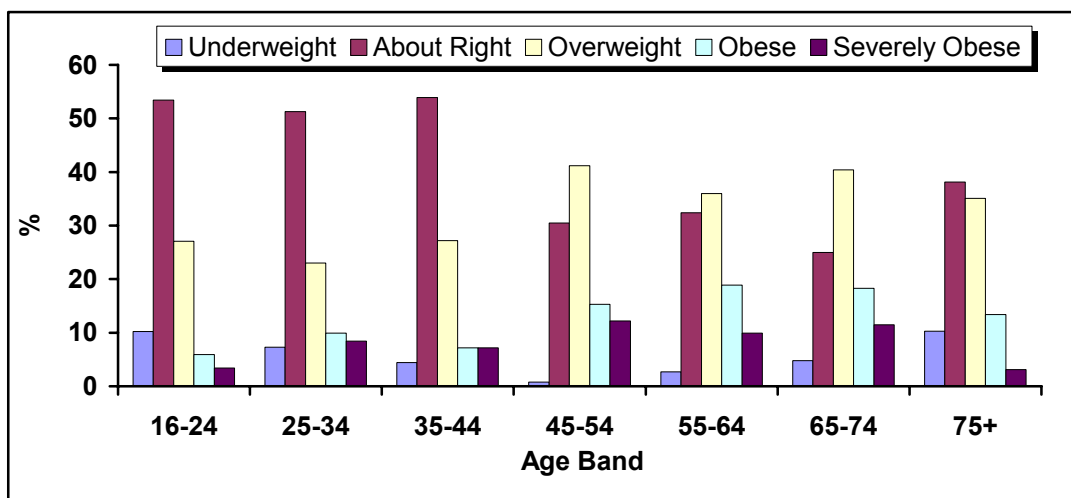
about the right weight. However, this figure decreased gradually in the older age groups to 19% of 55-64 year olds before rising again to almost 30% of males aged 75+. Middle-aged men (45-64 years) were more likely to be obese than those in either the younger or older age ranges. In terms of females, Figure 5.57 shows that more than half of those in each of the younger age bands (16-44 years) were about the right weight. However, in the 45-54 year age band 31% of females were the ideal weight, while the proportion of overweight females peaked in this age group at 41%. Across both gender groups there was a similar trend in the relationship between age and those who were underweight. People in the youngest and oldest age groups were most likely to have a lower BMI.

Figure 5.56 Body Mass Index of males by age



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

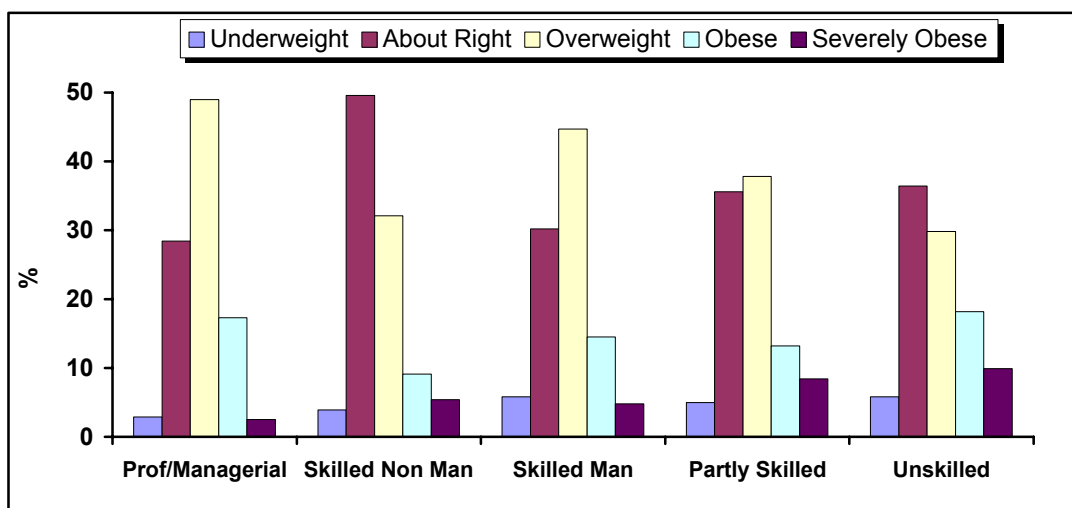
Figure 5.57 Body Mass Index of females by age



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

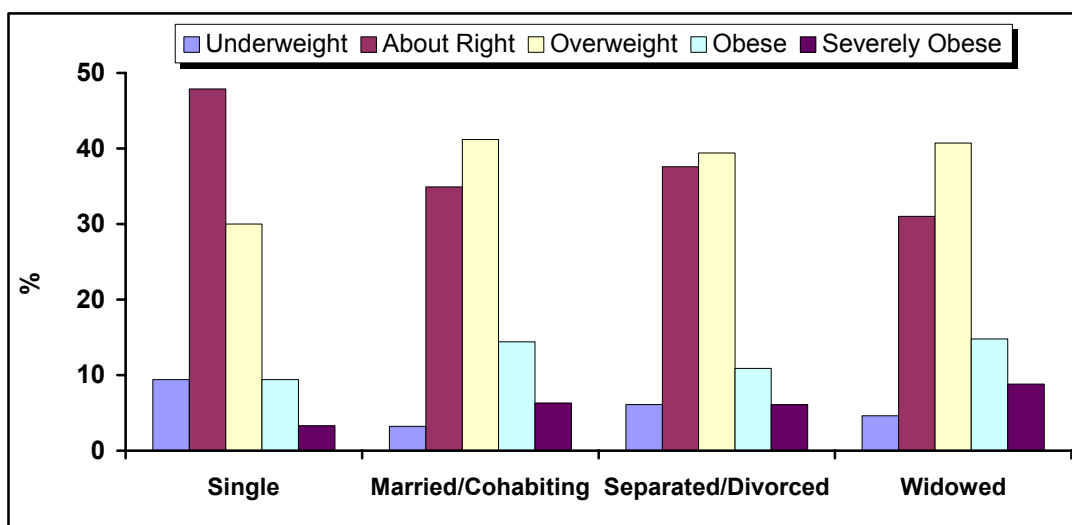
5.65 The results from the 1997 Northern Ireland Health and Social Wellbeing Survey showed no clear relationship between BMI and socio-economic group. The highest levels of obesity and severe obesity were among the unskilled (18% and 10% respectively), while professional and managerial people were more likely to be overweight than those in the other socio-economic groups (Figure 5.58). Figure 5.59 similarly shows that there was no obvious relationship between BMI and marital status. Although ‘about right’ weight levels were higher for single people than other marital status groups, and overweight levels were lower, this was likely to be an age effect rather than marital status.

Figure 5.58 Body Mass Index by socio-economic group



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

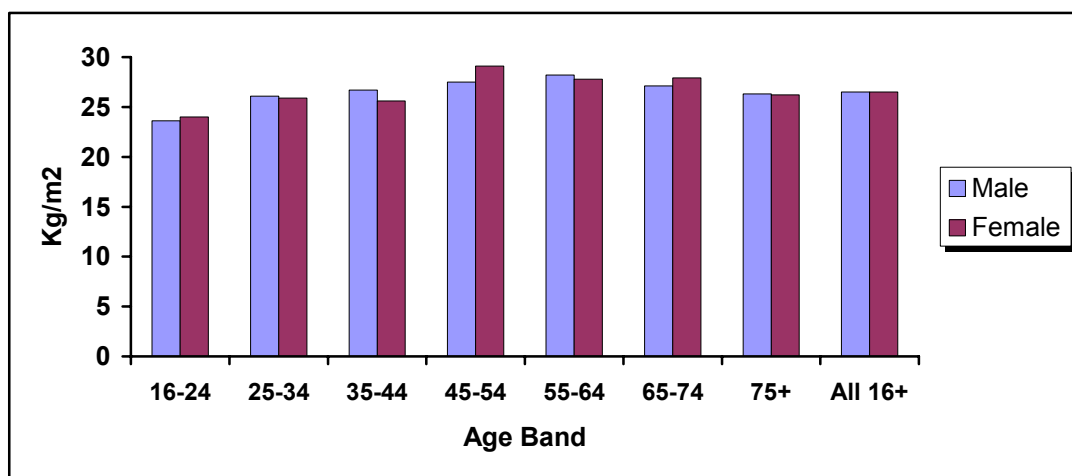
Figure 5.59 Body Mass Index by marital status



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.66 The mean BMI for both males and females was 26.5kg/m², which is considered to be overweight (Figure 5.60). The mean BMI for males increased from a healthy 23.6 kg/m² among 16-24 year olds to an overweight level of 28.2 kg/m² among those in the 55-64 age band. The mean BMI for females rose from 24 kg/m² in the youngest age group to a near obese 29.1 kg/m² among 45-54 year olds. The mean BMI was similar in all four HSS Board areas and across the two main religious groups.

Figure 5.60 Mean Body Mass Index by gender and age

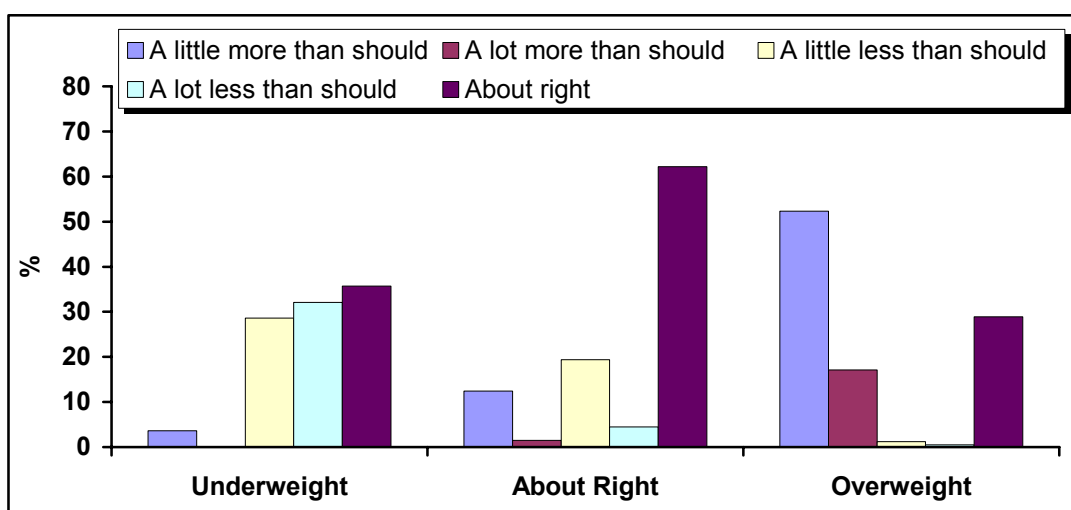


Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.67 Both the 1997 and 2001 Northern Ireland Health and Social Wellbeing Surveys asked respondents about their perception of their weight in relation to their height. Analysis of the 1997 survey found that peoples' perceptions about their weight tended to be very accurate when compared against BMI (Gaffney, 2001). Those who believed they were the correct weight for their height had a mean BMI of 23.9 kg/m², while those who believed that they weighed a lot more than they should, had a mean BMI of 33.8 kg/m². This was the case for both sexes and most age groups, suggesting that personal perception of weight quite accurately mirrored the mean BMI. More women than men, 58% compared to 49%, saw themselves as weighing more than they should. Women tended to see themselves as overweight at a lower BMI than men. This was best illustrated among women aged 16-24 as no females in this age group thought they weighed a lot less than they should, while 47% believed that they weighed more than they should. The corresponding figures for men in this age group were 7% and 22%. This was despite the fact that the mean BMI for women in this age group was lower than that of men.

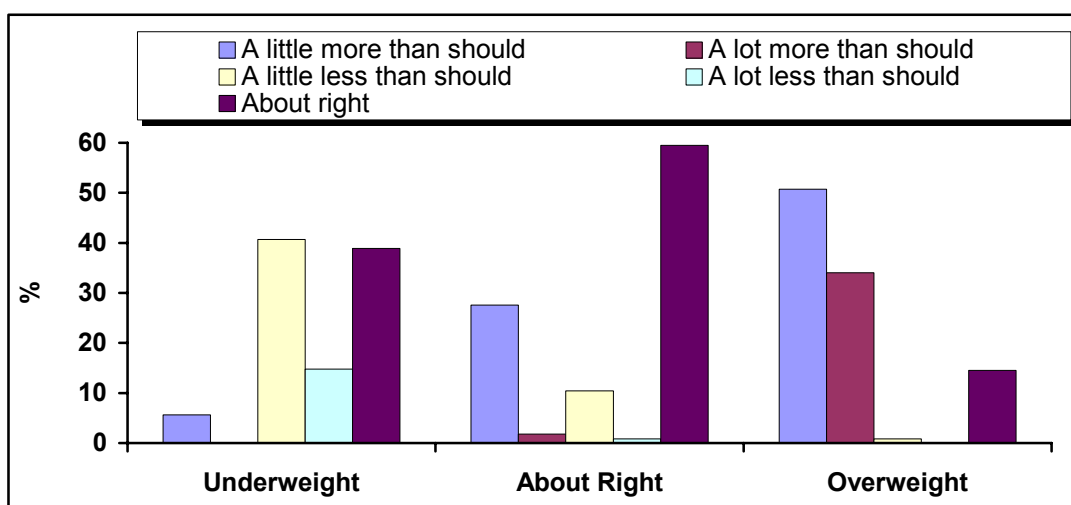
5.68 Figure 5.61 illustrates the relationship between male perception about their weight and their actual BMI grouping. Almost 36% of males who were underweight thought they weighed the right amount. Just less than 30% of overweight males thought they were the correct weight for their height, while a further 52% perceived that they weighed just a little more than they should. Among females, 39% of those who were underweight reported to be about the right weight (Figure 5.62). More than half of females who were overweight believed that they weighed just a little more than they should, while a further 14% thought they were about the right weight.

Figure 5.61 Body Mass Index of males by self-perception of weight



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

Figure 5.62 Body Mass Index of females by self-perception of weight

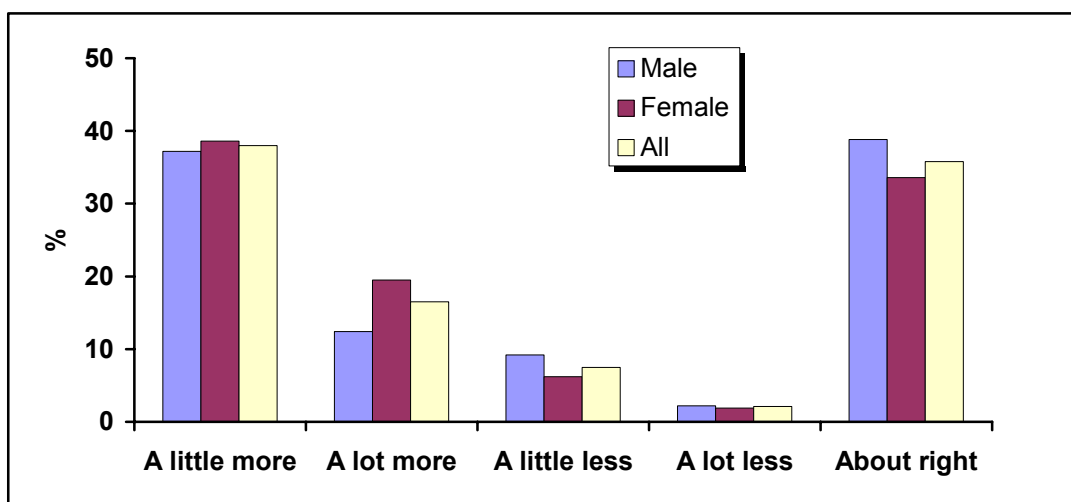


Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.69 In the 2001 survey 38% of people suggested they weighed a little more than they should, while 16% believed they weighed a lot more than they

should (Figure 5.63). Females were more likely to say that they weighed more than they should with 39% saying they weighed a little more than they should and 19% believing they weighed a lot more than they should. Almost half of males thought they weighed either a little or a lot more than they should. Peoples’ perceptions about their weight in relation to their height changed remarkably little between the 1997 and 2001 surveys.

Figure 5.63 Perception of weight to height by gender



Source: Northern Ireland Health and Social Wellbeing Survey, 2001

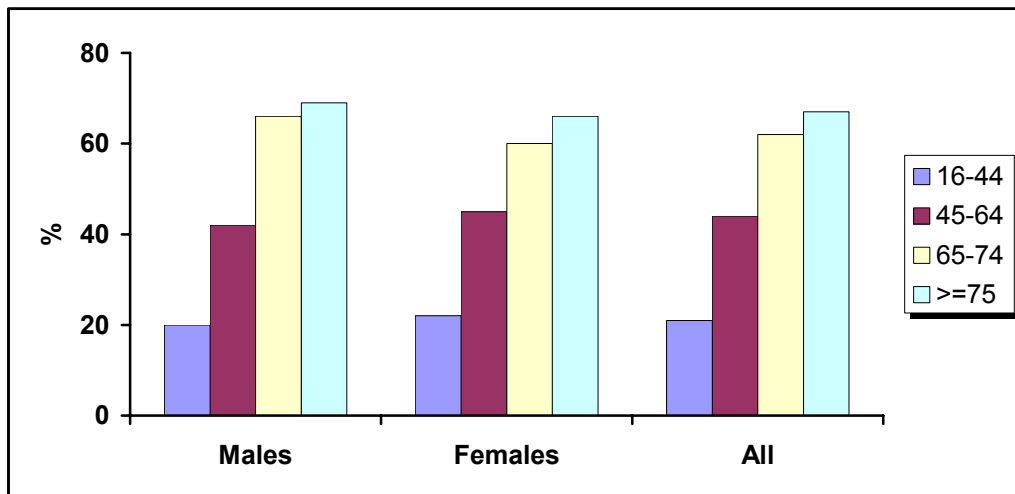
Children’s Weight

5.70 Although the analysis in this section has concentrated on the BMI of those aged 16 and over, the BMI of children is also an important area. However, published research on children’s BMI in Northern Ireland is very limited. One study on this subject (Yarnell *et al.*, 2001) looked at the prevalence and awareness of excess weight in 13 and 14 year olds in Northern Ireland. It found that 16% of boys were overweight and 4% were obese. The proportion of girls who were overweight was also 16%, however the prevalence of obesity in girls was lower at 2%. Although the study found a very high correlation between the height of both boys and girls to their fathers’ social class, the children’s BMI showed no such correlation to the social class of their parents. The study showed that more girls than boys perceived that a modified diet could be helpful. Over one third of obese girls were dieting compared with one sixth of obese boys. Furthermore, there were no consistent or significant differences in dieting between overweight children or obese children from different socio economic groups.

LONG STANDING ILLNESS

5.71 Figure 5.64 shows the expected increasing prevalence of long-standing illness as people become older. However, the small differences between males and females of increasing age are not statistically significant.

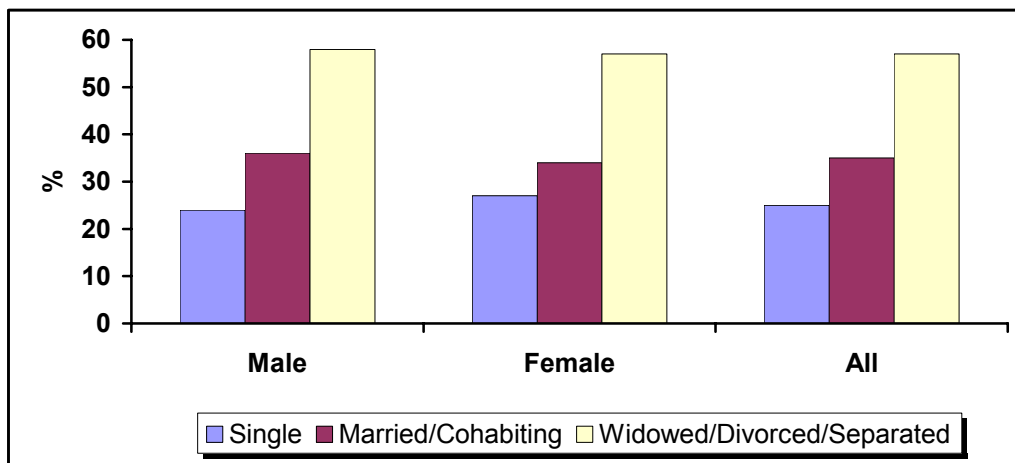
Figure 5.64 Prevalence of long-standing illness by sex and age



Source: Continuous Household Survey, 2002/2003

5.72 Figure 5.65 shows an apparent increase in long-standing illness with changing marital status. This difference, however, is likely to be merely an artefact of increasing age.

Figure 5.65 Prevalence of long-standing illness by marital status



Source: Continuous Household Survey, 2002/2003

5.73 The prevalence of long-standing illness by socio-economic group is illustrated in Figure 5.66. There is a higher prevalence of long-standing illness among the lower social classes. Thirty percent of

professionals/managers suffered from long-standing illness compared with just under half (47%) of unskilled workers.

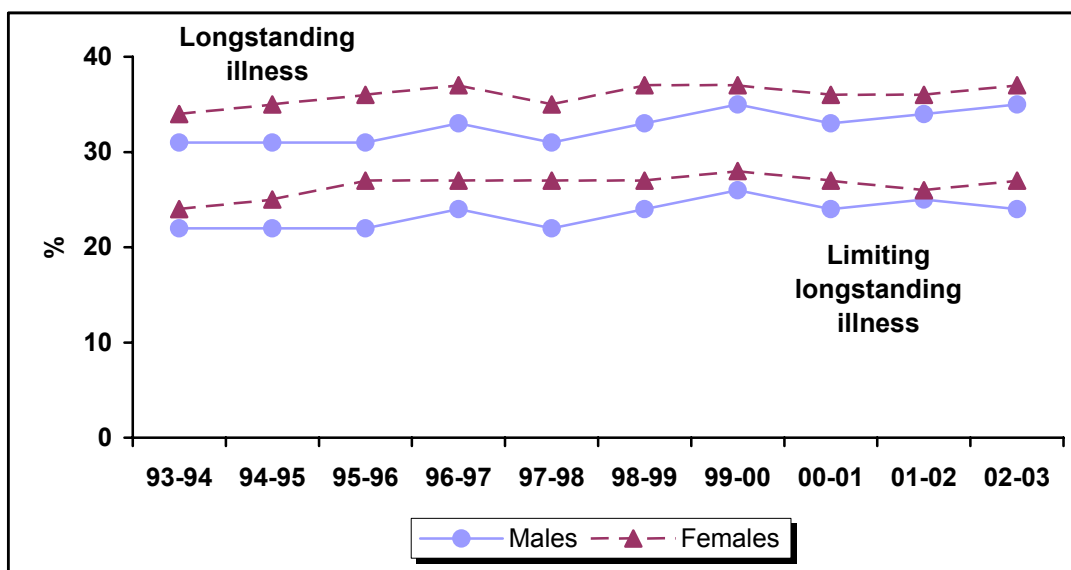
Figure 5.66 Prevalence of long-standing illness by socio-economic group



Source: Continuous Household Survey 2002/2003

5.74 Figure 5.67 shows a trend in long-standing and limiting long-standing illness in males and females from 1993-2003. This trend appears to highlight a particular problem for females. However, females tend to live longer than males and as a result higher levels of longstanding illness in females is likely to largely be the result of differential life expectancies between the sexes.

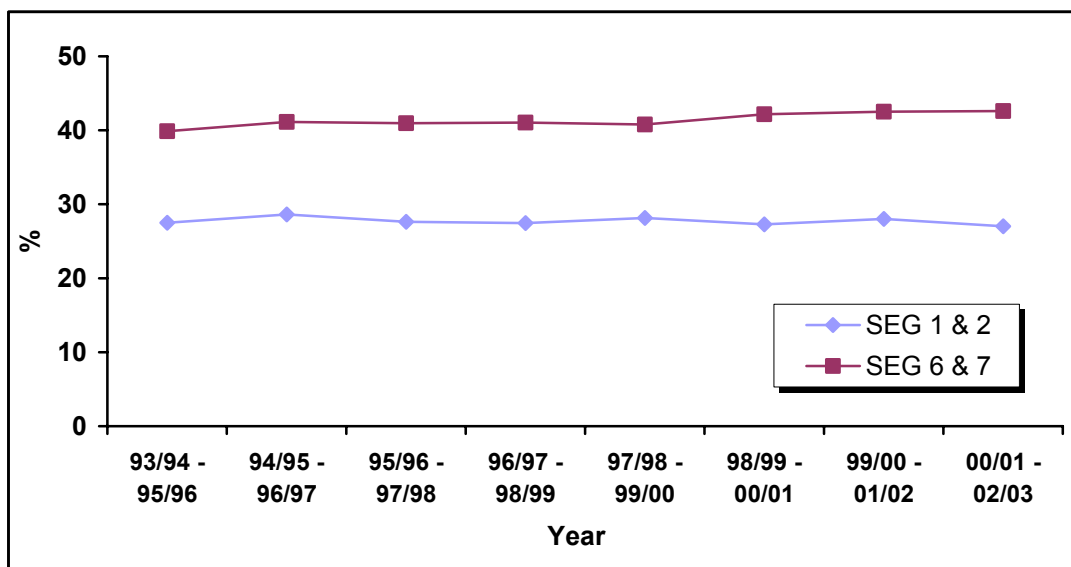
Figure 5.67 Trends in longstanding and limiting longstanding illness in males and females: 1993/94 – 2002/03



Source: Continuous Household Survey

5.75 The proportion of people in socio-economic groups 6 and 7 (unskilled and semi-skilled manual) with a long-standing illness is considerably higher than the proportion in socio-economic groups 1 and 2 (professional and managerial). This gap has remained fairly constant between 1993/96 and 2000/03 (Figure 5.68).

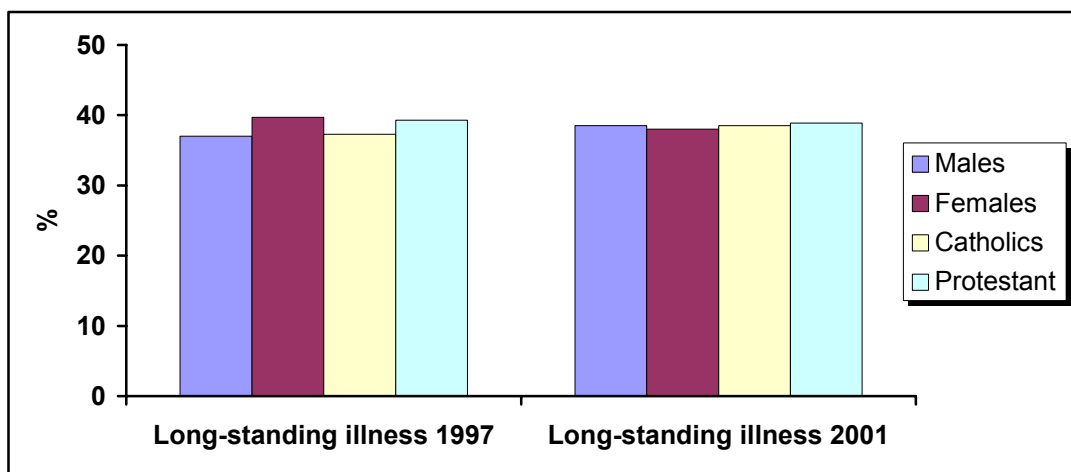
Figure 5.68 Trends in long-standing illness by socio-economic group (3 year moving average)



Source: Continuous Household Survey

5.76 Both the 1997 and 2001 Northern Ireland Health and Social Well-being Surveys asked questions on long-standing illness and disability. In 1997 39% and in 2001 38% of respondents reported a long-standing illness or disability. The prevalence of limiting long-standing illness or disability was 27% in both years.

Figure 5.69 Occurrence of long-standing illness by gender, religion and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

- 5.77 Figure 5.69 compares the occurrence of long-standing disabilities by gender and religion in both 1997 and 2001. Although small differences occur in these years differences are not significant. The Continuous Household Survey found that the prevalence of long-standing illness was slightly higher among Protestants. However, this is likely to be a reflection of the different age profile between the two communities in Northern Ireland, with Protestants having an older age structure than Catholics. O'Reilly and Stevenson (1998) examined the standardised limiting long-term illness ratios (SIR) between the two communities. They reported that areas with a higher proportion of one religion experienced higher SIRs and that this finding was stronger in predominantly Catholic areas.
- 5.78 Results from the Northern Ireland Health and Social Well-being Surveys indicate an association between the standard of housing – in particular the availability of full central heating and long-standing illness. Over half of the respondents who lived in rented accommodation reported a long-standing illness, while only a minority of owner-occupier respondents did so.

Table 5.1 Proportion of respondents in receipt of disability-linked state benefits by year (in %)

Type of benefit	1997	2001
Disability Living Allowance	9.1	5.4
Incapacity Benefit	5.5	6.0
Severe Disablement Allowance	1.0	0.5
Disability Working Allowance/Disabled Person's Tax Credit	0.5	0.1
Industrial Injury Disablement Benefit	0.3	0.2
War Disablement Pension (and related pensions)	0.5	-
Invalid Care Allowance	-	1.4
Total	16.9	13.6

Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

- 5.79 In the 1997 Northern Ireland Health and Social Well-being Surveys, 4.7% of respondents reported that they were registered as disabled. However, the 2001 NIHSWS survey asked slightly different questions in relation to long-standing illness. Table 5.1 compares the results of these two surveys on

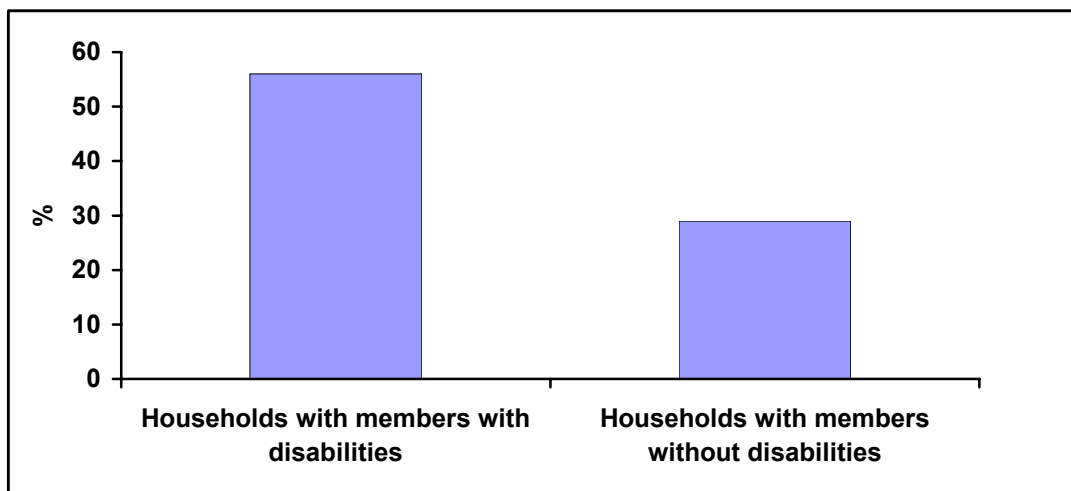
disability benefits. Overall, fewer respondents were in receipt of disability-based state benefits in 2001 than in 1997. The largest drop was in Disability Living Allowance (9.1% in 1997 fell to 5.4% in 2001).

DISABILITY

- 5.80 There is currently no standard method or single data source used in research and quantitative work to identify those people in Northern Ireland who have a disability. This is not only the case in Northern Ireland. The unreliability of statistics on the prevalence of disability in populations (Oliver and Burns, 1998) is documented in a recent report by the Equality Commission for Northern Ireland (Equality Commission, 2003). In order to address this, the Northern Ireland Statistical Research Agency (NISRA) has commissioned a technical review of all information, including definitions and estimates of the number of people in NI with a disability. The review will also identify gaps in existing information, in terms of meeting user requirements, and will recommend options for meeting any outstanding user needs. A similar review is underway in England, commissioned by the Department of Work and Pensions (DWP).
- 5.81 Different sources of information do not give an overall figure for the number of people with a disability. The Policy Planning and Research Unit Surveys of Disability in Northern Ireland (1990) found that 100,000 people, 40,000 of whom were under 60 years of age, had levels of physical or sensory disability, which significantly affected the quality of their lives. A few years ago, the Northern Ireland Disability Council estimated that one in six adults have a disability. That is 17% of adults in Northern Ireland compared with 14% in GB. The 2001 data from the Labour Force Survey shows that 19.4% of the working age population has a disability under the Disability Discrimination Act definition; the figure for the total adult population would be much higher than this. There are 26,500 people with a physical or sensory disability in contact with health and social services. Key Indicators of Personal Social Services in NI (2002) show that 8.7% of the total population receive Disability Living Allowance (DLA). This is more than twice the percentage in England (3.8%), Key Indicators (DHSSPS, 2002). Physically disabled people who had contact with care providers in 2001-2002 of all ages numbered 11,835 (Community Statistics, DHSSPS 2002).

- 5.82 Disability organisations often use different estimates of disability, particularly around impairment-specific groups. For example, the Royal National Institute for Deaf People (RNID) estimates that there are just under 9 million deaf and hard of hearing people in the UK and around 220,000 deaf or hard of hearing people in Northern Ireland (RNID, 2003). Meanwhile, the Royal National Institute of the Blind (RNIB) estimate there to be over 2 million people currently in the UK with sight problems and have estimated that over 24,000 of them live in Northern Ireland (RNIB, 2003).
- 5.83 There is an increasing prevalence of people with a learning disability, particularly those with severe conditions. This is related to a number of factors: increased survival and lifespan of babies with profound learning disabilities (these children would previously have died and can only survive with access to life support technology); growing numbers of children being identified as having autistic spectrum disorders and people with a learning disability living into old age.
- 5.84 Recent research (Hillyard *et al*, 2003), measured poverty in NI in terms of both low income and inability to afford things or activities most people regard as necessities of life. It showed that households with one or more disabled members are more likely to be living in poverty. Over half (56%) of households that contained one or more disabled people live in poverty compared with only 29% of households living in poverty who have no one with a disability (Figure 5.70). However, households reporting having at least one member with a disability made up only 6% of all those in poverty.

Figure 5.70 Poverty rate of households with disabled people



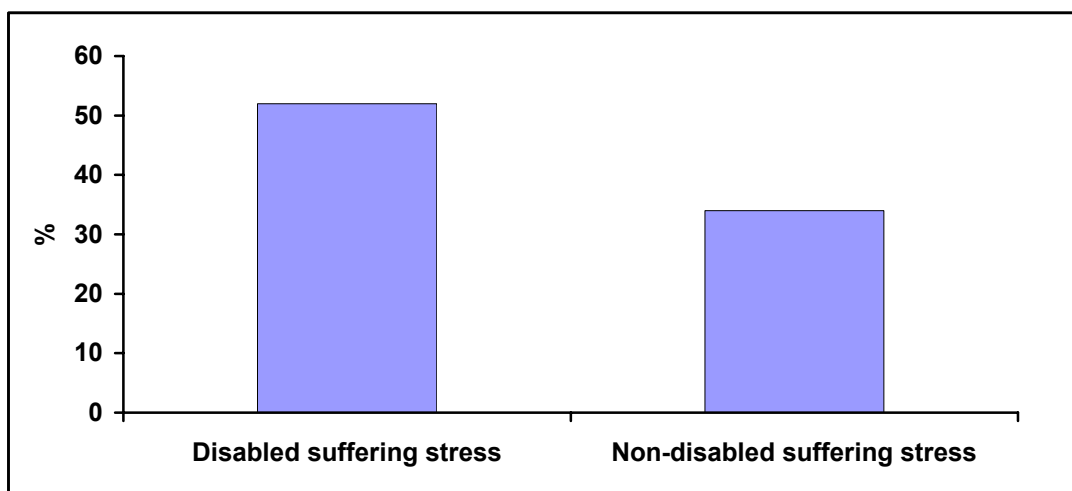
Source: Hillyard *et al.*, 2003

5.85 Respondents were also asked if they had a ‘long-term illness, health problem or disability which limits daily activities or work you can do.’ Those who answered ‘yes’, constituted half of all those in poverty, with a poverty rate of 42%. The researchers believe there may therefore have been some under-reporting of disability by survey respondents in poor households.

5.86 Surveys used in the Equality Commission’s report included definitions used in the Labour Force Survey and the Health and Well Being Surveys which are comparable to that of the Disability Discrimination Act, 1995. The Health and Social Well Being Survey 2001 showed that 38% of respondents reported having a long-standing illness or disability that has affected them over a long period of time. Twenty seven per cent reported having a health problem or disability substantially limiting their ability to carry out day-to-day activities. This latter group was used to represent disabled people for the Equality Commission’s research, where there were found to be proportionately more disabled women (29%) than men (26%).

5.87 Key findings showed that disabled people were more likely to have experienced a lot, or a great deal, of worry than those who were not disabled (Figure 5.71). Of the 21% who reported being depressed, women (24%) were more likely to report being depressed than men (17%). While 34% of those who were not disabled had experienced quite a lot or a great deal of stress in the 12 months prior to the survey, the percentage rose to 52% for disabled people. This was also higher among women who were disabled (44%) than men (34%).

Figure 5.71 Stress suffered in previous 12-month period by disability



Source: Equality Commission for NI, 2003

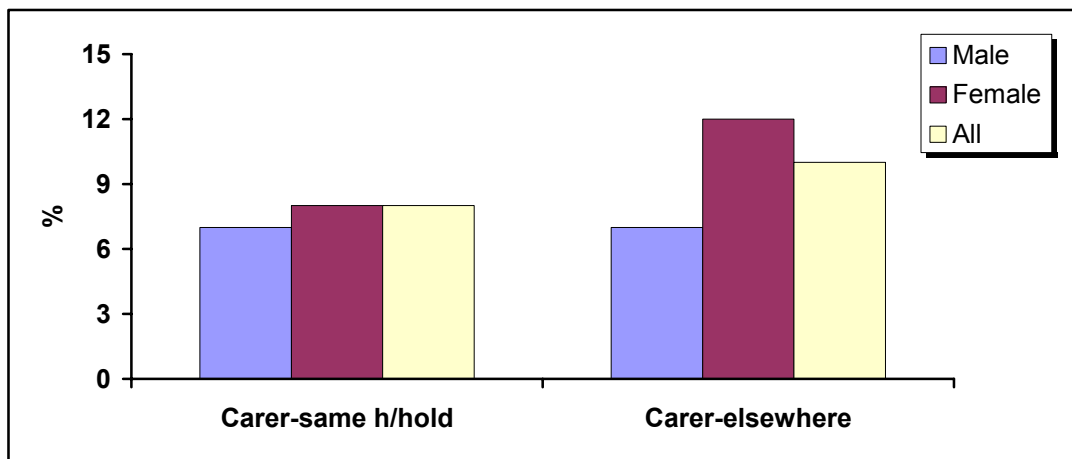
- 5.88 The Equality Commission's key findings, based on a literature review and focus groups with disabled women in Northern Ireland, found that sexuality and motherhood were among disabled women's main concerns. They felt that there was an expectation that they would not wish to, or be capable of having and caring for children. There were negative attitudes to the accessing of services which they felt would be of benefit to them including cognitive therapy and counselling. There was a general feeling that healthcare services tended to be centred in Belfast, with some women who took part in the focus groups reporting that they did not have access to certain services. These included routine cervical smear tests where there were problems due to physical accessibility at GP surgeries.

CARERS

- 5.89 This section provides information on informal carers in Northern Ireland. Carers are people who, without payment, provide help and support to a family member or friend who may not be able to manage without this help because of frailty, illness or disability (Valuing Carers, 2002). The main source used is the Informal Carers Report, which presents information from the 1997 Northern Ireland Health and Social Wellbeing Survey on those caring for a sick, disabled or elderly person. The survey identifies two main forms of caring roles: those looking after someone living with them as part of the household, and those providing care for a dependant living elsewhere.
- 5.90 Eighteen percent of people indicated that they act as informal carers; that is to say, they look after or give special help to someone who is sick, disabled or elderly. Women carried significantly more responsibility than men for the provision of care, with 20% of women providing care compared with 14% of men. This is slightly higher than the level of informal care reported in the 1995 Continuous Household Survey, which indicated that 14% of adults (10% of men and 17% of women) provided informal care. The 2000/01 Continuous Household Survey also found that 14% of adults were carers (10% of men and 16% of woman).
- 5.91 The proportion of people providing informal care for someone living with them (8%) was similar to those who provide care for someone living elsewhere (10%). Both men and women were equally likely to provide care for someone living with them (7% and 8%). Women, however, were more

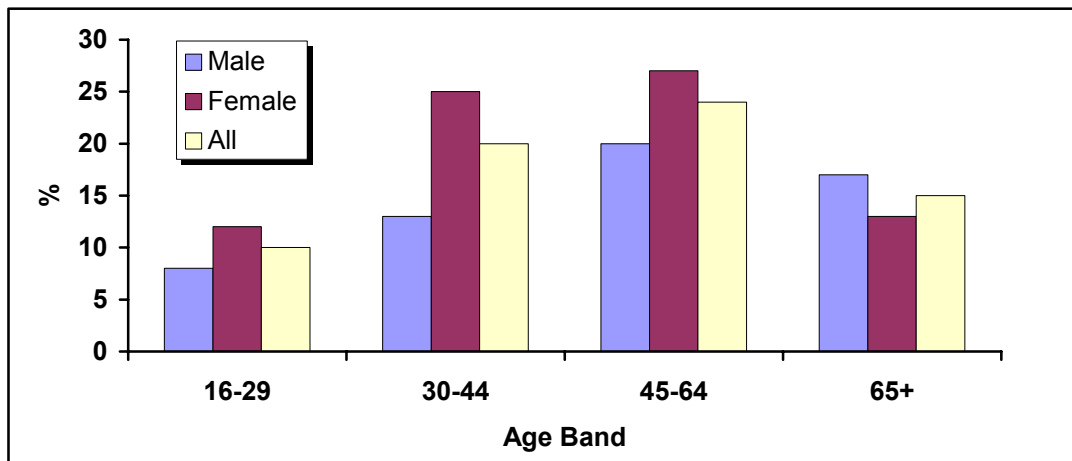
likely than men to provide care for someone living outside the household, with 12% of women providing outside care compared with 7% of men (Figure 5.72). Overall, 6% of adults provided care for at least 20 hours per week and women were slightly more likely than men to spend at least 20 hours per week caring for a dependant (7% compared to 5%). Both men and women were more likely to care for one dependant than for two or more.

Figure 5.72 Carers who live in the same house as their dependant or elsewhere by gender



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

Figure 5.73 Carers by age and gender



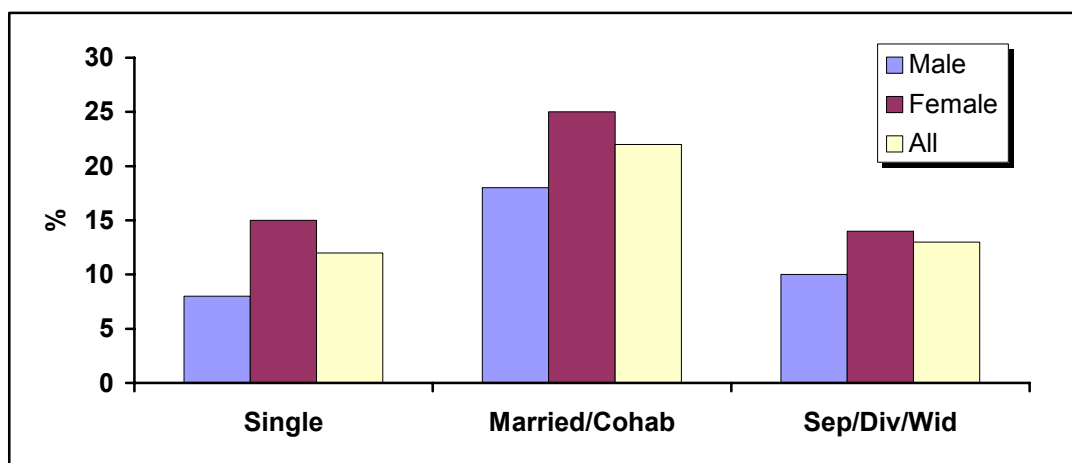
Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.92 The incidence of informal care was highest among those aged 45 to 64, with approximately a fifth of respondents acting as carers (Figure 5.73). Among those aged 45 to 64, just over a quarter (27%) of women act as carers compared with 20% of men. Women aged between 30 and 44 are almost twice as likely as men of the same age group to be carers (25% of women, compared with 13% of men). Overall, a higher proportion of

women reported being carers in all age groups, with the exception of the over 65-age group.

5.93 The Informal Carers Report identifies a strong association between marital status and the provision of informal care (Figure 5.74). Respondents who are married/cohabiting are much more likely to be carers (22%) than respondents who are single (12%) or separated/divorced/widowed (13%). A similar pattern was found in both men and women and those caring for a dependant in the same household or elsewhere. Single and married/cohabiting women, however, were more likely to be carers than single and married/cohabiting men. Separated, divorced, and widowed women were more likely to provide care for someone outside the household. The 2000/01 Continuous Household Survey, however, found no significant difference in the proportion of single people who were carers (15%) compared with the percentage of those who were married/cohabiting (14%).

Figure 5.74 Percentage of adults who were carers by marital status and gender



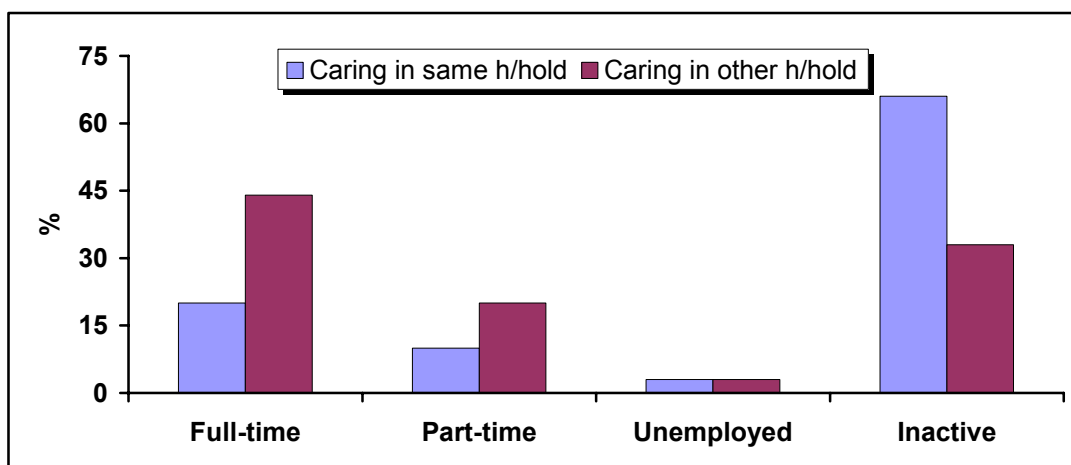
Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.94 Overall, almost half of all carers (48%) were economically inactive, a third (33%) were in full-time employment and 15% were working part-time. With the exception of full-time employment, the economic activity profile of non-carers was similar to that of carers. Non-carers were more likely to be in full-time employment (38%) than carers (33%).

5.95 The economic activity profile of carers varies considerably depending on whether they care for a dependant living with them or elsewhere (Figure 5.75). For example, carers who live with a dependant are twice as likely to

be economically inactive (66%) as those who care for a dependent elsewhere (33%), while those caring for a dependant who lives elsewhere are twice as likely to be working full-time (44%) or part-time (20%) as those who live with a dependant (20% and 10% respectively). This association, between the location of dependants and economic activity was similar for both men and women. Carers with a dependant outside their household were also more likely to be in full-time employment (44%) or part-time employment (20%) than non-carers (38% and 13% respectively). There was little variation in the overall proportion of carers in the manual and non-manual socio-economic groups. Male carers, however, were more likely to be in the manual socio-economic group (57%), and female carers were more likely to be in the non-manual group (56%).

Figure 5.75 Economic activity of carers

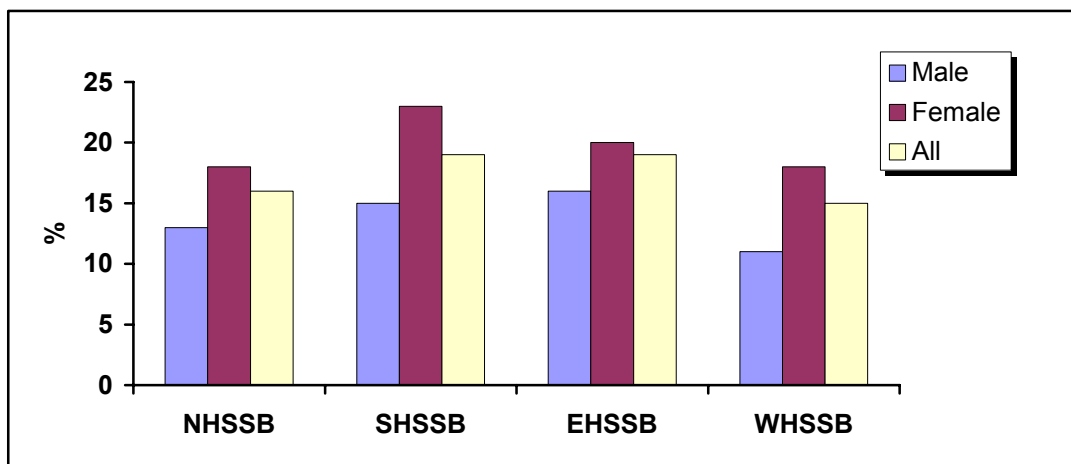


Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.96 There were only small differences between the HSS Board areas in the overall proportion of carers, with the Western Board area having the lowest proportion of carers (15%) and the Southern and Eastern Board areas having the highest (19% respectively) (Figure 5.76). Both men and women reported a similar pattern of care across the health boards. Women, however, were more likely to provide care than men in all health board areas. The main difference between the Board areas in the provision of care related to the location of the dependants. Carers in the Western Board area were less likely to provide care for someone who lived outside their household (6%) than carers in the other health board areas (9% to 12%). There were, however, no differences between the Board areas in the proportion providing care for someone in their household. There were also

no differences between the Board areas in the proportion of carers providing care for more or less than 20 hours a week.

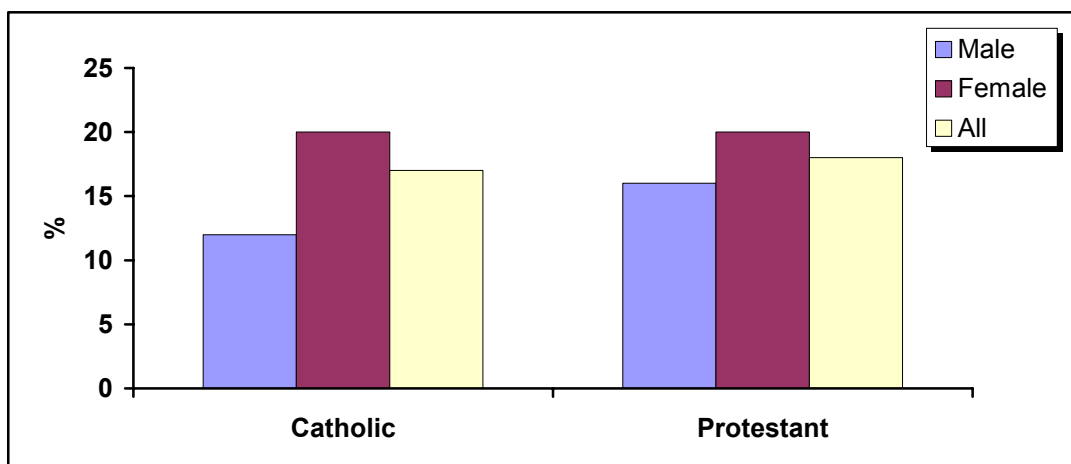
Figure 5.76 Carers by HSS Board and gender



Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.97 An analysis by religious denomination indicates no overall difference in the proportion of Catholic or Protestant respondents providing care (Figure 5.77). Protestant men, however, were more likely to be carers (16%) than Catholic men (12%). There was no difference between Catholic and Protestant women (20% each respectively). The results of the Continuous Household Survey 2000/01 also show no significant difference in the percentage of Catholics or Protestants acting as carers (15% and 13% respectively).

Figure 5.77 Carers by religion

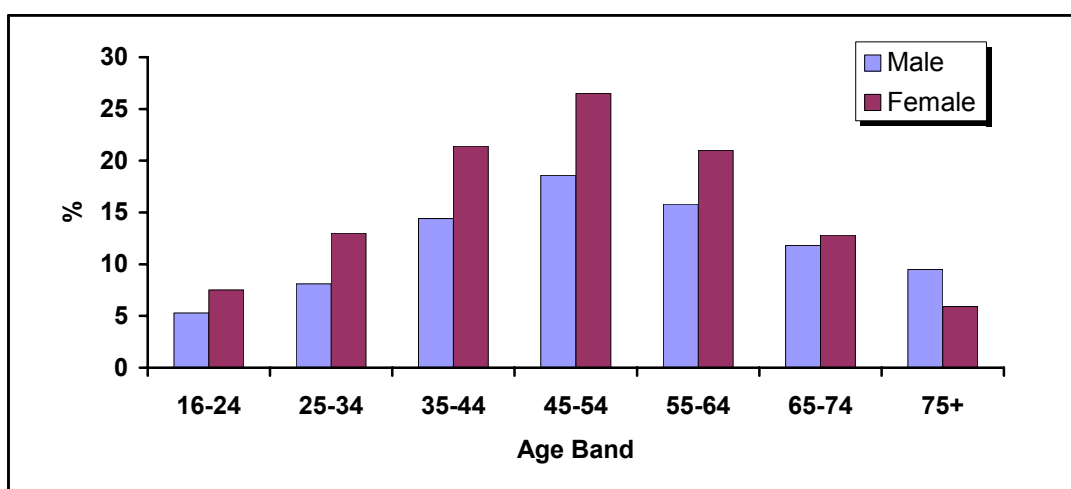


Source: Northern Ireland Health and Social Wellbeing Survey, 1997

5.98 The 2000/01 Continuous Household Survey also provides information on the prevalence of carers by dependant children. There was no significant

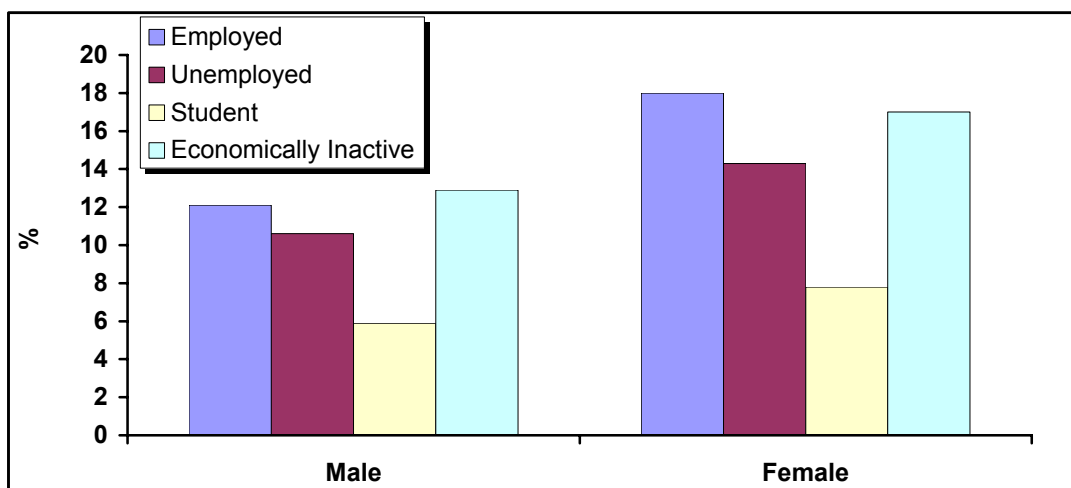
difference in the proportion of people with or without dependant children providing care (14% compared to 13% respectively). The 2001 Census included a question on the level of support given to family members, friends, neighbours or others because of long term physical or mental ill health or disability; or problems related to old age. More than one in ten people provided unpaid care (11%). The results were similar to those found in the Health and Wellbeing Survey with middle-aged women being most likely to be unpaid carers (Figure 5.78). Over one quarter (26%) of females aged 45-54 provided care.

Figure 5.78 Carers by age and gender



Source: Northern Ireland Census of Population, 2001

Figure 5.79 Carers by economic activity and gender



Source: Northern Ireland Census of Population, 2001

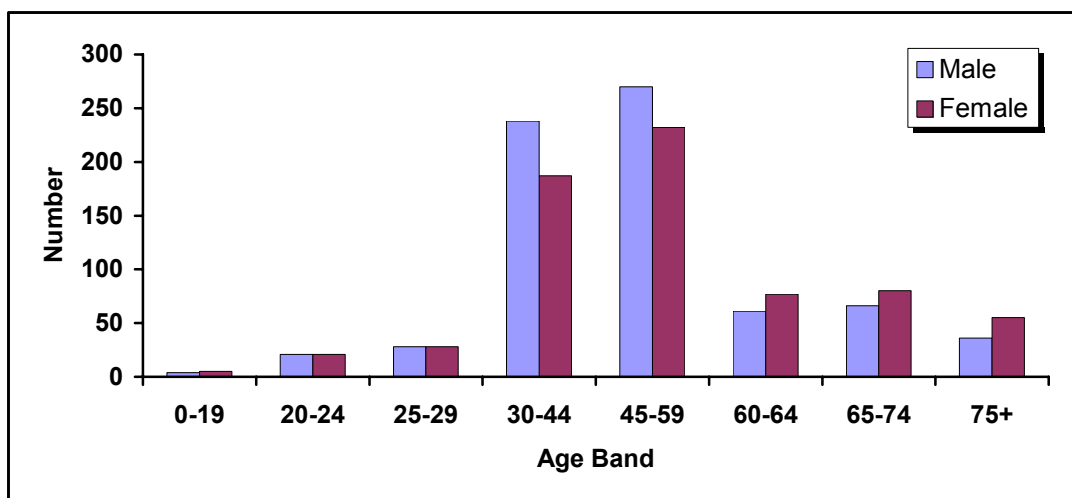
5.99 Figure 5.79 shows that the incidence of care was highest among employed females (18%). Among males, those who were economically inactive were more likely to provide unpaid care. Students were the least likely to look

after or support someone. There was no significant difference in the percentage of the adult population who were carers across the four HSSBs.

LEARNING DISABILITY

- 5.100 There is no register of people with a learning disability (LD) that covers all of Northern Ireland. As an alternative, the first study into the administrative prevalence of LD in Northern Ireland has been carried out (McConkey *et al.*, 2003) (primarily in order to inform the work of the Capitation Formula Review Group). This study undertook to identify the people who were recorded as having a 'learning disability' on existing databases commonly used in Northern Ireland. Two main sources of data were used for this study; information systems held by HSS Trusts in the period October 2002 to April 2003 (Soscare and Child Health System (Module V)) and Social Security data as at 11 November 2002. The overall prevalence rate of moderate, severe or profound LD based on Trust data was 9.69 persons per 1,000 and 4.41 per 1,000 using Social Security information.
- 5.101 The characteristics of three sub-populations were described; those living in long-stay hospitals; those in residential facilities and those living in community settings, mostly with family carers. According to McConkey *et al.* (2003) the various data sources available suggest that between 440 and 470 persons are likely to be living in long-stay hospital settings. Of the 390 persons with a hospital address on Soscare, 62% were male and 38% female. Females had a significantly higher mean age of 51.2 years compared with 47.0 for males.
- 5.102 Information on people living in residential accommodation was available from three data sources: Trust Soscare systems, Social Security data and data held in June 2003 on Trojan financial system (which records data for 10 of 11 Trusts). Of the 1,409 residents on Trojan, 51% were male and 49% female. Identical proportions were found for Soscare data. Figure 5.80 shows the number of people in residential accommodation as recorded on Trojan. Two thirds (66%) of people in residential accommodation were aged 30-59. Over one third (34%) of females in residential homes were aged 45-59 while among males the corresponding figure was 37%. In the older age bands, more females than males were in a residential facility.

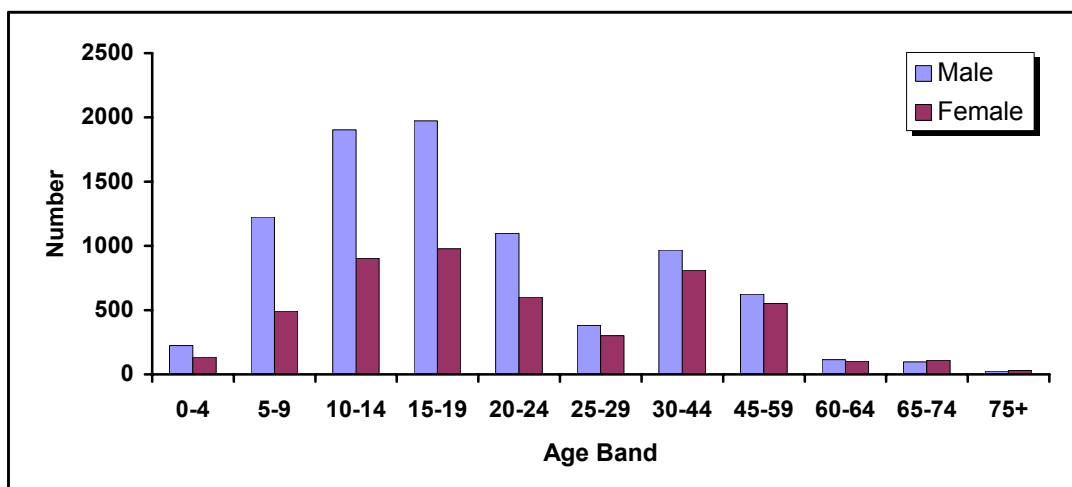
Figure 5.80 People with learning disability in residential accommodation by age and sex: June 2003



Source: McConkey *et al.*, 2003

5.103 A total of 14,273 persons, with ‘moderate, severe and profound disabilities’ resident in community settings, were identified from combining the data recorded on Soscare and Child Health System. Figure 5.81 shows the breakdown of this data by age and sex (for all 13,645 cases where this information was available). The majority (63%) of people resident in community settings were male. In all 57% of those in community settings were under 20 years of age. McConkey *et al.* (2003) reported that the small number of persons aged over 60 is a reflection of the early mortality that this client group experienced until recent years.

Figure 5.81 People with learning disability in community settings by age and sex: October 2002 – April 2003



Source: McConkey *et al.*, 2003