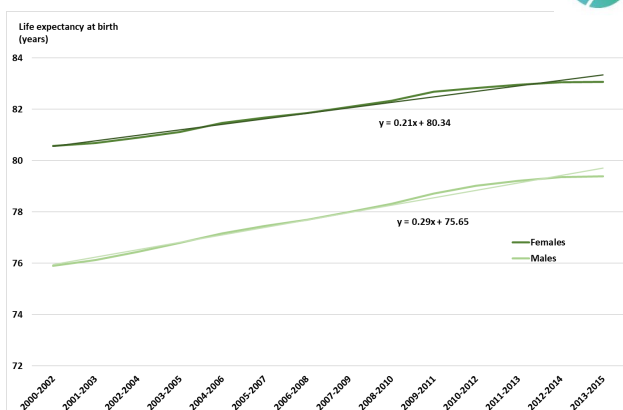




Squeezes on health services and rise in dementia deaths as life expectancy increases falter

Improvements in life expectancy at birth, which had been around a one-year increase every five years for women and every three and a half years for men, have slowed since 2010 to a one-year increase every 10 years for women and every six years for men.

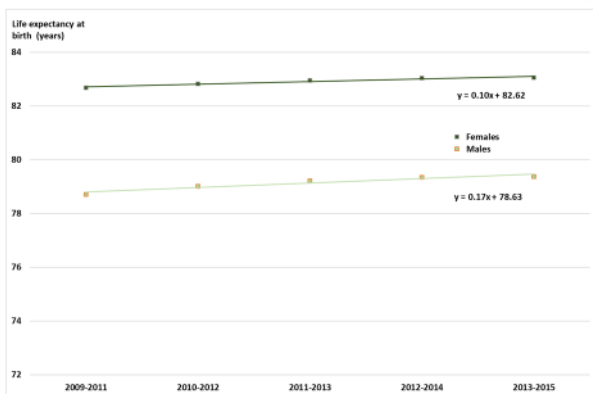
Life expectancy at birth, England, 2000-2015



Figures based on National Life tables using single years of age

Source: Office for National Statistics

Life expectancy at birth, England, 2009-2015



Figures based on National Life tables using single years of age

Source: Office for National Statistics

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Similarly increases in remaining life expectancy at age 65, which had been increasing at a rate of one year every six years for women and every five years for men, has slowed to a one year increase every 16 years for women and every nine years for men.

There are many potential explanations for this reduced level of improvement in this key indicator. However a key factor is the increasing role played by deaths at older ages. Three out of four deaths to women are at ages 75 and over, with two thirds of these occurring at ages 85 and over. For men, the respective figures are three out of five deaths are at ages 75 and over and half of these are at ages 85 and over.

There has been a sudden and sustained increase in numbers of people at these older ages. This is both as a result of improved survival to old age and because of demographic and health events in the 1920s and 30s (the post war baby boom in the early 1920s followed by sustained levels of births and greatly improved chances of surviving infancy and childhood). This has placed substantial pressures on all forms of social protection, such as health, social care, and pensions. At the same time there has been an increase in the recognition of age-related degenerative mental health conditions (particularly dementia). For example, the prime minister launched a national challenge to fight dementia in England in March 2012.

Similarly a scheme offered a £55 payment to GPs for each dementia diagnosis made between 30 September 2014 and the end of March 2015. Furthermore, ONS made changes to the coding of deaths due to dementia so that prior to 2010, in around half of deaths that mentioned dementia it was coded as the underlying cause. From 2014, this figure rose to 70 per cent.

However, dementia rates among those aged 85 and over had been rising since at least 2002, as a result of an increase in the rate at which dementia was certified as contributing to the cause of death by doctors.

As a consequence of all these changes the category “Dementia and Alzheimer’s” is the most common cause of death in women aged 80 and over (37,252 deaths) and in men aged 85 and over (12,258 deaths) i.e. at the most common ages at which people now die.

Leading causes of death by sex and age-group, England and Wales, 2015



Age	Males		Females	
	Cause	Deaths	Cause	Deaths
01-04	Congenital malformations etc	27	Congenital malformations etc	23
05-09	Congenital malformations etc	21	Malignant neoplasm of brain	13
10-14	Land transport accidents	15	Congenital malformations etc	12
15-19	Suicide and injury/poisoning of undetermined intent	135	Suicide and injury/poisoning of undetermined intent	51
20-24	Suicide and injury/poisoning of undetermined intent	271	Suicide and injury/poisoning of undetermined intent	68
25-29	Suicide and injury/poisoning of undetermined intent	291	Suicide and injury/poisoning of undetermined intent	93
30-34	Suicide and injury/poisoning of undetermined intent	343	Suicide and injury/poisoning of undetermined intent	98
35-39	Accidental poisoning	377	Malignant neoplasms of breast	146
40-44	Suicide and injury/poisoning of undetermined intent	427	Malignant neoplasms of breast	270
45-49	Ischaemic heart diseases	726	Malignant neoplasms of breast	478
50-54	Ischaemic heart diseases	1,271	Malignant neoplasms of breast	729
55-59	Ischaemic heart diseases	1,756	Malignant neoplasms of breast	741
65-69	Ischaemic heart diseases	3,628	Malignant neoplasm of trachea bronchus and lung	2,079
70-74	Ischaemic heart diseases	4,305	Malignant neoplasm of trachea bronchus and lung	2,310
75-79	Ischaemic heart diseases	5,473	Ischaemic heart diseases	2,742
80-84	Ischaemic heart diseases	6,332	Dementia and Alzheimer disease	6,588
85+	Dementia and Alzheimer disease	12,248	Dementia and Alzheimer disease	30,664

Source: Office for National Statistics

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Between 2002 and 2015, there was around 175% increase in dementia as contributing to the cause of death in women aged 85 and over and a 250% increase for men. While the largest contributor to this (particularly among women) was the increase in the rate of identifying dementia in the population, there were also substantial increases as a result of the larger population at older ages (and, separately, the combined effect of having a higher rate in a substantially increased population). Based on current ONS coding rules, the increases in deaths identified as being caused by dementia (i.e. underlying cause) were similar.

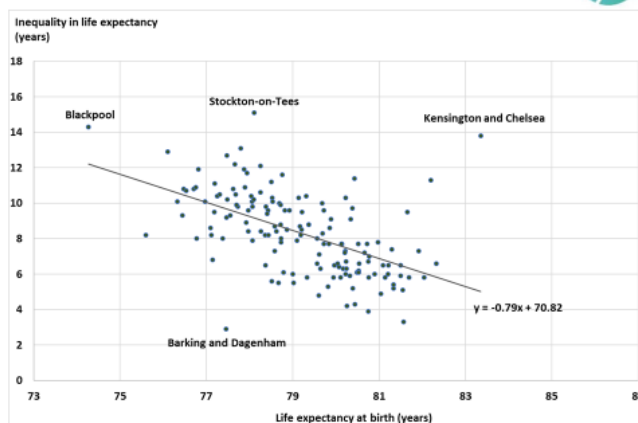
The implications for services of both a greater rate of dementia at death and a relatively rapid increase in the population at the most vulnerable ages is considerable. All social protection activities are placed under considerable strain. Although resources in health and social services have, in many areas, been maintained at previous levels (in contrast to cuts in other services), the pressures identified here suggest that “standing still” is not a sufficient response.

Inequalities within and between local authorities

Inequalities within and between local authorities have persisted. Life expectancy for men varied from 74 in Blackpool to 83 in Kensington and Chelsea – a nine-year gap. Among women it varied from 79 in Manchester to 86 in Kensington and Chelsea – a seven-year gap.

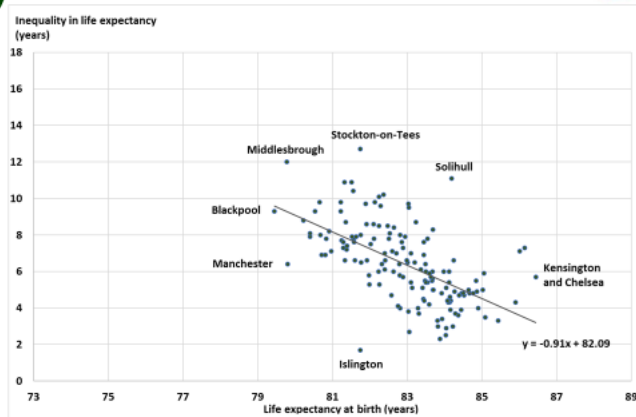
Within local authorities there was considerable variation in the inequality gradient in life expectancy between small areas based on level of deprivation. For men, in Barking and Dagenham these inequalities were equivalent to slightly less than a three year gap while in Blackpool, Stockton on Tees and Kensington and Chelsea the figures were in the region of 14 to 15 years.

Male life expectancy at birth and inequalities in life expectancy by local authority



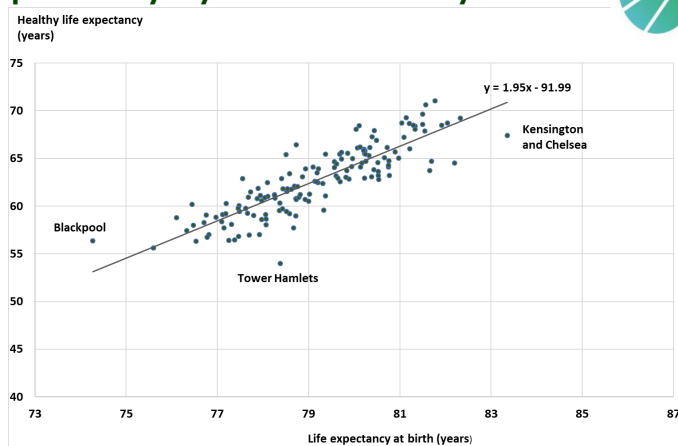
Similarly for women, the inequality gradient varied from less than two years in Islington to 12 years or more in Stockton on Tees and Middlesborough. Despite these notable exceptions, there was generally a strong relationship – the lower the level of life expectancy for the local authority, the steeper the inequality gradient within an authority.

Female life expectancy at birth and inequalities in life expectancy by local authority

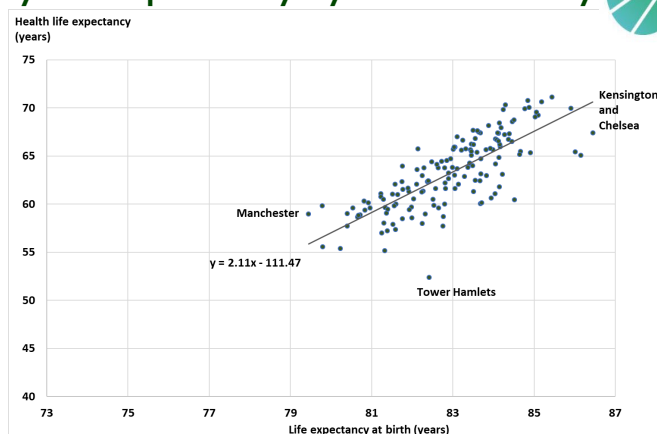


Healthy life expectancy for a local authority was similarly strongly related to life expectancy, with one principal exception. In Tower Hamlets, the gap between healthy life expectancy and life expectancy (i.e. years spent in ill-health) was considerably greater than that for other local authorities (30 years for females and 24 years for males).

Male life expectancy at birth and healthy life expectancy by local authority



Female life expectancy at birth and healthy life expectancy by local authority



Key Findings across the Social Determinants of Health

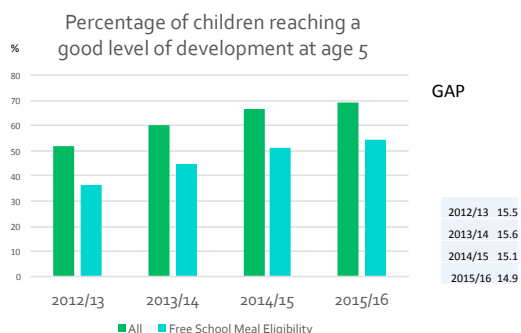
Early years development: impressive improvements and clear opportunities to reduce inequalities

Good early years development has profound and lasting impacts on prospects and health in later life. Latest figures on early child development at age 5 illustrate impressive improvement.

In 2012/13 only half of children reached a good level of development, and a third of children eligible for free school meals¹ reached a good level of development. In 2015/16, just under 70% reached a good level of development and over half of children on free school meals reached this level. The gap has reduced slightly but not significantly.

However we know that there are areas where children on free school meals are doing much better, over 67% of those on free school meals in Haringey, Lewisham, Bexley and Greenwich reached a good level of development in 2015/16, whereas less than 40% reached a good level of development in Stockton on Tees, Blackburn and Darwen and Leicestershire. Clearly there is much to be learned from areas doing well.

A. Give every child the best start in life



Good level of Development and eligible for FSM
 >67% Haringey, Lewisham, Bexley, Greenwich
 c. 4.0% Stockton on Tees, Blackburn and Darwen, and Leicestershire

GOOD

But room for improvement

GCSE attainment – stalled progress and clear opportunities to reduce inequality

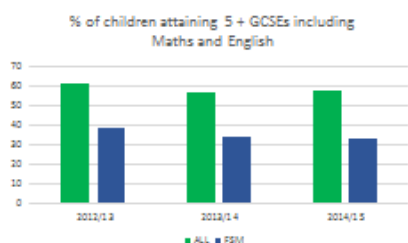
Inequalities can be reduced if we ensure that everyone makes the most of their capabilities. One aspect of this is to ensure that at school, inequalities in attainment are minimised.

There was little change in the percentages attaining five or more GCSE’s including English and Maths, or in the gap between all children and those eligible for free school meals between 2013/14 and 2014/15. Just under 60% of all children attained 5 or more GCSEs, and a third eligible for free school meals attained 5 or more GCSEs.

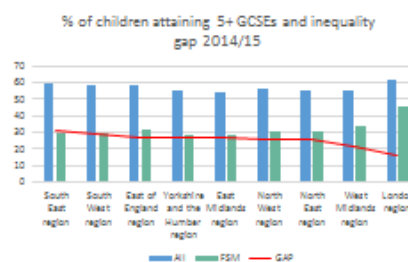
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives.

Percentage of children achieving 5 or more GCSEs*, all and children eligible for free school meals

* No GCSEs count as more than one, taken first time. New criteria for statistic introduced in 2014



Of concern



And room for improvement

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The indicators illustrate wide variation between children eligible for free school meals by region. As with early years development, the London region had significantly reduced the gap in attainment by 2014/15. If the success of children in London was replicated, 6% more children not on free school meals would get five or more GCSE's and 37% more children on free school meals would get five or more GCSE's. This would have a significant impact on inequalities.

The school funding formula should not punish London, as this could have a deleterious impact on their progress, but seek to enable other areas to have the same, obviously effective, level of resources for their children.

If the success of children eligible for free school meals in London is shared across the country...

MORE GET 5+ GCSEs IF COPY LONDON



Copying London formula to reduce inequalities

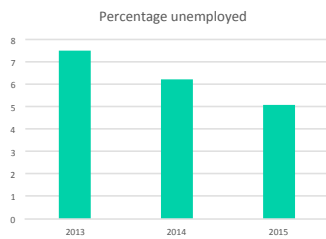
School funding per pupil has been frozen in cash terms between 2015–16 and 2019–20, resulting in a real-terms cut of 6.5%. London the largest loser. (IFS)

Work and income – IHE agrees with other commentators regarding the need to increase low pay.

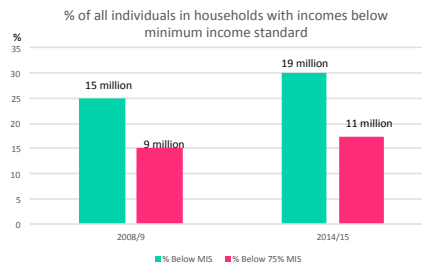
Despite reductions in unemployment, there have been significant increases in the numbers of people who do not have sufficient income to live an acceptable standard of living since the Marmot Review (see editors notes). This goes against our recommendations.

The Marmot indicators illustrate that across all regions the numbers not having enough money have increased. In London, the West Midlands, the North East, North West and Merseyside, and Yorkshire and Humberside, 3 out of 10 individuals live in households with insufficient income to meet a healthy standard of living.

C/D. Create fair employment and good work for all and a minimum income for healthy living



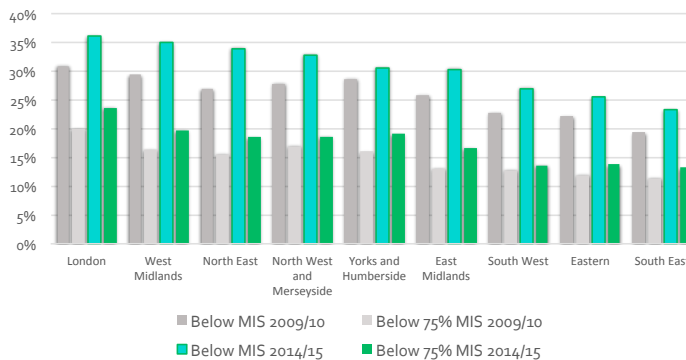
Good



But increases in numbers of people with insufficient income of concern

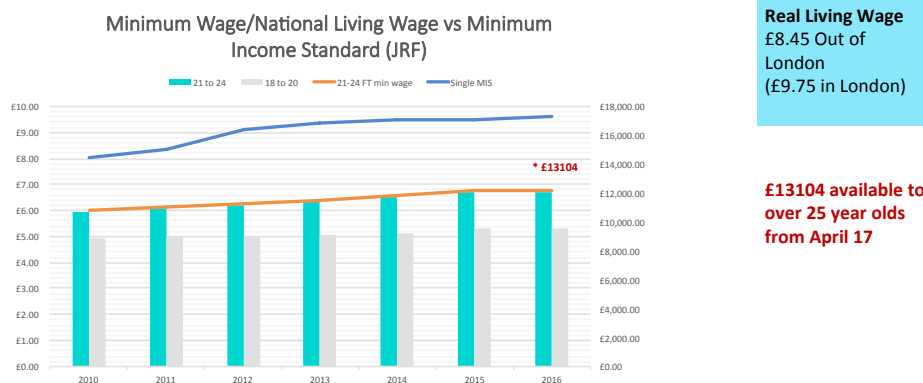
Having sufficient income is important for physical and mental health, children’s wellbeing and development, and to enable people to afford healthy lifestyles and be in the mind set to prioritise a healthy lifestyle.

**Minimum income for healthy living 2009/10 - 2014/15:
Numbers below minimum income standard**



Data from Joseph Rowntree Foundation

IHE present data to illustrate that the UK is falling behind other G20 countries, and that, as evidenced last week by the Joseph Rowntree Foundation, the new national living wage is insufficient for families and is in fact, leaving families with less income.



Real Living Wage
€8.45 Out of
London
(€9.75 in London)

**€13104 available to
over 25 year olds
from April 17**

National 'Living' Wage is insufficient and merely maintains same gradient as minimum wage.

Access and use of green space

There has been an increase in this measure with 18% reporting utilising green space for exercise/health reasons. The social gradient remains and more needs to be done to encourage those in more deprived areas to utilise green space.

Life satisfaction

Only around 4.5% of the population reported low life satisfaction in 2015/16, although these figures were higher in more deprived areas.

Notes to Editors

The Marmot Indicators

The Marmot indicators were set up following the publication of the government-commissioned review of health inequalities *Fair Society, Healthy Lives* (The Marmot Review) in 2010. The indicators track progress on the key policy recommendations made to reduce inequalities in social and environmental drivers and health.

The indicators are now regularly updated by Public Health England:

<https://fingertips.phe.org.uk/profile-group/marmot>

The UCL Institute of Health Equity periodically analyse the indicators to monitor progress and raise issues that are of concern. This press release and accompanying presentation highlight areas of interest and our reaction to the latest available data in 2017:

<https://www.gov.uk/government/publications/health-profile-for-england>

About the UCL Institute of Health Equity (IHE) www.instituteofhealthequity.org

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The IHE is a world leading independent think tank established in 2011 and led by Professor Sir Michael Marmot, who chaired the WHO's Commission on the Social Determinants of Health in 2008 and its 2013 European review of Social Determinants of Health and the Health Divide. Sir Michael also chaired Fair Society, Healthy Lives and is currently the chair of the WHO's Pan American Health Organization Commission on Equity and Inequalities in Health in the Americas.

The IHE works towards greater health equity through action on the social determinants of health (conditions in which people are born, grow, live, work and age), which are shaped by the distribution of money, power and resources at global, national and local levels. The Institute works to ensure up to date, high quality research evidence is used in the design and implementation of policies and practices by:

- Translating evidence into practice (through written and online materials)
- Identifying gaps in research and filling the gaps where possible
- Monitoring trends in health inequalities and social determinants of health at international, national and local levels
- Disseminating research evidence and best practice through our website and networks and facilitating knowledge exchange

ⁱ Based on the old eligibility criteria (we realise that everyone gets free school meals now) and so this is simply used as a measure of deprivation.