

Dimensions of Diversity

**Population differences and health
improvement opportunities**

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Scottish Public Health Observatory (ScotPHO) collaboration

The Public Health Observatory Division at NHS Health Scotland is part of this collaboration, led by ISD Scotland and NHS Health Scotland, that brings together key national organisations in public health intelligence in Scotland. We are working closely together to ensure that the public health community has easy access to clear and relevant information and statistics to support decision making. For further information, please see the ScotPHO website at www.scotpho.org.uk

Summary

Scotland has a long history of promoting fair treatment for all of its population. Yet it is impossible to say with any certainty how all the varied groups in its population are faring relative to one another. There are many statistics, but often they are incomplete, of uncertain robustness – with this uncertainty usually a marker of poor quality – and deployed selectively in advocacy and counter-advocacy. It is not easy to find up-to-date answers to basic questions in which one can have full confidence. *How many...? Who...? Where...?*

This report was written to give a concise overview, in a standard format, of basic information about a range of population groups in Scotland, linking users to further sources of information. Thirteen groups (listed in the Contents) were selected for inclusion: the six NHS Fair for All strands and seven other groups. The precise number was arbitrary – chosen from a longer list to be manageable within the resources available. We compiled existing statistical information, undertook some secondary analysis of extant data sources, and drew on academic and other literature. No original research was undertaken.

This report presents only a set of one-dimensional pictures of the selected population groups. Further work, by ourselves and others, needs to follow.

What did we find?

In terms of statistics, there is some information for all population groups, but, although much is robust, much is unsatisfactory, being based on broad estimates or out of date, or requiring generalisation to Scotland from the rest of the UK or beyond. Significant work is already under way in Scotland to improve data on equality. However, there is more that could be done with existing data were it to be analysed incisively.

Health problems are immensely varied and almost impossible to summarise. The very clear exception is mental health. Across most population groups, there is a repeated finding of diminished mental health because of the pervasive and insidious effects upon wellbeing of experiencing personal prejudice, collective discrimination and structural exclusion from full and fair participation in Scotland's material prosperity, social life and power structures. These effects may also contribute to poorer health-related behaviours.

Three specific health improvement opportunities can be recognised that are relevant to many groups.

- Scotland is still home to deeply rooted prejudice based on fear, perhaps even dislike, of difference. The more opportunities there are for people to mix, the more chance there is that prejudice will be worn down through the recognition of shared interests and the shared search for solutions, whether that be adequate housing, responsive health care or healthy choices in the local shop. Community health improvement initiatives using bottom-up community development approaches can contribute to this.
- Health services aspire to inclusion but can fall short in different ways for different population groups. It is difficult to design health improvement and healthcare services to be fully inclusive. Nonetheless, existing initiatives to ensure that NHS services and health improvement actions meet the needs of all parts of the population show the direction in which all services must travel.

- Only a few lucky individuals will not encounter mental and physical challenges in their lives. A systematic approach to building personal coping skills and resilience would not only equip the population to face the personal challenges that are part of life but also strengthen Scotland's ability to weather the global uncertainties of the twenty-first century.

The report will be used to inform the development of equalities resource web pages on the ScotPHO website in 2010.

1 Introduction

The data available on inequality are utterly inadequate in many ways, limiting people's ability to understand problems and their causes, set priorities and track progress. And even where data do exist, they are not consistently used well or published in a way that makes sense.¹

Scotland has a long history of promoting fair treatment for all of its population. This aspiration remains to be achieved. The uneven distribution of wealth, resources and power remains deeply embedded, although absolute poverty is rare. Likewise, a commitment to action on equity between, and equal respect for, the diverse groups that make up the Scottish population has seen progress made but with a long way to go to achieve the goal of a truly equitable society. Discriminatory attitudes are enduring: in 2006, 29% of adults thought there was sometimes good reason to be prejudiced, showing little change from 26% in 2002.²

Such is the received wisdom on population equity. In practice, it is impossible to say with any certainty how all the many different sections of the population are faring relative to one another. There are many statistics, but often they are incomplete, of uncertain robustness – with this uncertainty usually a marker of poor quality – and deployed selectively in advocacy and counter-advocacy.

It is not easy to find up-to-date answers to basic questions in which one can have full confidence. *How many...? Who...? Where...?* That was the starting point for this report: to provide a single resource that answered these basic questions for a range of population groups. We then built upon this aim to include information on significant health improvement challenges and opportunities for those drawing up policy, planning services or working with different groups.

We hope that the report will also be of value to the population groups themselves. They will know the statistics for their own areas of concern – and, indeed, have often contributed their advice to this report. But by highlighting recurring themes across diverse groups, this report can contribute to a better understanding of the common causes and outcomes of disadvantage, while also recognising the many different forms that disadvantage and prejudice can take.²

This report builds upon a range of work already undertaken on population diversity. The Scottish Government has undertaken several compilations and analyses of information on health inequalities across population groups in Scotland. These include the *High Level Summary of Equality Statistics*,³ published in 2006, the Health and Community Care Equalities Database⁴ and work carried out to support the Ministerial Task Force on Health Inequalities.⁵ In addition, much relevant work has been carried out by a variety of national and local organisations – public sector, academic and voluntary – and this is cited where appropriate in the report.

More recently, as this report was nearing completion, the Equality and Human Rights Commission produced a report on its proposed Equality Measurement Framework.⁶ In addition, work is being undertaken by both NHS Health Scotland and ISD Scotland, following recommendations from Equally Well,⁷ to assess and set targets for equalities data collection in NHS Scotland.⁸

Aim

To give a concise overview of basic information about a range of population groups in Scotland, linking users to further sources of information.

Objectives

For each group:

- to describe basic demographic information
- to identify some key health issues
- to suggest possible opportunities for health improvement
- to provide references to further sources of information.

And overall:

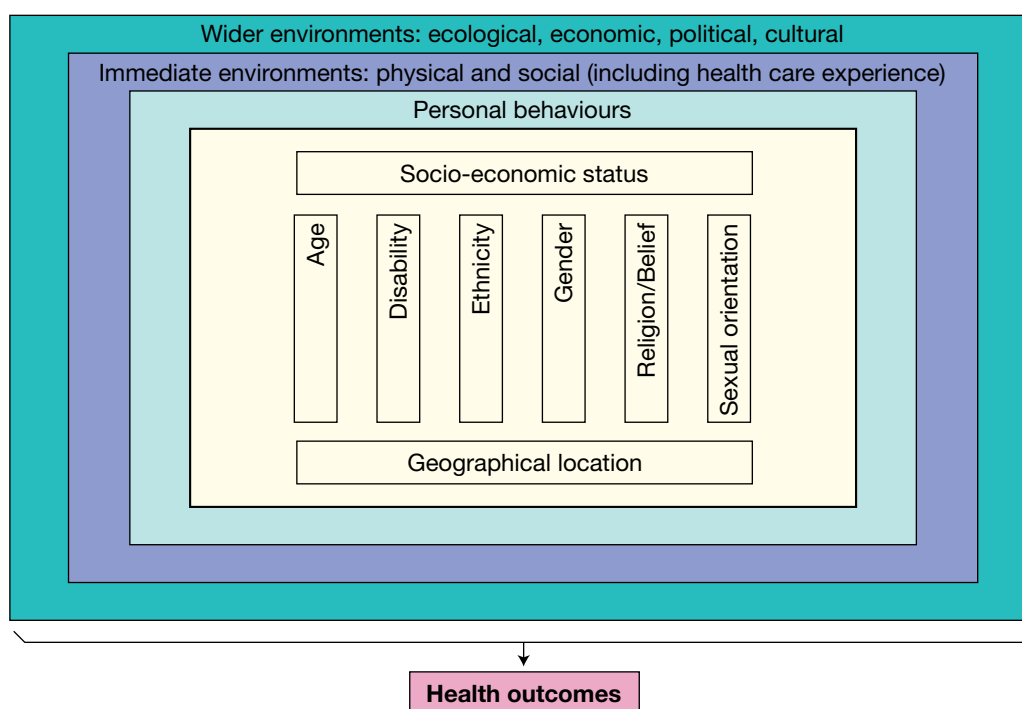
- to identify any common issues and opportunities that cut across groups
- to highlight gaps in information on diversity and health
- to provide a basis for equalities resource web pages on the ScotPHO website (to be developed in 2010).

The aim of this report might be thought to be too modest. Taking a group-by-group approach appears to deny the intersections between groups that often define disadvantage much more sharply than a single dimension.^{6,9} People are not one-dimensional, defined by a single characteristic. (Though, in some cases, discrimination based on one characteristic can be a dominant factor in shaping an individual's or group's whole experience of life.)

People are complicated. The ways in which we define ourselves are complex. Our physical characteristics, histories, influences, behaviours, cultures and sub-cultures are all exceptionally intricate narratives that we use to identify ourselves. We are all constantly defining and redefining different aspects of ourselves.⁹

All individuals are the sum of their personal characteristics (which vary on multiple dimensions, shown in faint yellow in [Figure 1.1](#)), the immediate social and physical environments that surround them, and the wider ecological, economic and political environments that in turn shape the immediate environment ([Figure 1.1](#)). Disadvantage in one respect may be offset by advantage in another, or compounded by further disadvantage. Personal financial resources can be a particularly powerful lever for reducing the impact of other disadvantages.

We fully acknowledge that this report presents only a set of one-dimensional pictures. All we have attempted is a *manageable* first step, setting out some basic facts. This is intended to be simple but not simplistic. It reflects the limited availability of cross-group work in general and in Scotland in particular. Further work, by ourselves and others, needs to follow this report.

Figure 1.1 **Personal characteristics in context**

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All web links were verified as working on 17 September 2009.

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2 Approach

The purpose of this report is to describe the diversity of the Scottish population in a short, standard format.

We identified 13 ways of dividing the whole population or identifying specific groups of concern according to significant characteristics. The starting point was the six NHS Fair for All strands.¹ Other strands were then identified through formal and informal consultation and whittled down to seven to provide a manageable number.

Some of the characteristics are analysed for the whole population: age, ethnicity, gender, language, religion and sexual orientation. Others are analysed mainly for specific sections of the population: asylum seekers and refugees, migrants, prisoners, carers, disability, literacy and poverty. These are not the only ways to divide the population and certainly not the only groups that might be of interest to health improvement. Nor are groups homogeneous. Disability, for example, is a high-level characteristic that encompasses a range of types and levels of impairment, long-term illness and health conditions.

We describe each strand, broken down into subgroups if appropriate, in a standard format:

- definition of the strand and any subgroups
- introduction to the strand and statistical issues
- population size
- age and sex composition
- distribution by deprivation status
- geographical and urban/rural distribution
- some health challenges
- health improvement opportunities
- conclusion
- references.

We use this framework consistently, even when data are sparse, in order to highlight gaps in current knowledge.

We have tried to be sensitive in our use of terminology to describe different strands and subgroups. However, this whole area can be emotive. For example, in the early consultation on this work, three respondents offered conflicting views on the strand under which to consider transgender people (see [Box](#)). We have had to take a pragmatic approach, while recognising that not everyone will agree with our decisions.

‘The LGBT strand should include transgender people.’

‘The gender strand should include transgender people as the gender legislation encompasses this group.’

‘Possible consideration of transgender identity as a strand on its own, but acknowledging the difficulty of whether transgender health inequalities are best described in terms of population statistics because of low absolute numbers of trans people and difficulty collecting central data...’

We sought data from a range of sources. Ideally, we have used Scottish data that are collected centrally, are regularly produced and are publicly accessible. In the absence of such data, we have provided the most robust figures that we could find for Scotland or, in the absence of data for Scotland, used data from elsewhere that are reasonably likely to be generalisable to Scotland. We have not undertaken any primary research. The value of this report comes not from its presentation of original data but from the presentation of existing data in one consistent framework across strands and sources.

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3.1 Age

Key points

- The population of Scotland is ageing.
- There are broadly similar numbers of men and women until old age, when women substantially outnumber men.
- Age variations by deprivation, rurality and local authority are mostly modest at a national level, though important locally. The most deprived quintile has a disproportionate number of very young children. Urban areas have higher proportions of teenagers/young adults. Remote and rural areas have higher proportions of older people.
- Many children experience an adverse start in life. In the transition to adulthood, unhealthy behaviours become embedded in identity-affirming lifestyles. By middle age the accumulated negative effects on health start to become apparent. In old age, ill-health is commonplace though many health behaviours of the current older generation are positive.
- Action to provide a good start to life needs to focus on the most disadvantaged without neglecting more widespread challenges such as excess calorie intake. Young adults do not value health: health actions need to appeal to values and aspirations other than 'health'. Motivation can increase in middle age as the prospect of ill-health limiting enjoyment of life becomes more real: imaginative engagement in behaviour change in health-promoting environments is key to capitalising on this. Perceptions of health in old age focus on healthcare needs: perceptions need to change to bring health improvement more strongly onto the agenda.

Definitions

Age is continuous between birth and death. There are biological milestones only at puberty and, for women, the menopause. There are, however, many ways in which society demarcates population groups by age. These include, for example, different stages of education, varying ages at which 'adult' activities are legally permittedⁱ and the state retirement age. Age is relative: 50 may be old in a population with low life expectancy. The experience of particular social roles or life stages can vary with age – for example, becoming a parent as a teenager or in one's 40s. Cultural context also affects how age is perceived and the expectations of roles and treatment appropriate at different ages. Biological age is a different concept relating to how fast the human organism decays – smokers age faster than non-smokers, for example. We consider only chronological age here.

ⁱ The Children (Scotland) Act 1995¹ defines a child as a person under the age of 18 years.

Introduction

We cover the whole age spectrum in this chapter, but highlighting four stages of the life course with different implications for health improvement.

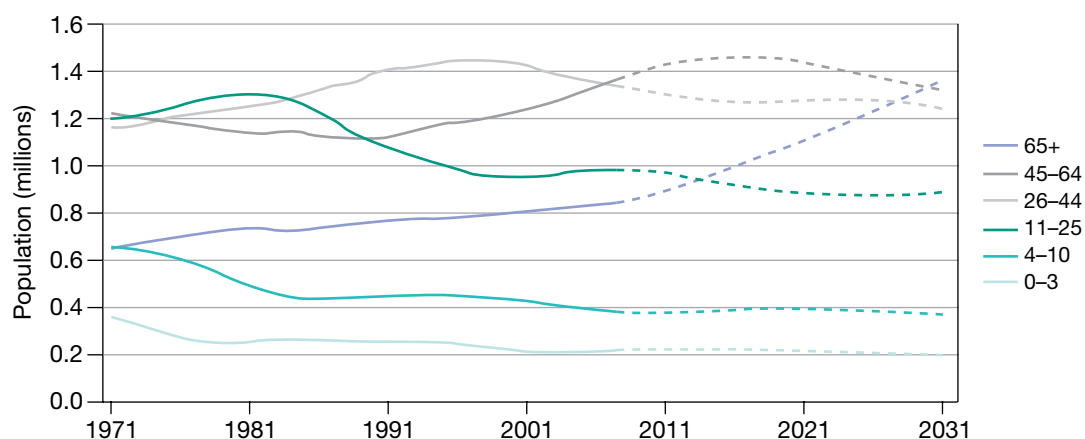
- The early years from conception to age 3 establish the foundations for later health.
- Age 10–24 covers the multiple transitions that mark the path to adulthood and the establishment of values and behaviours that will influence health throughout the rest of life.
- Middle age (45–64) marks the time when the accumulated harms of the previous decades of life start to make their impact on health felt, and thus is a time of increased interest in healthier behaviours.
- During older age, often defined as from age 65, but increasingly as from age 75, the focus is more on maintaining function and reducing the gap between life expectancy and healthy life expectancy.

The first two age groups are the groups in which society is investing to establish a healthier society in future years.² The last two age groups present different opportunities for health improvement, with the aim of maintaining health and deferring or slowing decline.

Population

The population of Scotland is ageing (Figure 3.1.1).^{3,4} To capture this in a nutshell, compare the population aged 4–10 and that aged 65 and over. They were almost the same size in 1971. By 2007, there were more than twice as many people aged 65 and over as there were aged 4–10. Notwithstanding recent gains from migration into Scotland of people of childbearing age, the overall trend of population ageing is expected to continue. The number of children aged under 16 is projected to decrease by 7%, and the number of people aged 65 and over is projected to rise by around 62% by 2031.⁵

Figure 3.1.1 Population and projected population by age group, Scotland, 1971–2031



Source: General Register Office for Scotland.

Age and sex

Slightly more males are born than females, but in most age groups the number of men and women is broadly similar (Table 3.1.1). The large difference comes after age 65, when there are many more women than men, reflecting their greater life expectancy.

In Scotland, 67% of men and 59% of women are of 'working age' – age 16 to pensionable age (currently 60 for women, 65 for men).

Table 3.1.1 Population of Scotland by sex and age group, 2007

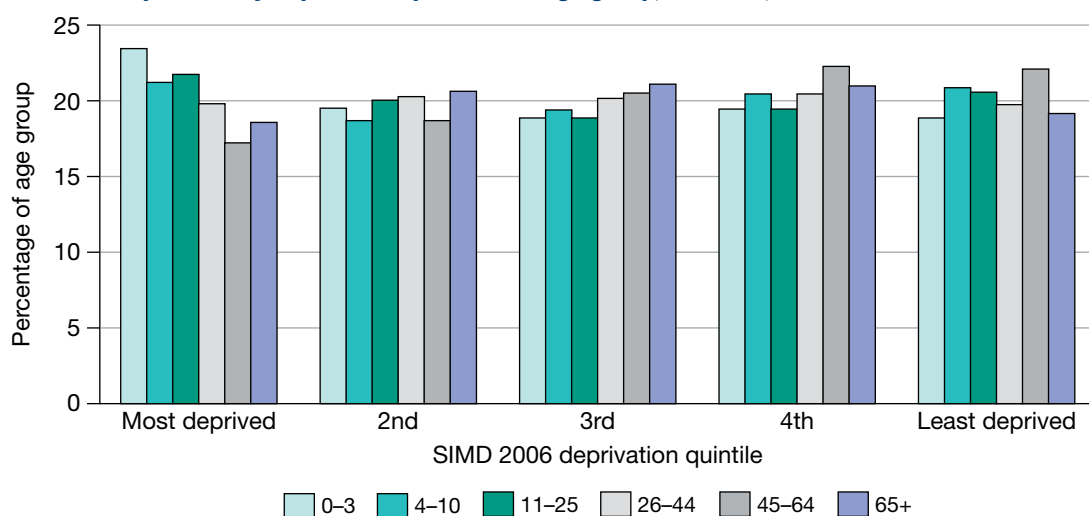
Age group (years)	Males		Females		Total N
	N	%	N	%	
0–3	114,137	51	108,108	49	222,245
4–10	197,356	51	188,353	49	385,709
11–25	502,577	51	483,753	49	986,330
26–44	653,972	49	689,505	51	1,343,477
45–64	663,383	49	697,443	51	1,360,826
65+	354,174	42	491,439	58	845,613
All ages	2,485,599	48	2,658,601	52	5,144,200

Source: General Register Office for Scotland.

Deprivation

People of all ages are found in areas of low and high deprivation (Figure 3.1.2). The most important variation is that very young children disproportionately live in the most deprived quintile of neighbourhoods.

Figure 3.1.2 Population by deprivation quintile and age group, Scotland, 2007



Source: General Register Office for Scotland and Scottish Neighbourhood Statistics.

Geography

In Scotland as a whole, there are 59 people under age 16 or over state pension age (currently 60 for women, 65 for men) for every 100 people of working age. The oldest populations are found in remote small towns and remote rural areas (Table 3.1.2). The youngest are in large urban areas, partly boosted by student migration from remote areas.⁶

Table 3.1.2 Population by urban–rural classification and age group, Scotland, 2007

Urban–rural classification	Age group (years)								All persons N	Number of people of non-working age per 100 working-age people
	0–3		11–25		45–64		65+			
	N	Row %	N	Row %	N	Row %	N	Row %		
Large urban areas	85,199	4	417,619	21	482,051	24	309,294	15	1,998,881	53
Other urban areas	70,664	5	296,215	19	414,243	27	254,476	16	1,555,063	61
Accessible small towns	20,116	4	84,018	18	128,666	28	78,648	17	461,318	64
Remote small towns	7,525	4	32,568	17	51,073	27	38,534	21	186,582	72
Accessible rural	26,339	4	103,700	17	180,049	30	99,043	16	608,170	63
Remote rural	12,402	4	52,210	16	104,744	31	65,618	20	334,186	70
Scotland	222,245	4	986,330	19	1,360,826	26	845,613	16	5,144,200	59

Source: General Register Office for Scotland.

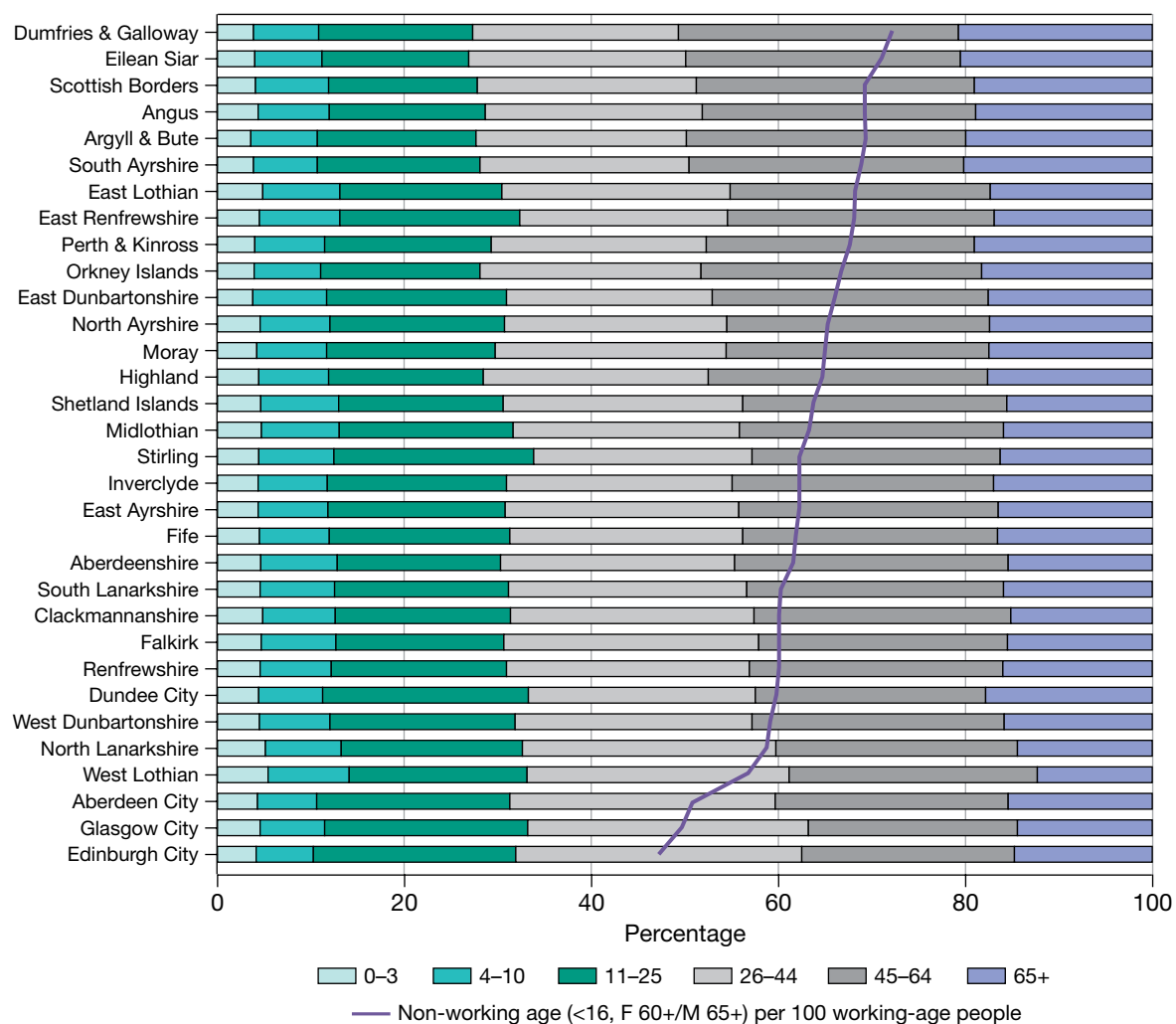
These patterns are seen again when the data are presented for local authorities (Figure 3.1.3). The cities attract young adults; older working-age adults are more common in commuter areas but also in many rural local authority areas; more rural and remote local authority areas also have higher proportions of older people. There are many local exceptions to these general patterns, reflecting local demographic history and current opportunities for study, work, family life and retirement.

West Lothian contains the highest percentage of young children (aged 0–3) in Scotland (5.2% compared with the Scottish average of 4.3%). The lowest percentage is found in Argyll and Bute (3.5%). Dumfries and Galloway has the highest percentage of people aged 65 and over (21%), whereas West Lothian (12.8%) has the lowest.

Some health challenges

The critical factors for health in the earliest years are the quality and context of parenting, and the quality of services that support it.⁷ Adverse exposures – such as smoking during pregnancy, brief or no breastfeeding, a sugar-rich and high-fat infant diet, chaotic home

Figure 3.1.3 Age distribution by defined age groups (bars) and working age–non-working age balance (purple line) by local authority, Scotland, 2007



Source: General Register Office for Scotland.

circumstances, parental stress – are amplified by cultural and environmental contexts that promote and perpetuate such exposures.^{8,9}

Substantial numbers of young people have mental health problems, consume a poor diet and undertake insufficient physical activity.¹⁰ Not surprisingly, an unhealthy weight is common.¹¹ Smoking has reduced among school-age children, but prevalence at age 16–24 does not match this downward trend.¹² Scotland has among the highest teenage pregnancy rates in Europe.¹³ Scots’ unhealthy relationship with alcohol starts young,¹⁴ and suicide, violence and drug-related deaths¹⁵ are part of a nexus of self-destructive behaviour. There are differing data and interpretations on whether mental wellbeing is deteriorating or improving.^{16,17} In a society centred on the acquisition of material possessions, having unequal access to (and skills to exploit) economic and socio-cultural opportunities gives young people from different backgrounds very different trajectories for the future.^{8,18}

Young bodies are resilient, but by age 45–64 the effects of accumulated harms to the body and mind from environment and behaviour – as well as biological inheritance and chance – are becoming evident. The effects of tobacco smoking on premature mortality, for example, are as large as those of class and gender.¹⁹ Deaths directly linked to particular behaviours

(e.g. alcohol misuse) increase in this age group, but most mortality and morbidity is from heart and circulatory disease and cancers which are more diffusely linked to multiple behaviours, including diet, physical activity, smoking and drinking.¹⁵

More people reach old age than ever before and older people are living longer. But many are living with long-standing illness or disability (54% of people aged 75+).²⁰ Older people are more likely to feel that their health-related quality of life is poor and more likely to report that poor health and pain affect their daily life.²¹ Poor oral health is common in old age.²² Many older people are well integrated into their communities and families, but a significant minority – around 1 in 40 – experience abuse, neglect or other mistreatment in a year.²³ Mental wellbeing tends to be better above retirement age,³ but around 1 in 25 of those aged 65+ are affected by depression at any point in time.²² Older people tend to have better health habits than younger adults – diets are less energy dense and fewer smoke or drink excessively – though physical activity levels are low.²⁴ Often, these characteristics reflect the cohort into which individuals were born. For example, as higher-drinking cohorts age, their drinking moderates but is still higher than it was for previous cohorts.²⁵

Health improvement opportunities

The *Early Years Framework*, sensibly, does not put a timescale on most of its actions.⁸ Tackling the challenge of poor parenting and of unpropitious environments through support for parenting, early intervention and improved services is a long-term task. This needs a focus on those in the most disadvantaged circumstances, but must also address challenges that face all social groups – reducing overconsumption of calories and promoting resilience and positive mental health.

Health is not a major concern for young adults. They ‘lack urgency... to take care of their own health’, health coming to the fore only when an illness develops.²⁶ Health-harming activities that provide short-term gratification are more appealing than a proactive approach to health. ‘Health’ has to be ‘sold’ to young people in different ways to the adult agenda of health,²⁷ for example by appealing to the desire to form relationships (‘Kiss a non-smoker – taste the difference’) or as a part of a lifestyle package around sporting activity.

Health is a more direct concern when the prospect of illness is more real. The Keep Well programme of health checks in middle age for secondary prevention (treating the precursors of disease to prevent or slow further progression) builds on this motivation. But individual behaviour takes place in a context. That context involves both other people’s behaviour and the physical environments in which behaviours are enacted. Changing behaviour is easier if one is not alone and if the environment favours the change.

Despite the fact that the largest single group of users of the NHS is older people,²⁸ from the 1942 Beveridge Report onwards the NHS has ‘explicitly prioritised the healthcare needs of younger people. Much of the resulting discrimination remains evident today...’.²⁹ It is notable that the Equalities Review concluded this, as have others,³⁰ even though the majority of health care expenditure is on older people. Health improvement prioritises youth and middle age for sound reasons. Investing in health at an earlier age yields more healthy life years than an equivalent investment in old age. However, this runs the risk of creating a false perception that older people cannot also benefit from health improvement. Healthy behaviours and healthy environments can be of benefit at any age, but older people may be considered only in the context of care services.³¹ If older people are not seen as partners

in health improvement, the gap between life expectancy and healthy life expectancy will continue to widen. We will add years to life but not life to years.²²

Conclusion

There is a wealth of information on age. Too often, however, age is not analysed as a characteristic in its own right but is regarded only as something to be standardised for in statistical comparisons of populations with different age structures. A life course approach focuses attention back on age (and generation) as a fundamental characteristic of individuals and of society.³² Age is one of the most ubiquitous measures in standard administrative and survey datasets and better analytical use should be made of it.

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3.2 Asylum seekers and refugees

Key points

- In 2007, there were 4,230 asylum seekers living in Scotland, 92% living in Glasgow City.
- Around half of asylum seekers in Glasgow are women and 80% are under the age of 40.
- Most asylum seekers in Scotland are housed in Glasgow in deprived areas.
- Asylum seekers suffer particularly from mental health problems on arrival. These are compounded by the pressures of asylum-seeking status, enforced inactivity and isolation from the mainstream of society. Language is an additional barrier to inclusion.
- There is little information on the health improvement needs of asylum seekers and refugees but there is compelling evidence from a variety of one-off research surveys that mental health improvement must be a priority.

Definitions

The 1951 United Nations Convention defines a refugee as a person who

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and unable to, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his formal habitual residence... is unable or, owing to such fear, is unwilling to return to it.¹

A refugee is a person who has been granted leave to stay in the UK under the Refugee Convention; an asylum seeker is someone whose application for protection to the UK Government is pending.

Introduction

When a person arrives in the UK and wishes protection under international law, he or she is required to apply for asylum as soon as possible at a port or an Asylum Screening Unit (in Croydon or Liverpool). A screening interview takes place in order to determine the asylum seeker's identity and nationality. The immigration officer then decides whether the applicant is given permission to enter the country to allow his or her application to be considered.

Applicants can apply for subsistence support (financial support only) or for a package of accommodation and financial support while their application for asylum is being dealt with.ⁱⁱ Those with accommodation support may be dispersed to one of a number of destinations across the UK. They have no choice as to destination. Glasgow is the only dispersal authority in Scotland. Asylum seekers applying for subsistence support only are assumed to be staying with friends or family. This can be in any part of the UK. One in four (24%) people making an asylum application in the UK in 2007 applied for subsistence support.¹

Asylum seekers receive accommodation and support in 'initial accommodation' for between two and three weeks. During this period they will receive briefings on the asylum process and be signposted and assisted with accessing a range of services including legal representation and health care. This is provided in Scotland by the YMCA and Scottish Refugee Council at the 'Scottish Induction Service' in the north of Glasgow. After the initial period, the applicant (and any dependants) will be 'dispersed' to housing across Glasgow and be provided with support, currently set at 70% of basic income support.² Accommodation is provided by Glasgow City Council, a private contractor (the Angel Group) and the YMCA.

An applicant may receive a 'positive' decision on his or her claim and be granted refugee status or another form of leave to remain (Humanitarian Protection or Discretionary Leave). He or she and any dependants can then access mainstream benefits and the labour market.

If the UK Border Agency refuses the initial claim for asylum, applicants will, in the majority of cases, have a right of appeal to the Asylum and Immigration Tribunal. They remain in the UK while an appeal is in progress. The only financial support available to an individual asylum seeker whose claim has been refused is 'Section 4' support.³ This is provided in the form of accommodation and £35 per week in vouchers. To be eligible, the asylum seeker must be destitute and be taking steps to leave the UK, unable to leave for logistical or health reasons, or have an outstanding judicial review on their claim or a fresh asylum claim.

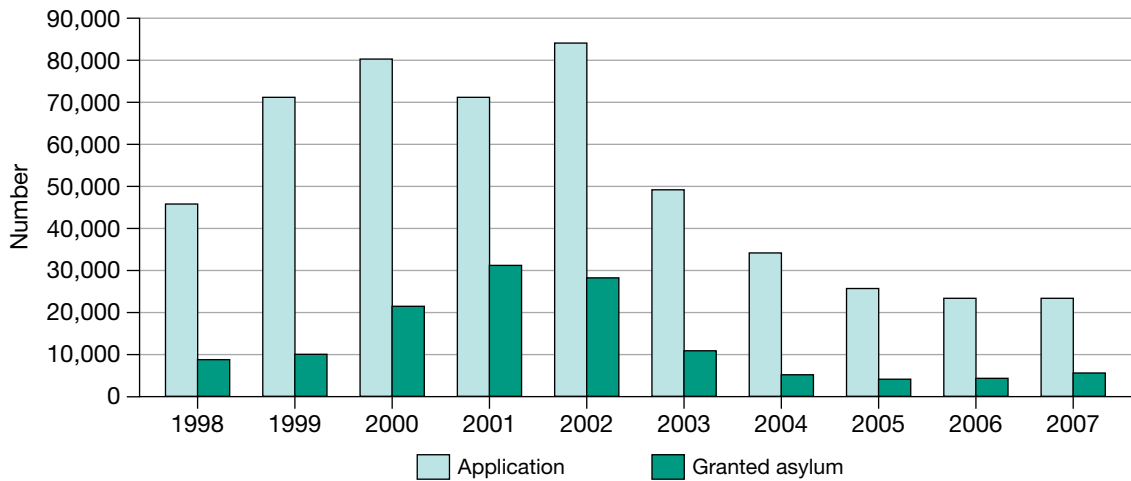
Once an asylum seeker is granted refugee status or other leave to remain, he or she becomes part of the general population and statistically almost invisible. This chapter therefore includes information mainly on asylum seekers because of the lack of information on refugees in Scotland.

Population

In 2007, 23,430 asylum applications were received in the UK, a reduction of more than 60,000 from 2002. An initial decision was made for 21,775 applications (these include applications from previous years), and 26% ($n=5,745$) of the asylum seekers were permitted to stay after being granted asylum, humanitarian protection or discretionary leave (Figure 3.2.1).¹

ii Asylum seekers are forbidden from entering the labour market. They may apply for the right to work if their case has not received an initial decision within 12 months. Most cases receive an initial decision within this time.

Figure 3.2.1 Applications received for asylum and asylum granted in the UK, 1998–2007

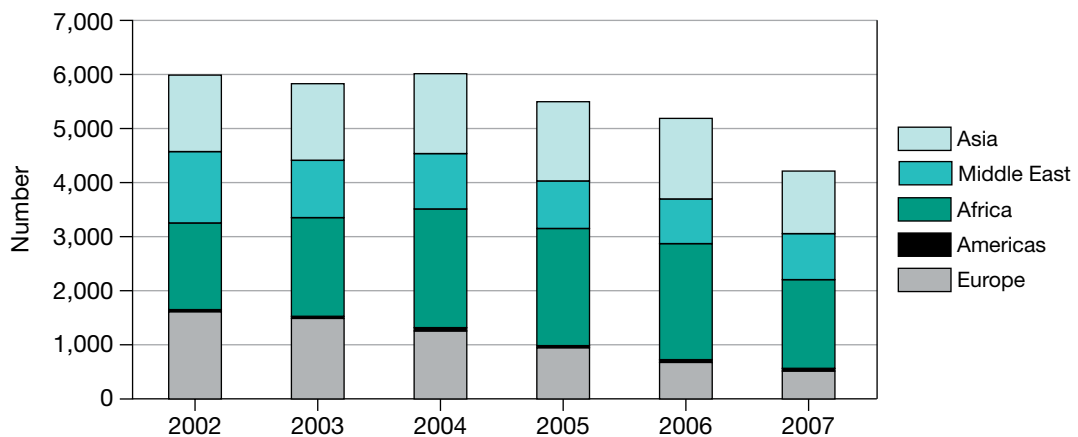


Source: Home Office Asylum Statistics United Kingdom 2007.¹

The Scottish Refugee Council broadly estimates that there are approximately 10,000 asylum seekers and refugees currently living in Scotland, mainly in Glasgow.⁴ In 2007, 4,230 asylum seekers were accommodated in Scotland. This was a 19% reduction from the previous year, continuing a downwards trend since 2004 (Figure 3.2.2). Glasgow City is among the top three dispersal towns in the UK, with 3,905 supported asylum seekers living in dispersed accommodation.¹

Asylum seekers in Scotland come from many different countries (Figure 3.2.2). The greatest number is from Africa. However, the largest single country of origin is Pakistan (12%), followed by Somalia (9%) and Iran (9%) (Table 3.2.1).

Figure 3.2.2 Number of supported asylum seekers (including dependants) in Scotland, by nationality group, at end of December, 2002–2007



Source: Home Office Asylum Statistics United Kingdom 2007.¹

Table 3.2.1 **Number of supported asylum seekers in Scotland by country/region of origin, as at end of December, 2007**

Region/country of origin	<i>N</i>	%
Africa	1,625	38
Somalia	360	9
Democratic Republic of Congo	260	6
Asia	1,145	27
Pakistan	515	12
Afghanistan	215	5
China	200	3
Middle East	845	20
Iran	365	9
Iraq	305	7
Europe	580	14
Turkey	230	5
Americas	15	0.4
Nationality not known	20	0.5
Grand total	4,230	100

Source: Home Office Asylum Statistics United Kingdom 2007.¹

Age and sex

In the UK, most (80%) principal applicants are under 35 years old, 16% are aged between 35 and 49, and only 4% are aged 50 or older. Most (70%) principal applicants are male.¹

Information on the age and sex of asylum seekers in Scotland is not publicly available. However, some limited demographic information is available on the asylum seeker population of Glasgow (Table 3.2.2). This suggests that the asylum seeker population in Glasgow has a more even gender balance than in the UK as a whole, but is similar in terms of being 'youthful'.

Table 3.2.2 **Age and sex breakdown of asylum seekers for Glasgow City, January 2008**

	<i>N</i>	%
Male	1031	51.9
Female	956	48.1
Age (years)		
18–19	76	3.8
29–29	740	37.3
30–39	761	38.3
40–49	287	14.5
50–59	79	4.0
60–69	34	1.7
70–79	8	0.4
80+	1	0.1
Total ^a	1987	100

^aAge missing for one case.

Source: Convention of Scottish Local Authorities, personal communication, February 2009.

Most asylum seekers are not accompanied by dependants. There were 4,870 dependants in the UK in 2007 – an average of one dependant for every five principal UK applicants. Over 80% of dependants of applicants were under 18 years old, with 36% aged from 0 to 5 years old.

Asylum seekers accommodated in Scotland are more likely than the UK average to be accompanied by dependants: 1,332 principal applicants were referred to the Scottish Induction Service in 2008 (511 female), with 577 accompanying dependants (G. Christie, Scottish Refugee Council, personal communication, February 2009).

Unaccompanied asylum-seeking children (UASC) are young people under the age of 18 who arrive in the UK without their parents or another person who has been customarily caring for them and claim asylum. These young people are accommodated and financially supported by local authorities. In 2007, 3,525 UASCs aged 17 or under applied for asylum in the UK, 2% more than in 2006 ($n=3,450$).¹

According to the Scottish Refugee Council, there are currently approximately 160 UASCs in Scotland, the majority of whom are living in Glasgow (G. Christie, Scottish Refugee Council, personal communication, July 2009).

Deprivation

The vast majority of asylum seekers in Scotland live in Glasgow, in communities where the proportion of people who are income deprived is higher than the Scotland average.⁵ The GoWell baseline study examined income sources among asylum seekers and refugees living in Glasgow. It found that their (2006) income profile was similar to that of white Scots in these areas: 67% of white Scots, 82% of asylum seekers and 66% of refugees were wholly dependent on state benefits or pensions.⁶ Poverty among asylum seekers (and their children) is linked to the prohibition on working. Poverty among refugees is linked to difficulty in gaining employment, which is affected by factors such as lack of information, language barriers and a lack of recognition of their qualifications.⁷

There are also extreme cases of deprivation. Research by the Scottish Refugee Council conducted in January–February 2006 found that 154 asylum seekers, including 25 children under the age of 18, were destitute in Glasgow.³ Almost half were destitute for more than six months: the main cause (77%) of destitution was refusal of asylum seeker status, though administrative error and delays in accessing support accounted for another 16% of cases.

Geography

The vast majority of the asylum seekers live in Glasgow in neighbourhoods such as Petershill, Sighthill, Carnwadric West, Roystonhill, Blochairn, Govanhill, Scotstoun, Cardonald and Pollokshaws.⁸ In Red Road, Sighthill and Shawbridge, between one-third and one-half of the resident population are asylum seekers, and a further one-tenth to one-fifth are refugees.⁶ The distribution of refugees across Scotland is unknown.

Some health challenges

Most asylum seekers are relatively physically healthy on arrival. However, some asylum seekers, usually older people, children and women, can arrive with some health problems associated with having travelled long distances.^{9,10} Some asylum seekers suffer from physical trauma but many more have mental health problems. A survey in 2003 which interviewed 63 asylum seekers living in Glasgow identified multiple mental health problems, including emotional problems (anxiety, fear, frustration, disappointment, anger, unhappiness), depression, past trauma, and uncertainty over the future, specifically their asylum claim.¹¹ Some individuals' experiences carry a high and enduring emotional impact, for example women who have been subjected to rape or sexual violence.¹² Findings from a pilot study in 2009 of 46 asylum-seeking women in Scotland revealed that 70% had experienced physical or sexual violence in their lifetime.¹³ Reports from professionals support this.¹⁴ Post-traumatic stress disorder appears to be common.¹³

However, mental health problems can develop once living in Scotland. In a sample of asylum seekers in Glasgow, 'worries, problems and the pressure of everyday life related to being an asylum seeker or refugee and the negative impact of the asylum process' were the main perceived causes of mental health problems.¹⁵ In a small-scale study of female asylum seekers in Glasgow, half reported that their health was worse in Scotland than it had been in their home country, with depression and anxiety and suicidal thoughts also more common among this group.¹³ The lack of meaningful occupation and social isolation added further pressure. The stigma of being an asylum seeker and racism and discrimination experienced compounded the problem further.

Achieving refugee status relieves some of the mental pressures, but 42% of a sample of refugees in Edinburgh had some form of depression and levels of anxiety and depression increased with length of stay in the country.¹⁶ Four in five of this sample had social contact only within refugee communities.

Asylum seekers and refugees can experience social exclusion and victimisation if they are seen as a threat to the existing population. A study carried out by the Institute for Public Policy Research in Scotland reported that 'Many people, particularly younger people and those from social classes C2DE [working class], feel that asylum seekers are a threat to jobs, and are concerned about their impact on public services, particularly housing'.¹⁷

Asylum seekers face the problem of difficulty in communication because of language barriers. These language problems contribute to social isolation, with some professionals reporting that '95% of... problems are language based'.¹⁸ Some cultural issues have been identified in the past regarding the provision of health care by male/female practitioners.² However, an inspection of services found that all asylum seeker children had registered with a GP and had a health assessment within 48 hours of arriving in Glasgow.¹⁹

There can be confusion around eligibility for free NHS treatment because government policy is different in Scotland. In England and Wales, changes in 2004 mean that asylum seekers whose claims have been refused are subject to NHS charging for secondary care services. In Scotland, the position remains that, for all practical purposes, refused asylum seekers who have previously been resident in Scotland and remain in Scotland will remain in the care of the NHS in Scotland until they leave the country.²⁰

Despite their adverse experiences and circumstances, asylum seekers are often more healthy than the Scottish average. A 2006 survey of Glasgow asylum seekers found that

they were less likely to smoke, more likely to consume five portions of fruit and vegetables a day and more physically active than the local population in their (generally extremely deprived) host communities.²¹ Alcohol consumption was less common among the asylum seeker population, and the level of alcohol consumed was generally lower than among non-asylum seekers.²¹ Self-reported health, across a variety of measures, was also better among the asylum seeker population, even after adjusting for age, sex and deprivation.²¹

Health improvement opportunities

It is unlikely that asylum seekers will be responsive to health improvement while basic health needs remain unaddressed, which could explain the limited information on health behaviours in asylum seeker surveys. Hence, the first requirement for health improvement is that there are good health care services to deal with the more immediate problems. Services need time to handle cases appropriately, including adequate support (e.g. translators) and access to specialist staff.²² Some local practices have employed extra staff specialised in asylum seekers (for example, Castlemilk Medical Centre has a GP specifically dealing with victims of torture).

Despite the lack of information on health behaviours and attitudes, there is a major challenge to improve the mental health of asylum seekers and refugees. Strategies are needed to counter the social isolation, loss of social and occupational roles, loss of control and self-esteem arising from operating in an alien environment, and loss of material resources that many asylum seekers experience.¹⁶

Conclusion

There is only a limited amount of information on asylum seekers and refugees. There are some administrative data on asylum seekers, but refugees become (statistically speaking) part of the general population and invisible. Much of the information on health comes from one-off studies drawing on local samples. These have primarily focused, understandably, on health care needs and access to services rather than the collection of basic health behaviour and values data, but there is compelling information on the scope for mental health improvement.

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All web links were verified as working on 17 September 2009.

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3.3 Carers

Key points

- In 2006, 2% of Scottish adults provided unpaid care to someone in the household and 10% provided care to someone living in another household.
- Two-thirds (69%) of unpaid carers looking after other household members provide 20 or more hours a week of care compared with only 11% of adults caring for persons living in other households.
- Women are more likely to care than men at all ages except for the youngest (16–24 years) and the oldest (75+ years) age groups
- People providing 20 or more hours of unpaid care a week are significantly more likely to live in deprived communities.
- Carers are distributed evenly geographically across Scotland. However, local authorities with higher levels of deprivation are more likely to have more carers providing 20 or more hours a week of care.
- The physical and mental health of those providing high levels of care is poorer than that of non-carers.
- Adults providing care for 20 or more hours a week and those looking after people living in the same household appear to be at higher risk of suffering health problems.
- Young carers, co-resident carers and those providing a high level of care report poorer health. Mental health is particularly affected by caring. Little is known about health behaviours.
- Discussion of carers' health focuses on service needs and provision with little consideration of wider health improvement possibilities. Attention needs to be paid to ways in which carers can maintain their mental health, for example by having time and space for a 'non-caring' life.
- The number of carers in Scotland is unclear because different approaches provide different estimates. An authoritative estimate is desirable.

Definitions

Unpaid caring is defined in the 2001 census as 'looking after, giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems relating to old age' excluding any care provided as part of any paid employment.

The Scottish Household Survey (SHoS) asks if each household member provides care to any other household member because of ill-health, disability or frailty, and asks a random

sample of one adult per household whether they provide 'any regular help or care for any sick, disabled or frail person' not living with them.

Introduction

The Community Care and Health (Scotland) Act 2002¹ highlighted the need for carers to be supported and recognised by both the NHS in Scotland and local authorities. As a result of this Act, unpaid carers have been formally recognised as partners in care provision.

This section mainly reports on people providing any level of care. But it also takes into consideration the level of care provided. The main information sources are the Scottish 2001 census² and the 2005/06 SHoS.³

Population

At the time of the 2001 census, 1 in 10 of the Scottish population (481,579) were unpaid carers. Although these figures are comprehensive, they are likely to underestimate the true extent of caring because some people might not self-identify as carers. Also, they relate to a single point in time and do not include people moving in and out of the caring role.⁴

More recent figures on adult carers come from the SHoS. In 2007, 12% of Scottish adults provided unpaid care: 2% (85,545 people) for one or more people in the same household and 10% (422,725) for people not living with them. This has remained steady since 1999 (Table 3.3.1). Simply summing the figures for the two types of carer gives a total of 507,270 adult carers in Scotland in 2007. Even allowing for carers under 16 (see next section), this is markedly lower than the generally quoted estimate for Scotland of 660,000.⁵ This higher figure came from an ad hoc Scottish Executive analysis of the SHoS published in 2003 which we have been unable to replicate.⁶ A more recent in-depth analysis of the SHoS quoted 13% of households as containing an adult carer and 'around one in eight adults' as being a carer.⁷ Applying these to the 2007 population gives a range from 528,000 to 550,000 carers aged 16 and over.

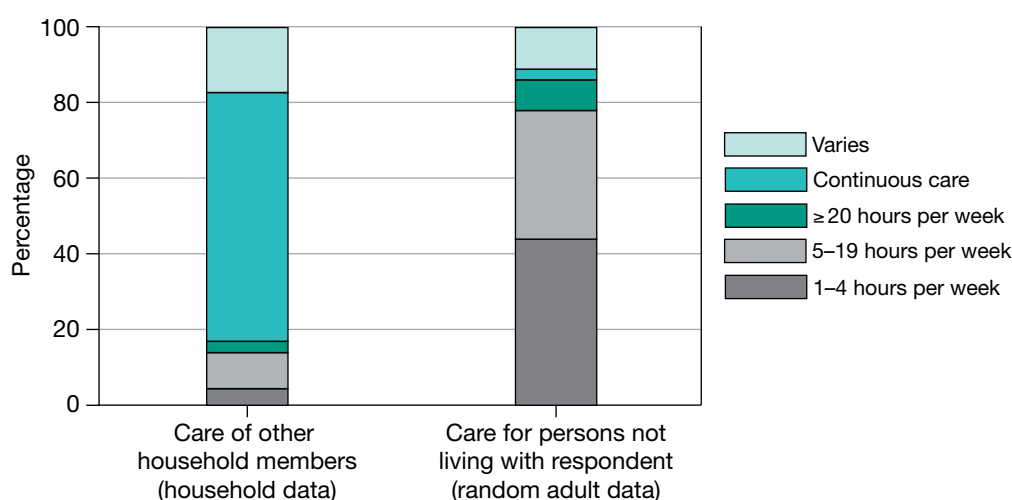
A key difficulty lies in the structure of the SHoS data on caring. The SHoS is administered in two parts. The highest-income householder (or his or her partner/spouse) is interviewed about him- or herself and all other members of the household. In addition, a randomly selected adult (aged 16+) member of the same household – who may, by chance, be the same person – is interviewed on other topics. Items related to caring are included in both parts of the survey. However, since the caring-related questions asked to householders and to random adults are different, combining them in order to estimate the total number of carers in Scotland gives rise to problems of overcounting and appropriate weighting of the different parts. We are unable to resolve these issues here. However, from a range of calculations we have undertaken, we conclude that the total number of carers in Scotland is likely to be below 600,000.

In 2005/06, two-thirds (69%) of unpaid carers looking after other household members provided 20 or more hours of care a week or continuous care. In contrast, nearly 8 out of 10 (78%) adults caring for people living in other households provided less than 20 hours a week of care, and just 11% provided 20 or more hours of unpaid care a week (Figure 3.3.1).

Table 3.3.1 **Caring status of Scottish adults aged 16+ as percentage, 1999 to 2007**

Adult population	1999	2000	2001	2002	2003	2004	2005	2006	2007
Is not a carer	88	88	87	88	89	88	88	88	88
Carer outwith home	10	10	10	10	9	10	10	10	10
Carer in the home	2	2	2	2	2	2	2	2	2
Both	0	0	1	0	0	0	0	0	0

Source: Scottish Household Survey, 1999 to 2007.

Figure 3.3.1 **Intensity of care provided by people caring for other household members and caring for persons not living with the respondent, Scotland, 2005–06 combined**

Source: Scottish Household Survey, 2005–06.

Age and sex

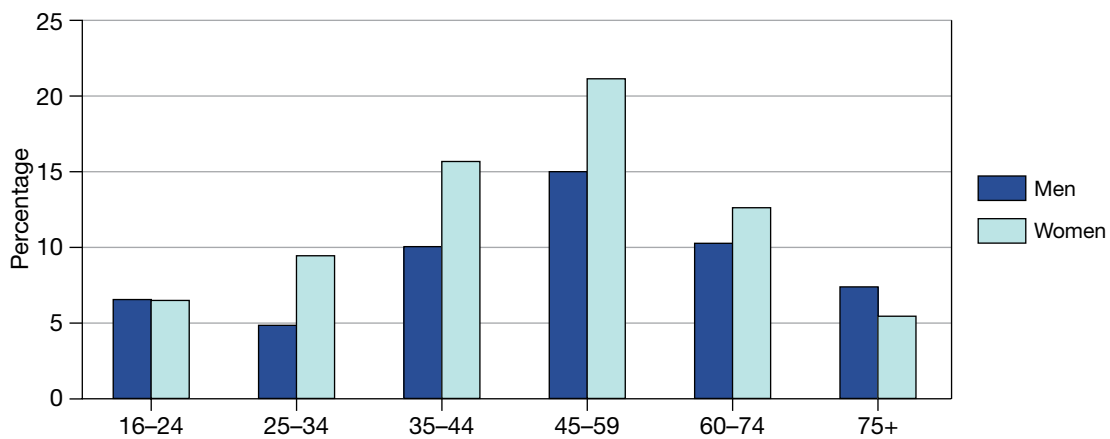
Women are more likely to care than men (13% and 10% respectively in SHoS 2005–06). This applies to all age groups except those aged 16–24 and 75+ (Figure 3.3.2).

The likelihood of providing unpaid care rises with age to a peak at age 45–59 and falls off thereafter. One-fifth (21%) of women and 15% of men in the 45–59 age group provided unpaid care in 2005/06 (Figure 3.3.2).

Patterns of caring vary with the condition/disability of the person being cared for. For example, sick or disabled children aged under 20 are mainly cared for by younger carers (83% aged less than 50) and women (91%), whereas carers of partner and spouse are typically older (60% aged 50 or older) and two-thirds are women.⁸

The 2001 census also reported that a small proportion of children (1.2% of those aged 0–15) provided unpaid care in 2001.⁹ This would be equivalent to 11,000 children in 2007. These figures are, however, likely to be an underestimate, because of a ‘culture of secrecy’ around the issue and lack of awareness of support services for young carers.¹⁰

Figure 3.3.2 **Provision of care by adults aged 16+ in Scotland, by sex and age, 2005–06 combined**

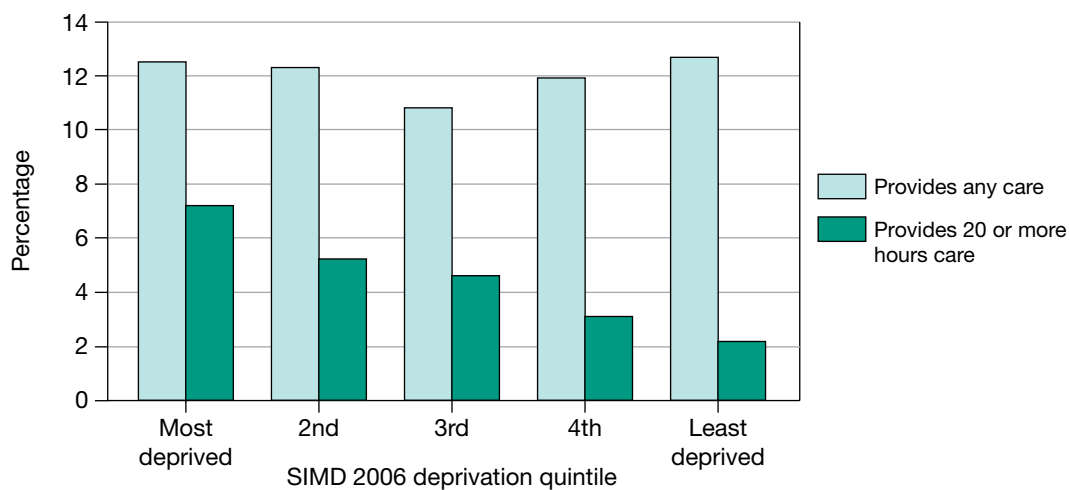


Source: Scottish Household Survey, 2005–06.

Deprivation

Provision of unpaid care is distributed fairly evenly across Scotland by deprivation quintile. However, people providing 20 or more hours of unpaid care a week are more likely to live in deprived communities. In 2005–06, 35% of carers in this position lived in the most deprived Scottish Index of Multiple Deprivation (SIMD) quintile compared with less than 10% in the least deprived quintile (Figure 3.3.3).

Figure 3.3.3 **Population of carers providing any unpaid care and providing 20 or more hours unpaid care a week by deprivation quintile, 2005–06 combined**



Source: Scottish Household Survey, 2005–06.

Geography

Carers are fairly evenly distributed geographically throughout Scotland as a proportion of the population. In 2001, the percentage of people providing any care varied from 11% in East Dunbartonshire to under 8% in Aberdeenshire.

The 2005–06 SHoS showed no major difference in the distribution of carers between urban and rural areas (both for all carers and for those providing 20 or more hours a week) (Table 3.3.2).

Table 3.3.2 **Carers as percentage of adult (16+) population by urban–rural classification, 2005–06 combined**

	Large urban areas	Other urban	Small accessible towns	Small remote towns	Accessible rural	Remote rural	Total
Carer outwith home	9	11	11	8	11	10	10
Carer in the home	2	2	1	2	2	2	2
Total	11	13	12	10	13	11	12

Source: Scottish Household Survey, 2005–06.

Some health challenges

The labour of caring is unevenly distributed in society. When that reflects positive choice, it is unproblematic. However, it often reflects the constraints of both circumstances and opportunities, which raises issues of fairness, particularly in relation to gender.¹¹ Caring disproportionately affects certain groups, for example parents with a child needing special care, children with a parent whose capacity is limited so that conventional caring roles are reversed, middle-aged people caring for older relatives and older people caring for ailing spouses. Caring is more commonly undertaken by women, and more intensive caring is relatively more common in more deprived areas. The caring role can be extremely long-lasting, but it can also be relatively short term. There is a high turnover of carers: each year over one-third of carers start caring within the year and a similar proportion stop.¹²

Carers come from all demographic groups. Nothing links them except the experience of caring, with its physical and emotional labour and the constraints it imposes on the carer's own life. Even these are not experienced in the same way by all carers. The experience of caring varies with the characteristics and circumstances of the person being cared for, the condition that makes care necessary and the characteristics and circumstances of the carer. The common element is the mental and/or physical labour of caring and the constraints that caring imposes on the carer's own life.⁴

In 2005/06, there was no significant difference between adults providing any unpaid care and the general population when reporting their health status in the last 12 months (87% and 86%, respectively, reported their health as good or fairly good). However, adults providing unpaid care in the home were *less* likely than those providing care outside the home to report that their health was good/fairly good (80% versus 89%).¹³ Carers in the same household, especially lone carers, are financially disadvantaged and have poorer health.⁷

The physical and mental health of those providing high levels of care is worse than that of non-carers. This is seen in higher reported rates of stress, anxiety, depression and sleeplessness.⁷ Adults with a heavy care burden (20+ hours a week) and those providing care for more than two years appear to be at higher risk of suffering health problems.^{12,14–16}

Carers in poor health were considerably more dissatisfied than other carers with the services available.⁸ Carers' frustrations in accessing services and the limited support they receive contribute to their poor health; and carers in poor health, whether in paid work or not, are more likely to be struggling financially than other carers.

Health and wellbeing issues for young carers are complex. Their physical health may be affected by tiredness and (in the case of those caring for adults with mobility impairments) health problems associated with lifting. Although young people report many positive aspects to their caring role, many young carers also suffer from stress, anxiety, low self-esteem and depression. Social isolation is also more common among young carers. The impact of caring responsibilities on their education is more ambiguous: some studies report that caring has a detrimental effect but others have found no impact.¹⁷

There is little information available on carers' health behaviours. In 2005/06, carers' smoking rates were no different to those of the general population (both 26%), but those caring within the home had higher smoking rates (30%).¹³

Health improvement opportunities

Involvement in caring and the experience of caring vary on several dimensions including gender and age. Most important is the nature and quality of the pre-existing relationship with the person being cared for. It is on this that the caring relationship is built – as a labour of love, an accepted responsibility, an unsought duty or a resented imposition. (Care of a child with ongoing care needs is a special case because there is no pre-existing relationship, but the spectrum of acceptance is similar.) We lack statistical data on the prevalence of these diverse relationships and the consequences for health, perhaps particularly for mental health.

High levels of care are more common in areas of higher levels of deprivation. The steady gradient across deprivation quintiles suggests that the distribution reflects disadvantage rather than choice, for example an inability to negotiate suitable care from public services or to purchase it from alternative providers.

Carers need recognition, practical support (including support directly to the dependent person) and the ability to maintain a 'non-caring' life for the benefit of both their immediate mental wellbeing and their future health. Primary care settings can play a crucial role in highlighting carers' rights and sources of support including, if necessary, referral to respite services.¹⁸ Such knowledge will allow them to cope better with the pressures of caring.¹⁹ Opportunities to enable childhood for child carers, to enable the more 'normal' aspects of parenthood and, in due course, 'separation', for parental carers, to relieve stress in health-enhancing ways for adult carers, and to maintain relationships for older carers will all contribute to improved mental wellbeing. These need to be delivered against a backdrop of adequate financial support and policies and services that are 'both flexible and comprehensive... to respond fully to carers' heterogeneous needs and changing circumstances'.¹²

Conclusion

The number of carers in Scotland is unclear because different approaches provide different estimates, even using the same survey data source. A reanalysis of the complex data in the Scottish Household Survey by the SHS team to establish a single robust figure is desirable. Aside from this uncertainty, there is a reasonable amount of data on carers, but there is little on the quality of relationships – the prior and evolving emotional context of caring – or on health-related behaviours and values. ‘Health’ is thus generally seen in narrow terms of service needs and provision without consideration of wider health improvement possibilities.

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3.4 Disability

Key points

- There are different definitions and perceptions of disability. The 'social model' is commonly accepted but basic statistics, such as those used here, are generally reported in terms of individuals' impairments. This implicitly promotes the individual (or medical) 'model'.
- One in five of the population of Scotland had a disability and/or a long-term illness in 2007.
- The most common types of disability vary depending on the data source and definition used. Physical disability, chronic illness, mental health problems and deafness have large numbers in most sources.
- Disability is slightly less common in men, but this varies by age group. Disability rates increase substantially with age.
- Disabled people are more likely to live in deprived areas: 27% of those living in the most deprived quintile reported a disability in 2005/06, compared with 10% in the least deprived quintile.
- In 2005/06, the prevalence of disability in the population varied from over 23% in Glasgow City and West Dunbartonshire to less than 12% in Aberdeenshire, East Renfrewshire and Stirling.
- Disability is slightly more common in urban areas.
- Disabled people have poorer health than average. Their disability may lead to other health problems being overlooked. Health behaviours are poorer than in the non-disabled population, though this varies depending on the disability. Employment is lower and income is lower. Some conditions attract particular stigma and discrimination.
- For a rounded view of disability, a mix of social and individual models is needed. Cultural change to place a higher value on diversity, improved employment levels, more accessible services and tackling adverse behaviours and other risk factors all have a part to play in improving health.
- Future improvement in data quality and use needs to focus less on individual impairment and more on function and environment.

Definitions

'Disability is no longer considered to be simply a reflection of an individual's impairment or functioning. The physical and social environment also plays a large part in acting as a barrier or facilitator in individual lives.'¹ However, almost all national measurement of disability is partial and collects information only on individual impairment and functioning and not on the social and physical environment. This is partly because it is easier (though questions can mix up functioning and illness^{2,3}), but also because a key consideration in framing questions is meeting statutory requirements under the Disability Discrimination Act (DDA) 1995 and subsequent amendments.

The DDA defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

For the purposes of the Act:

- Substantial means neither minor nor trivial.
- Long-term means that the effect of the impairment has lasted or is likely to last for at least 12 months (there are special rules covering recurring or fluctuating conditions).
- Normal day-to-day activities include things like eating, washing, walking and going shopping.
- A disability is considered to adversely affect normal day-to-day activities if it affects capacities such as mobility, manual dexterity, speech, hearing, seeing and memory.

Some conditions, such as drug misuse and hay fever, are specifically excluded from the definition. The DDA 2005 amended the definition of disability to include, from the time of diagnosis, people with HIV, cancer and multiple sclerosis.⁴

The DDA definition is extremely wide. A range of other definitions is in use, such as those on eligibility for various social security benefits.^{2,5,6} The focus, however, remains firmly on the individual. Most statistics identify disabled people rather than disabling environments.

Introduction

There are different definitions and perceptions of disability. The 'individual' or 'medical' model focuses on the person and their impairment, whereas 'social' definitions emphasise the restriction imposed upon the person by their social and physical environment.⁷ Around half those meeting the criteria for disability under the DDA do not describe or want to think of themselves in those terms, often because they associate 'disability' with someone in a wheelchair, completely dependent on others and housebound.⁸

The Disability Rights Commission recommended that data be disaggregated by impairment type.⁹ Data are just beginning to be collected in Scotland on this basis: physical impairment, sensory impairment, learning disability, mental health problem and long-term health condition.

A substantial range of data on disability is available, but different sources provide different results. Survey results on the prevalence of disability can vary two- to threefold depending on the questions used and how the responses are grouped.¹⁰ Some sources are seriously deficient: for example, the Register of Blind and Partially Sighted Persons reported 34,486 adults in 2007,¹¹ but research studies suggest that in Scotland only 15% of visually impaired people are on such registers.¹²

The information presented here is mostly sourced from analyses of the Scottish Household Survey (SHoS). In this survey, disability data are based on a subjective, self-perceived measure aligned to the 'individual model' (*Do you have any longstanding illness or disability...?*). This includes long-term health conditions as well as disabilities. Only around half of people with a long-term condition have a disability.¹³ For example, 60% of children and 36% of adults reporting a long-standing illness in the Scottish Health Survey 2003 did not report being limited in their day-to-day activities.¹⁴

Data are also available from a variety of administrative sources. Practice Team Information provides data on consultations for a sample of general practices. Benefits data include information of the numbers of people receiving Disability Living Allowance (paid to children and adults under the age of 65 who need help with personal care or have walking difficulties because they are physically or mentally disabled) or Attendance Allowance (for people aged 65 or over who need help with personal care because they are physically or mentally disabled).¹⁵ Service-based administrative statistics can count only those in contact with services.

Population

In 2007, nearly one in five people in households in Scotland (18.5%, 952,500) had a long-standing illness, health problem or disability: 447,400 men and 505,100 women.ⁱⁱⁱ The 2001 census gave similar numbers: 19.6% of the population (978,376 people) reported a limiting long-term illness. The difference between the two sources reflects the inclusion of people living in care homes and other long-stay establishments (who are more likely to have disabilities or long-term health problems) in the census.^{iv}

Types of disability

Different sources of information will yield different estimates of the numbers affected by particular disabilities in Scotland. Figures will differ if not for the same age group. They will differ if for main or all conditions: nearly 60% of disabled people report more than two impairments.^{2,16}

Table 3.4.1 shows the wide divergence between statistics drawn from different sources. The list of disabilities is that being developed across government surveys.¹⁷ Only the GP Access Survey has reported in this format. We have grouped results from other sources to this newer format, which might account for some of the variation, as might differences in the age distribution of the samples (see note to table).

ⁱⁱⁱ Proportion of males and females (all ages) taken from SHoS 2007. Absolute numbers derived by applying proportions to 2007 total mid-year population estimates (from General Register Office for Scotland) for men and women separately.

^{iv} The 2001 census recorded 36,627 people living in nursing homes or residential care homes in Scotland.

Table 3.4.1 **Variant estimates of Scottish population with disability or chronic illness, self-report (age 16+) and administrative data (all ages), c. 2007**

	Aged 16+		All ages	
	GP Access Survey	SHoS	Benefits	PTI
Deafness	310,130	93,777	3,370	n/a
Blindness or severe vision impairment	82,981	75,820	11,970	n/a
Physical disability ^a	798,409	544,706	168,880	416,767
Learning disability (e.g. Down's syndrome)	22,455	19,953	26,890	n/a
Learning difficulty (e.g. dyslexia)	47,573	6,983	n/a	n/a
Mental health problem (e.g. depression or schizophrenia)	327,962	109,739	73,890	441,734
A chronic illness ^b	621,262	593,590	118,460	1,333,899
Other	765,387	137,673	78,120	68,373
Total persons	2,261,563	997,631	481,580	n/a

^aA condition that substantially limits one or more basic physical activities such as walking, climbing stairs, lifting or carrying.

^bSuch as cancer, HIV, diabetes, heart disease or epilepsy.

Sources:

GP Access Survey conducted October–November 2008 (www.scotland.gov.uk/publications/2009/06/30083150/5) – self-reported, all conditions.

SHoS: Scottish Household Survey 2005–06 – self-reported, all conditions.

PTI: ISD Scotland Practice Team Information, patients consulting at least once with GP or nurse in 2007/08, all conditions.

Benefits: people claiming Disability Living Allowance/Attendance Allowance, Q2 2007, main condition.

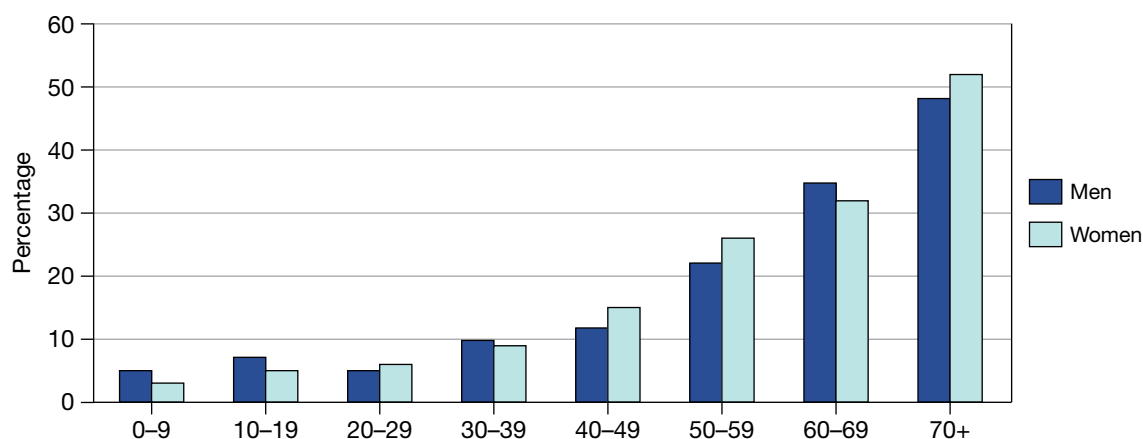
All survey results were scaled to the Scottish adult (age 16+) or total population using General Register Office for Scotland population estimates for 2007 with no age/sex weighting.

Age and sex

There are more disabled women than men (19% compared with 18%), but this varies by age group (Figure 3.4.1). The prevalence of disability increases steadily with age for both genders.

The major types of disabilities experienced vary by age.¹⁸ Some of the variation reflects life expectancy – many people with learning disability or multiple sclerosis do not survive to age 65. Some reflects the operation of service/benefits eligibility criteria.

Figure 3.4.1 **Percentage of the population with a disability, by age and sex, Scotland, 2007**

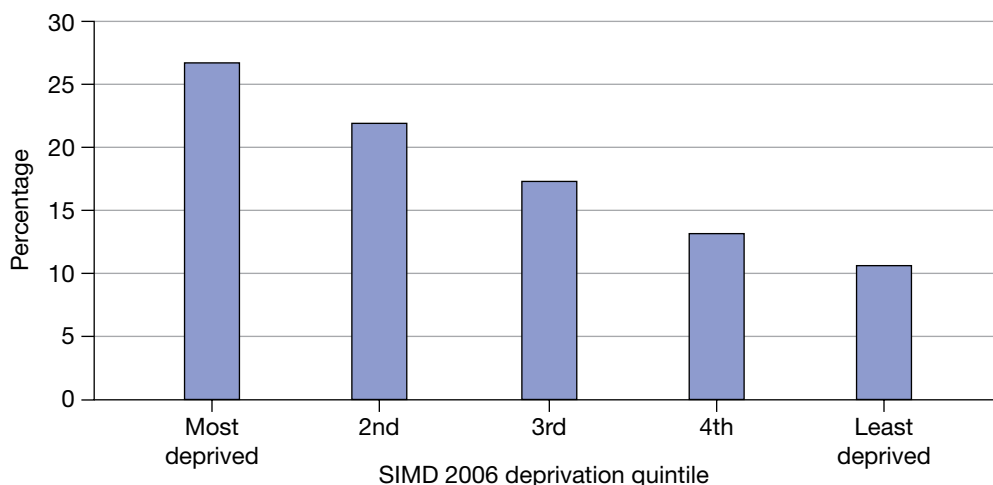


Source: Scottish Household Survey 2007.

Deprivation

Disabled people are more likely to live in deprived areas, as measured by the Scottish Index of Multiple Deprivation (SIMD). In the most deprived quintile, 27% of people in households reported a disability/health problem, compared with just over 10% in the least deprived quintile (Figure 3.4.2). After housing costs, nearly a quarter of people living in a disabled household were in poverty in 2007/08, compared with 17% of those living in non-disabled households.¹⁹

Figure 3.4.2 **Percentage of the population with a disability by deprivation quintile, Scotland, 2005–06**



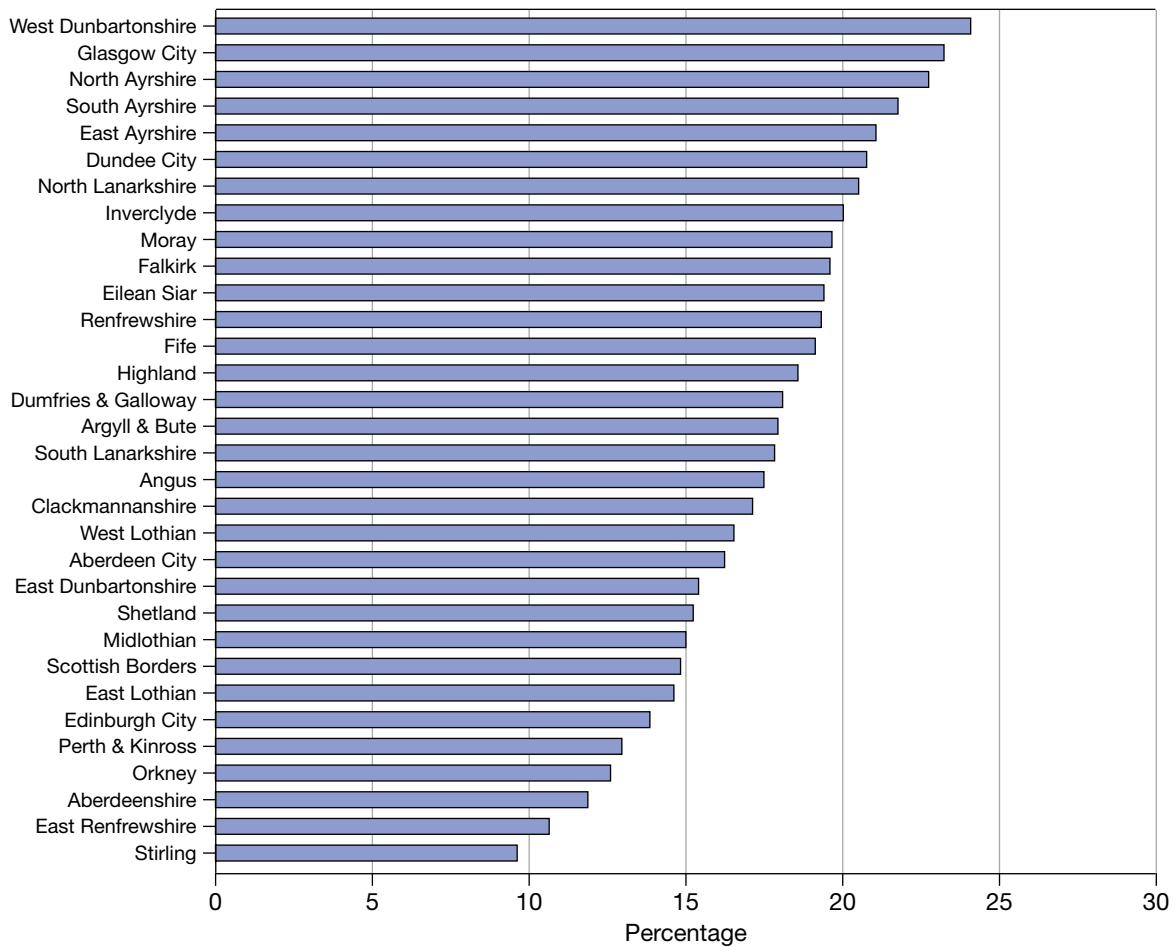
Source: Scottish Household Survey 2005–06.

Geography

Disability is more common in some parts of Scotland. The percentage of people with a long-term disability, illness or health problem varies from over 23% in Glasgow City and West Dunbartonshire to under 12% in Aberdeenshire, East Renfrewshire and Stirling (Figure 3.4.3).

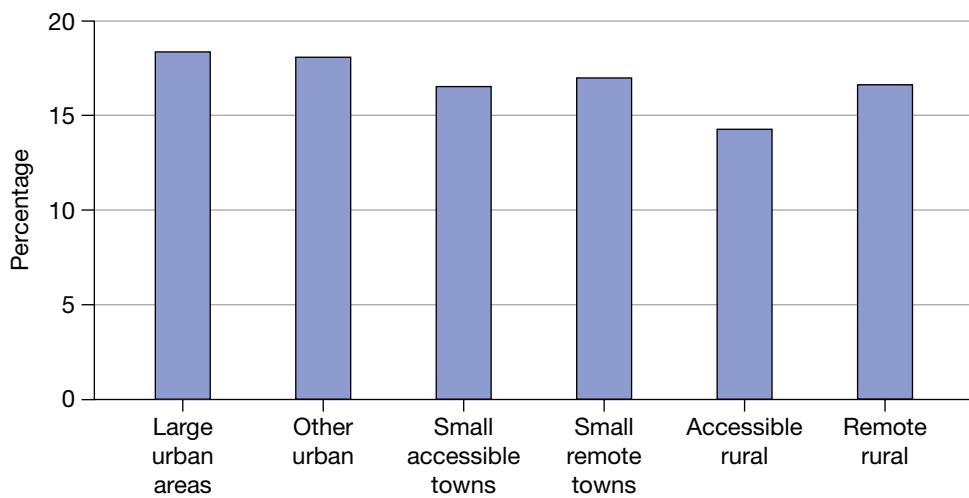
Disabled people are slightly less likely to live in accessible rural areas. In 2005/06, 14% of those living in accessible rural areas reported a disability, illness or health problem, compared with 17–18% in other types of area (Figure 3.4.4).

Figure 3.4.3 **Percentage of the population with a disability by local authority, Scotland, 2005–06**



Source: Scottish Household Survey 2005–06.

Figure 3.4.4 **Percentage of the population with a disability by urban–rural classification, Scotland, 2005–06**



Source: Scottish Household Survey 2005–06.

Some health challenges

More than half (51%) of disabled people rated their health over the past 12 months as 'not good' compared with 9% of non-disabled people.²⁰ There appears to be a greater upwards trend in the prevalence of disability than would be expected solely because of population ageing.²¹ How much of this rise is real and what its drivers are is unclear.⁵

The mixing of function and health conditions in many of the data on 'disability' can obscure both the nature of disability and the health of disabled people. Disabled people can have other health problems; some of these can be associated with their disability, whereas others may be unconnected. If disabled people are seen primarily as their disability, then other health problems can go unheeded. For example, people with serious mental health problems have an increased risk of coronary heart disease (CHD) and stroke before age 55.²² People with learning disabilities are at higher risk of respiratory illness and obesity.²³ However, both groups are less likely to receive standard tests and treatments, such as spirometry or statins.²⁴ Cervical and breast cancer screening rates are very low among people with learning disability.²⁵

People with a physical disability may have poorer mental health than the general population. In 2007, one-quarter of people aged 16–74 in Scotland with a long-standing illness, disability or infirmity had symptoms of mental distress compared with 19% in the general population.²⁶ Again, mental health problems can be overlooked by a focus on the most obvious disability, or thought of as 'problematic behaviour' (e.g. as a 'deaf personality' or as a 'difficult' person with a learning disability).^{27,28} The experience of people with physical disabilities who also experience mental health problems is of services being unable to recognise or accommodate these dual issues.²⁹

Adults with a disability or long-term health condition are more likely to be smokers, and heavier smokers, physically inactive and obese.¹³ Nutrition can also be an issue, with disability associated with both malnutrition³⁰ and obesity.³¹ Although the Scottish Health Survey found that disabled adults were less likely to eat five or more portions of fruit and vegetables a day than those without a disability (18% compared with 23%),¹⁴ disabled people are so diverse on other characteristics that affect diet – such as age, sex and socio-economic status – that it is not meaningful to generalise.

Disabled people are more than twice as likely to be living in poverty than non-disabled people.² Nearly two-thirds (63%) of Scottish households with a disabled person had a total income in 2005/06 not exceeding £15,000, compared with 36% of households with no disabled person.¹³

Economic activity rates are low for disabled people. In 2007, 44% of disabled people of working age were in employment in Scotland, compared with 80% of non-disabled people.³² Although unemployment rates are very similar among the disabled and non-disabled working-age population (c. 4%), disabled people are much more likely to report that they want a job but are not currently looking or available to start: 16% compared with 4%. More than one-third (37%) of disabled people of working age lack even this tenuous link to the labour market, compared with only 13% of non-disabled people who are not economically active and express no wish to be.

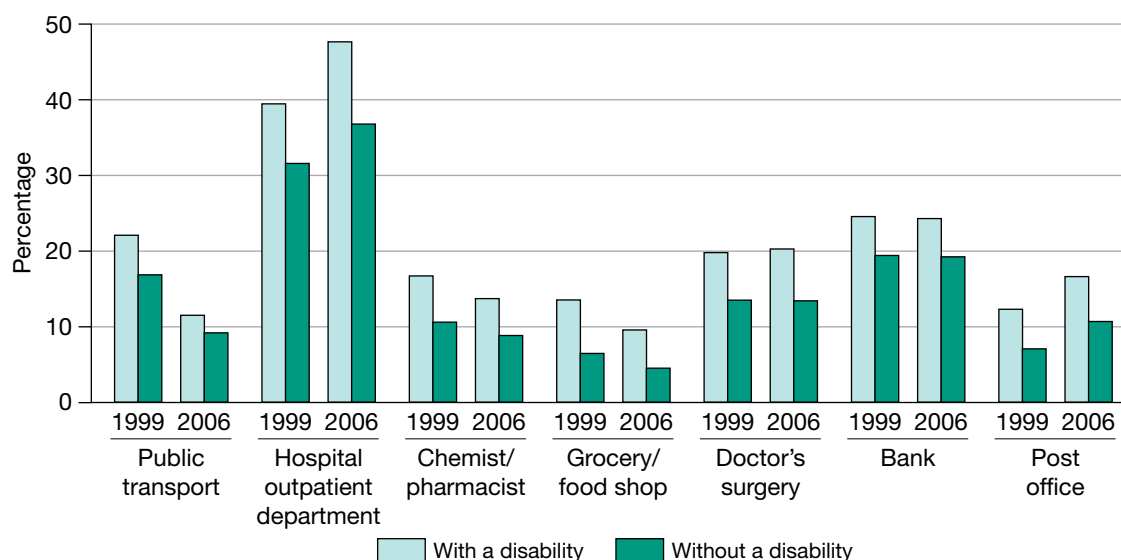
Participation in the labour market varies markedly by type of disability or health problem, with those with mental health problems having particularly low employment rates.³³ Employment also varies by social class: disabled people from lower social classes are

less likely to be in employment than people of higher social class, and this gap has grown – as has the employment gap between disabled and non-disabled people – since the introduction of the DDA.³⁴

People with some conditions, particularly but not exclusively mental health problems and learning disability, experience even greater disadvantage through stigma, discrimination and victimisation.³⁵

Physical accessibility of core public services shows no overall improvement in recent years (Figure 3.4.5). In part, this is about transport, but accessibility of public transport has improved whereas accessibility of GP premises has been static. There are other barriers to access. One in six deaf and hard-of-hearing people has avoided going to a GP because of communication problems, and nearly one-quarter have left a GP appointment unsure of what was wrong with them.²³ Staff awareness and attitudes can also create barriers. Can we be confident that health improvement accessibility and communication is any better?

Figure 3.4.5 **Percentage of adults reporting that they found it fairly or very inconvenient to access certain services, by disability status, Scotland, 1999 and 2006**



Source: Scottish Household Survey 1999 and 2006.

Health improvement opportunities

The population of disabled people is heterogeneous not only in terms of impairments but also demographically, socially and economically.^{3,13} In routine statistics, this heterogeneity is compounded by the mixing of all forms of disability, long-term illness and health conditions in the data. Experience of disability (aligning with the social model) is rarely covered by routine data sources.³⁶ For a rounded view of disability, a combination of social and individual ‘models’ is needed,¹ with the objective of challenging cultural disadvantage, removing structural disadvantage and maximising personal function.

Cultural change is at the root of health improvement for disabled people. ‘Changing individual and social attitudes to place a higher value on diversity would help counter behaviours and attitudes that cause disabling conditions in society.’²¹ The public sector, working alongside organisations run by and for disabled people,⁵ has an important part to play in shaping perceptions and attitudes.

Increasing employment levels would improve incomes³⁷ and, no less important, social health and wellbeing.³⁸ The process, though, is likely to be complex and require recognition of the nature of varied health problems: disabled people cannot neatly be divided into those who ‘can’ and ‘cannot’ work.³⁹ This approach is also dependent on employers’ recruitment patterns and local and national demand for labour. Low employment rates for disabled people at a time of economic stability and growth in jobs – the time to which the statistics presented here relate – bodes ill for employment at a time of adjustment and recession such as Scotland is now experiencing.

General practice and pharmacy could play an important role in improving health, given the high rates of adverse health behaviours and other risk factors that disabled people experience. In 2008, 30% of Scottish adults with a long-term condition, health problem or disability had contacted their GP more than 10 times in the last year, compared with 12% of the whole adult population.⁴⁰ The existence of a disability or limiting condition does not remove the need to promote a healthy lifestyle in a healthy environment, with appropriately personalised advice, support and adaptations.

Conclusion

Although there is a significant amount of data on disability, it is limited by its focus on individual impairment and health conditions, and by the variety of definitions that hinder comparability and make it difficult to combine data across sources. A start on addressing this is the adoption of standard disability questions by the main Scottish population surveys. This will improve data from an ‘individual model’ perspective, though still muddling function and condition. This may also improve data on children and young people, which are poorer than those on adults. However, the difficulty of comparability will remain as administrative data are collected for varying purposes requiring different definitions. Disaggregation into specific impairments is limited by the sample size of key surveys.

The prospect of improved data on individual impairments and conditions is to be welcomed. However, if the social model is going to be appropriately embedded in public sector thinking, more attention needs to be directed towards regular measurement and reporting of function and environment.

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3.5 Ethnicity

Key points

- The largest non-white ethnic minority groups in Scotland in 2001 were Pakistani, Chinese and Indian. Recent migrants from the European Union are not included in this chapter.
- All minority ethnic groups are younger than the white Scottish, British and Irish populations.
- Those from non-white minority ethnic groups tend to live in large urban areas, particularly in the cities of Glasgow, Edinburgh, Dundee and Aberdeen, but also the more suburban areas of East Renfrewshire and East Dunbartonshire.
- Chinese and Indian ethnic groups are more likely to be living in less deprived areas, whereas Pakistani and other South Asian and other ethnic groups have concentrations in both the most and the least deprived neighbourhoods.
- Minority ethnic groups, identified by country of birth, in general have lower mortality than the general population in Scotland, but can have specific health problems, such as heart disease and diabetes among South Asians. Some minority groups, such as gypsy/travellers, experience high levels of poor health.
- Many opportunities to improve the health of those from minority ethnic groups lie in ensuring that services and initiatives are inclusive and are delivered through culturally sensitive means.
- There is a further opportunity to improve the health of minority ethnic groups in Scotland by increasing the availability of ethnically disaggregated health data.

Definitions

This chapter is primarily about ethnic minority groups outwith the majority white culture, though some reference is made to groups within the white population who might not be regarded as 'mainstream', such as gypsy/travellers. Recent migrants from the European Union are covered in Section 3.8, Migrants.

When thinking about ethnicity, it is important to note that it reflects social more than biological differences between people and communities, and that a person's ethnic identity can change over time.¹ Bhopal defines ethnicity as:

the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race.²

Ethnicity is self-defined, and the classification of ethnicity is essentially pragmatic, based on categories that include common self-descriptions, are acceptable to respondents and

identify variations that are important for research or policy. There is increasing recognition that people may want to identify themselves with more than one ethnic group, and the 'mixed' category introduced in the UK 2001 census attempted to do this. Ethnicity differs from country of origin, given that many countries include more than one ethnic group.

In July 2008, the Scottish Government announced it was changing the way it collected data on ethnicity in its major surveys, including the 2011 census.³ The proposed question 'What is your ethnic group?' invites respondents to tick one box that best describes their ethnic group. The recommended question, along with guidance on asking questions on ethnic group, is available from the Scottish Government website.⁴ The question categories are compared against those used in the 2001 census in [Table 3.5.1](#). Most information available at present utilises a range of different ethnic categories, mostly based on the 2001 census. Compared with the 2001 census, what is proposed for the 2011 census will have more categories for white respondents to describe their backgrounds and adds 'Arab'.

Table 3.5.1 **Ethnic categories in 2011 (proposed) and 2001 censuses**

2011 proposed categories		2001 categories	
Top level	Detail	Top level	Detail
A: White	Scottish; English; Welsh; Northern Irish; British; Irish; Gypsy/traveller; Polish; Any other	A: White	Scottish; Other British; Irish; Other White
B: Mixed or multiple ethnic group	–	B: Mixed	–
C: Asian/Asian Scottish or Asian British	Pakistani, Pakistani Scottish or Pakistani British; Indian, Indian Scottish or Indian British; Bangladeshi, Bangladeshi Scottish or Bangladeshi British; Chinese, Chinese Scottish or Chinese British; Other	C: Asian, Asian Scottish or Asian British	Indian; Pakistani; Bangladeshi, Chinese; Other Asian
D: African, Caribbean or Black	African, African Scottish or African British; Caribbean, Caribbean Scottish or Caribbean British; Black, Black Scottish or Black British	D: Black, Black Scottish or Black British	Caribbean; African; Other Black
E: Other ethnic groups	Arab; Other	E: Other ethnic background	Any Other Background

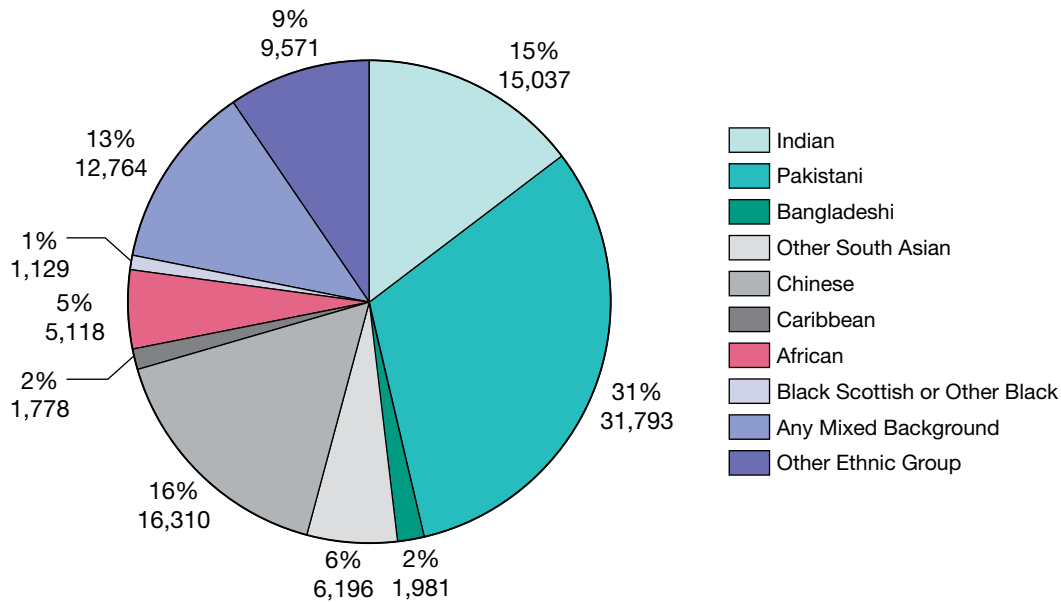
Introduction

At present, hardly any Scottish surveys produce large enough samples of minority ethnic groups to allow detailed analysis of specific issues or breakdowns into different non-white categories. Much of the analysis that follows is drawn largely from the 2001 census of population,⁵ supplemented with analysis from the Health Survey for England, which included boosted samples of minority ethnic groups in 1999 and 2004, and bespoke pieces of research conducted with minority ethnic groups in Scotland.

Population

In 2001, there were 101,677 people from non-white minority ethnic backgrounds living in Scotland: 2% of the population. Of these, the largest distinct groups represented were Pakistani, Chinese, Indian and those of Any Mixed Background (Figure 3.5.1).

Figure 3.5.1 **Non-white Scottish population, by ethnic group: 2001**



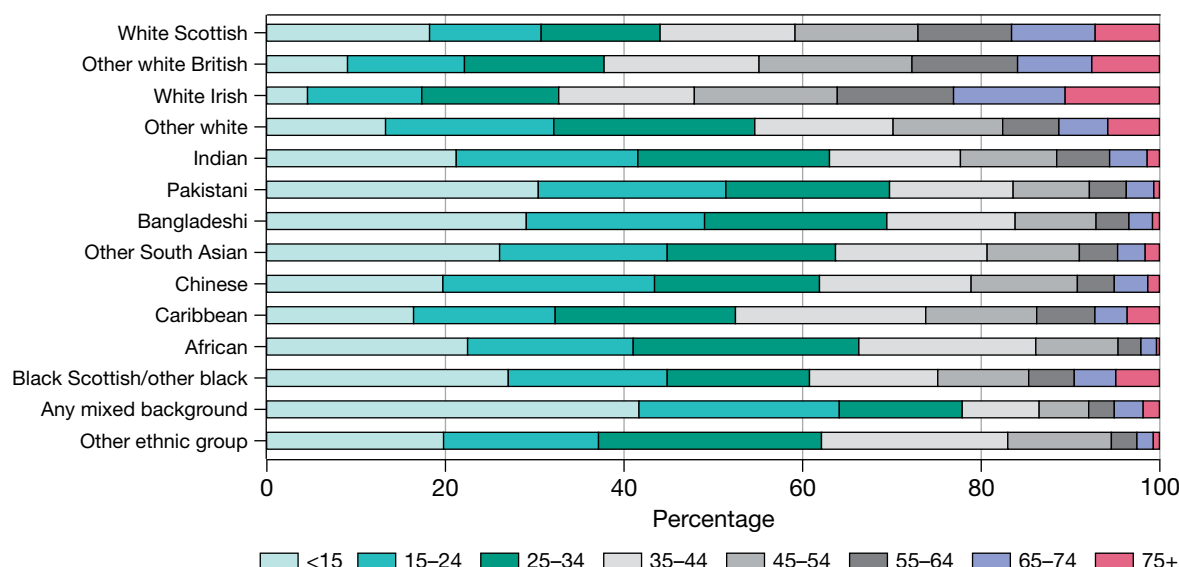
Source: General Register Office for Scotland.

In addition, the latest available data suggest that there were 1,547 gypsies/travellers in Scotland in January 2008 and 2,455 in July 2008.⁶ The nature of travelling life means that this population can vary considerably at different times. This is particularly true between the winter and summer months.

Age and sex

Those in minority ethnic groups in Scotland have a younger age profile, with more people under the age of 35 and fewer aged 55+ than in the white population of Scotland (Figure 3.5.2). More than 40% of non-white ethnic minorities (rising to one-half of Pakistanis and other South Asians) were under the age of 25 at the time of the 2001 census, compared with one-third (32%) of the white population. The age distribution is similar for both men and women. Any interpretation of health issues needs to take these differing age profiles into account. For example, looking at all adult data for some chronic diseases may obscure the extent of the problem among older minority ethnic groups.

Figure 3.5.2 **Distribution of population by ethnic group and age: Scotland, 2001**

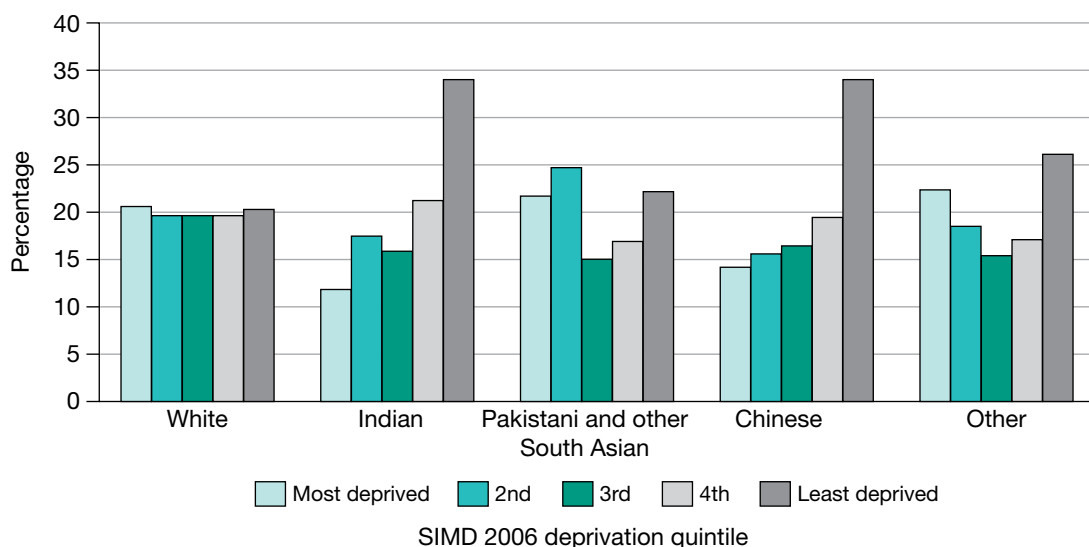


Source: General Register Office for Scotland.

Deprivation

Figure 3.5.3 shows the distribution of broad ethnic groups in Scotland by Scottish Index of Multiple Deprivation (SIMD) deprivation quintile. Whereas people describing themselves as Indian or Chinese are more likely to live in the least deprived quintile, the situation is more varied for Pakistanis and other South Asians and other ethnic groups. Pakistanis and other South Asians are more likely to live in the most deprived two quintiles and the least deprived quintile. Other ethnic groups are more likely to live both in the most deprived and in the least deprived quintile than the white population.

Figure 3.5.3 **Distribution of population by ethnic group and deprivation quintile, Scotland, 2001**



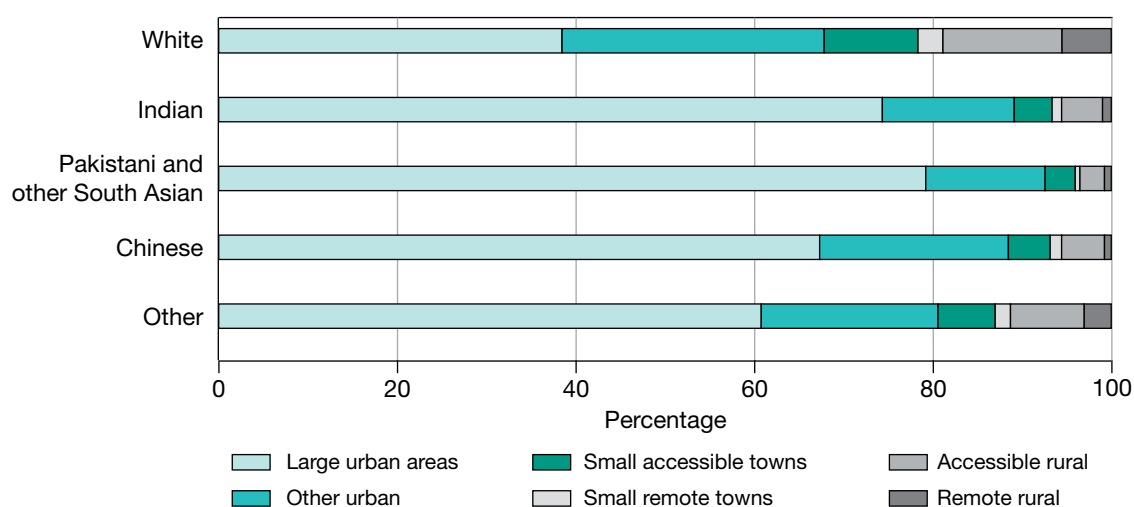
Source: General Register Office for Scotland.

Geography

In 2001, non-white residents of Scotland were most likely to be living in 'Large urban areas': 74% of Indians, 79% of Pakistanis/other South Asians, 68% of Chinese and 61% of other ethnic groups were doing so on census day, compared with 38% of white residents (Figure 3.5.4).

At a local level, ethnic minorities tend to be more numerous in the cities of Glasgow (5.5% of the population), Edinburgh (4.1), Dundee (3.7) and Aberdeen (2.9), as well as in East Renfrewshire (3.8) and East Dunbartonshire (3.1) (Figure 3.5.5).

Figure 3.5.4 Distribution of population by ethnic group and urban–rural classification, Scotland, 2001



Source: General Register Office for Scotland.

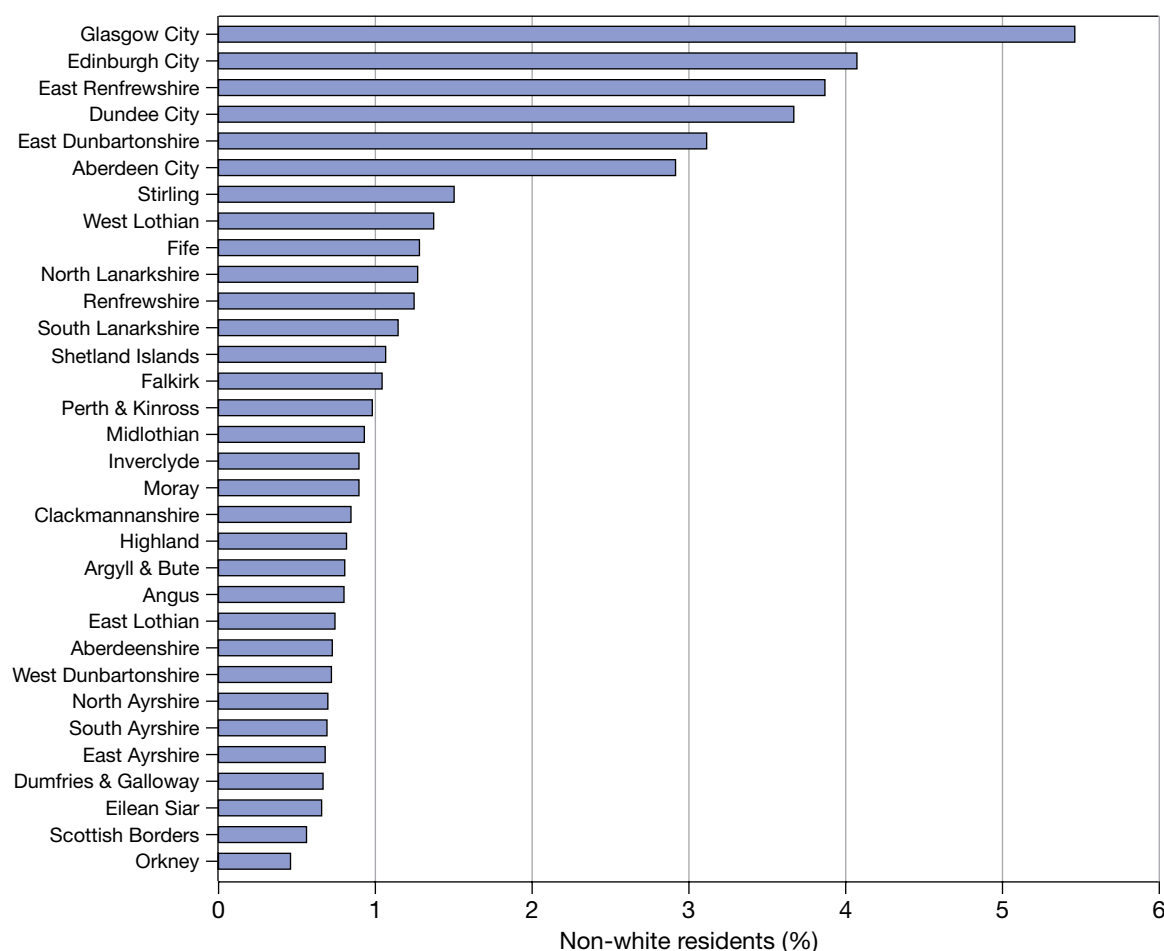
Some health challenges

The many factors that combine to identify a person's ethnic group also contribute to the differences in health status and health care between ethnic groups. For example, differences in culture and religion may influence a person's exposure to certain modifiable risk factors such as drinking alcohol or diet. The reasons for health differences across ethnic groups are therefore complex and can include differences in environmental circumstances during the life course, socio-economic disadvantage, barriers to access to health services, biological factors for a few conditions⁷ and the effects of racism.⁸

The complexity of understanding health inequalities between different ethnic groups is further compounded by the lack of data for different ethnic groups in Scotland on health outcomes, health-related behaviours and use of services. Most attention has focused on non-white groups, but important health differences have also been shown for some white populations, such as gypsy/travellers⁹⁻¹¹ and people of Irish background.¹²

Differences in health status and health care by ethnic group are evident at all stages of life.¹³ Birth weight varies by ethnic group, and these variations persist for children of women who were themselves born in the UK.^{14,15} Birth weight provides an indicator of maternal health, is a determinant of neonatal and infant survival and has been linked to development

Figure 3.5.5 Non-white residents as percentage of usual resident population, by local authority, 2001



Source: General Register Office for Scotland.

of chronic diseases in later life.¹⁶ Recent UK research has shown that Indian, Pakistani and Bangladeshi infants are 2.5 times more likely to be of low birthweight than white infants.¹⁷ The study found that socio-economic factors were important in explaining differences for Bangladeshi and Pakistani infants and that maternal factors (e.g. physical and behavioural) and infant factors (e.g. gender and gestational age) were important in explaining differences for Indian and Bangladeshi infants.

Those of South Asian ethnicity have been shown to have lower rates of childhood asthma and wheezing illness.^{18,19} However, households most likely to have problems communicating with British health services are less likely to report asthma and wheezing,²⁰ which may account for some of the differences observed.

Levels of self-reported poor health among Pakistani and other South Asian adults were higher than those of the general population at each age group according to the 2001 census in Scotland. Similar patterns were observed for reports of limiting long-term illness. Comparison of results from census questions across ethnic groups should, however, be viewed with some caution as the cross-cultural validity of these questions is not fully understood.

The incidence of specific health conditions can vary by ethnic group. A recent study in Scotland found that the age-standardised prevalence of diabetes in South Asians was around three to four times higher than that among non-South Asians.²¹ This finding is consistent with other literature on diabetes prevalence across ethnic groups.^{19,22,23}

It has been shown that the incidence of acute myocardial infarction (AMI) is higher among South Asians than non-South Asians living in Scotland; however, *survival* following AMI has been found to be better among South Asians.²⁴ Higher survival may be a reflection of the poor survival of non-South Asians in Scotland because the survival patterns observed for South Asians in Scotland are similar to those observed in studies in England and elsewhere.²⁴

There is a lack of information on the prevalence of mental health problems in ethnic minority groups and our knowledge of differences is therefore limited. Different cultures may have a different understanding of mental illness and wellbeing, different attitudes towards disclosure of mental health problems and different presentation of symptoms.^{25,26} Such differences are thought to account for the apparently lower levels of mental health problems among South Asian and Chinese populations.²⁷ Research has suggested that levels of unreported psychological distress among Asian communities, and particularly Asian women, are high.²⁸ Self-harm is relatively high among South Asian women but low for South Asian men, relative to white women and men.²⁹ In addition to the recognised risk factors for mental health disorders common to the general population, there are some additional risk factors more specific to ethnic minorities, e.g. racial discrimination, victimisation and stigma within one's own community.³⁰ More generally, racism impacts on mental wellbeing in minority groups.²⁷

In the absence of the recording of ethnicity on death certificates, country of birth is often used as a proxy for ethnicity. It is considered a reasonable proxy for recent migrants and older members of ethnic minority groups; however, it excludes ethnic minority people who were born and brought up in Scotland and, in smaller numbers, includes immigrant children born to white British parents settled abroad. An analysis of all-cause and cardiovascular mortality by country of birth for Scotland for the period 1997–2003 found that there was only modest mortality excess among Scottish residents born in India, Pakistan and Bangladesh.³¹ However, residents of Scotland are known to be at increased risk of CHD compared with those in the rest of Europe,³² and a more useful comparison with residents of England and Wales for those aged 25–69 years highlighted raised CHD risk among South Asians living in Scotland.³¹ In terms of all-cause mortality, those born in China and men born in India, Pakistan, Bangladesh and Hong Kong had significantly *lower* all-cause mortality.

There is no national Scottish evidence on differences in health risk behaviours for ethnic minority groups; however, disparities are evident from local Scottish studies and the Health Survey for England.

A series of studies in Glasgow has found that among members of ethnic minority groups, with the exception of Pakistani men, smoking rates are much lower than among the general population, with particularly low rates among ethnic minority women (4–5%).³³ Other studies have shown a high prevalence of use of other tobacco products, particularly in the Pakistani and Bangladeshi communities.³⁴

Self-reported consumption of alcohol in Scotland and England is often much lower among ethnic minority groups than in the general population, with women from all ethnic minority groups particularly likely to report never having drunk alcohol.^{19,33,35,36} Those from all ethnic

groups are less likely to engage in physical activity than the general population in both Scotland and England.^{19,34,37}

People from different ethnic groups may have different diets from the wider population because of cultural differences or to meet religious requirements, and diet is also influenced by practices in the general population. Patterns of diet are quite varied and difficult to summarise. The proportion of the Chinese and black African and Caribbean populations who report eating at least five portions of fruit and vegetables per day is higher than in the general population, whereas the proportion among the Pakistani community is lower.³⁴

Sexual health awareness and behaviour varies by ethnicity, though much of the research is centred on London and generalisation to Scotland may be misleading.^{38,39}

Health improvement opportunities

Many opportunities to improve the health of ethnic minorities lie in ensuring that services and initiatives are inclusive and are delivered through culturally sensitive means. This includes practice that is sensitive to differences *within* ethnic minority groups and to similarities that cut across ethnic groups, such as economic disadvantage.⁴⁰ These comments apply to service needs assessment as well as to service planning and delivery.⁴¹

Ethnic minorities can face greater difficulties when trying to access services in relation to a specific health condition, though this is not invariably the case.⁴² Reasons for such difficulties include a lack of knowledge about existing services and an inability to communicate effectively with GPs. Measures to ensure that health services are delivered and promoted through more culturally sensitive means include use of bilingual workers, opening hours that take account of the working patterns of patients and venues that accommodate the preferences of their users.³⁴

The same approach is relevant to health promotion and prevention initiatives. A recent systematic review of health promotion initiatives related to cardiovascular disease and cancer prevention involving Pakistani, Chinese and Indian communities found that targeted interventions can bring about positive changes in knowledge, health-related attitudes and behaviours and health status.⁴³ The study also recommended that, where targeted interventions are not feasible, initiatives that target the general population should take measures to include minority ethnic groups. Successful targeted interventions include a social marketing programme on mental health stigma for the four largest minority ethnic communities in Glasgow, which saw positive changes in attitudes towards mental health problems and highlights the importance of community approaches.²⁶ Community projects have a potential role not only in direct health promotion but also in fostering wider social links.⁴⁴

Socio-economic factors play a substantial part in explaining some health inequalities.^{45,46} Given that some ethnic minority groups in Scotland include a higher than average number of people living in the most deprived areas, measures to reduce poverty and raise educational attainment in deprived areas could reduce ethnic inequalities in health.²⁷ However, in itself, this will not reduce any 'ethnic penalty' attributable to racism and discrimination.⁴⁷

Conclusion

Progress is being made in increasing the availability and quality of ethnically disaggregated health data, including ongoing work to link ethnicity information from the census to Scottish hospital discharge and mortality data⁸ and the use of name search methods.²¹ This will continue to provide new insights into the health of ethnic minorities in Scotland. However, embedding ethnic data collection and coding into health systems, surveys and evaluation of initiatives – something currently lacking throughout Europe⁴⁸ – will provide the firmest foundation for better understanding of the health of ethnic minorities in Scotland.

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All web links were verified as working on 17 September 2009.

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3.6 Language

Key points

- There are currently no national data sources on the range of languages spoken by people in Scotland or the number of people who speak them.
- It is estimated that about 150 languages in addition to English are spoken in Scotland.
- Over 19,000 pupils in Scotland's publicly funded schools have English as an additional language, of whom three-quarters are not competent in English. An additional 8,000 speak a language other than English at home (as do the 19,000). Polish is the most common non-English language, closely followed by Punjabi and Urdu.
- People who have low-level English skills are likely to face higher levels of unemployment and/or lower-paid employment than the English-speaking population. Whether they disproportionately live in areas of deprivation is unknown.
- It is estimated that most people in need of language support in Scotland are based in the major cities.
- The health status and behaviours of non-English-speaking people in Scotland are not known. Evidence from other countries suggests that non-English speakers are at a disadvantage. Information on the health needs of migrants, ethnic minorities and asylum seekers/refugees can, with care, be read across to non-English speakers.
- English language training opens doors to non-English speakers. Health promotion materials could be used in such training. Innovative approaches to providing translation and information should be encouraged in all parts of Scotland.
- The 2011 census will provide data on language use. Capturing language assistance needs in routine health data would improve health service delivery and, as a by-product, provide better and more timely statistical information.

Definitions

Language is a systematic means of communication by voice, sounds, gestures or written symbols. The term 'language' is used to identify the system of communication used by the people of a particular country or other distinct community. British Sign Language, for example, is a language.¹

Introduction

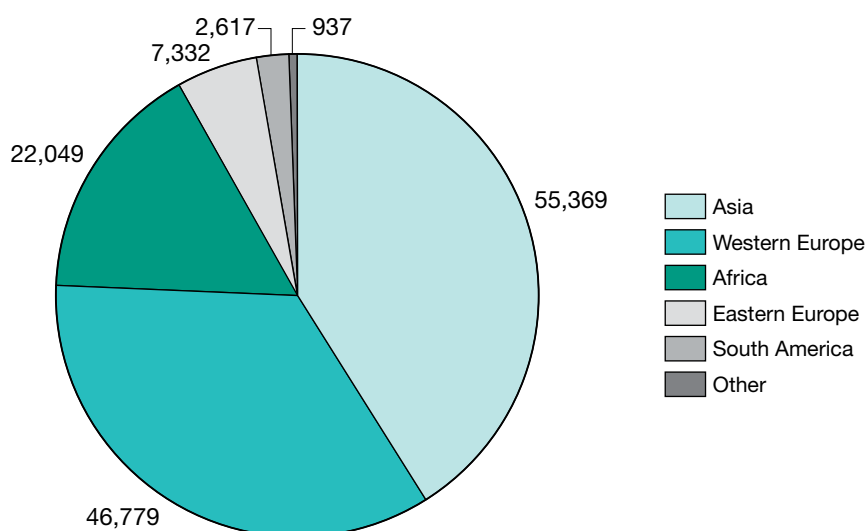
English is the predominant language of Scotland and the language of public services, of commerce and of everyday life. A lack of English language skills can therefore prevent or make difficult participation in society at the most basic level. Competency in English is known to improve the quality of daily life, help secure employment and contribute to inclusion, integration and active citizenship.² Despite a national commitment to celebrate the language diversity of Scotland’s population,¹ there is a lack of robust, relevant and routine information regarding language use.³ Consultation on a draft strategy for Scotland’s languages closed in March 2007.¹ A substantive strategy has not yet followed.

The focus of this chapter is on fluency in English. It does not include the 92,400 Gaelic language users in Scotland⁴ as their fluency in English can be assumed. Health improvement communications, however, must bear in mind people’s *preferences* for language as well as *ability*. More information on Gaelic in Scotland can be found in Scotland’s 2001 Census: Gaelic Report.⁴

Population

It has been estimated that about 150 languages in addition to English are spoken in Scotland.¹ However, there are currently no national sources of information on the range of languages or the number of people who speak them. Using country of birth as an approximate language indicator (i.e. those not born in an English-speaking country),⁵ it can be estimated that about 3% of Scotland’s population in 2001 were not native English speakers (Figure 3.6.1). A similar figure of 3% was found in the National Adult Learners Survey 2005⁶ and, for the UK, in the British Social Attitudes Survey 2005.⁷

Figure 3.6.1 Estimated second language speakers by region of birth, 2001



Source: General Register Office for Scotland.

With the additional rise of in-migration of economic migrants (see section 3.8, Migrants, for more information), most of whom are from parts of the world where English is not the first language, it was estimated that there were at least 150,000 second-language speakers living in Scotland in 2004. Of these, one-third (about 50,000) were estimated to be in need of English language support.³

There were 147 different languages reported as the main home language of pupils in Scotland's publicly funded schools in 2008.⁸ The most common after English was Polish, closely followed by Punjabi and Urdu (Table 3.6.1). A total of 26,801 pupils (3.9%) spoke a language other than English at home, of whom 19,001 (2.8% of all pupils) were identified as having English as an additional language. Of these, 25% were competent in English, 31% were developing competence, 22% were in the early stages of acquisition of English and 21% were new to English. This number has doubled since 2006 and a similar increase has been seen in pupils 'new to English' (Figure 3.6.2). The rise may have tailed off as economic migration is forecast to drop with the economic recession in Britain.⁹

There are an estimated 6,000 people in Scotland for whom British Sign Language (BSL) is their first or preferred language.¹ This figure is likely to be underestimated as it does not include people who have acquired BSL as a result of a range of other hearing loss problems.¹⁰

Table 3.6.1 Main language used at home by pupils in Scotland's publicly funded schools, 2008

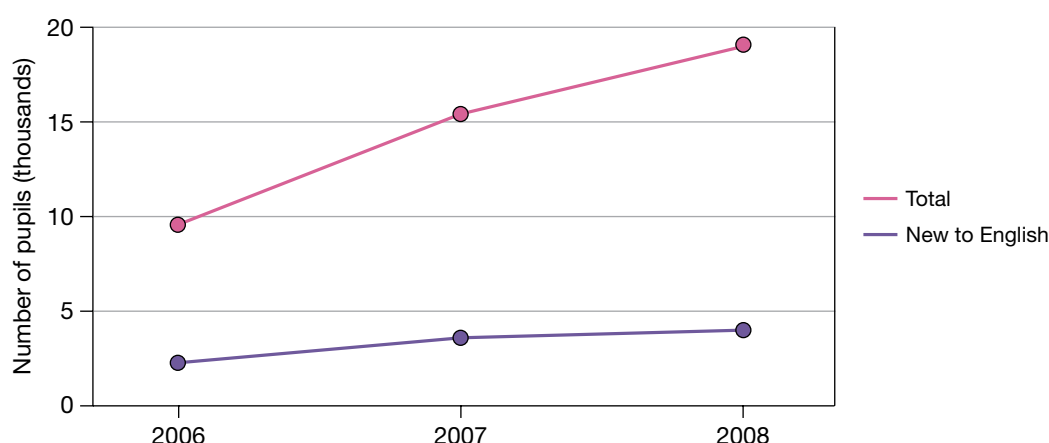
Language	N ^a	Language	N	Language	N
English	653,731	Russian	363	Latvian	199
Polish	4,677	Turkish	358	Dutch	150
Punjabi	4,622	Chinese (Mandarin)	323	Pashto	150
Urdu	4,207	Slovak	318	Bahasa Malaysia	142
Cantonese	1,506	Scots	306	Hungarian/Magyar	139
Arabic	1,403	Hindi	292	Kurdish	139
French	788	Lithuanian	290	Thai	135
Gaelic (Scottish)	681	Italian	265	Shona	134
Bengali/Bangala	539	Portuguese	263	British Sign Language	131
German	496	Farsi/Iranian/Persian	260	Other ^b	2,234
Spanish	463	Somali	246	Not known/not disclosed	2,219
Malayalam	406	Tamil	243		
Tagalog/Filipino	406	Swahili/Kiswahili	208		

^aData include 1,859 pupils who are not based in their reporting school and hence are likely to be double counted.

^bLanguages in the 'Other' category are Afrikaans, Akan/Twi, Albanian, Algerian, Amharic, Armenian, Azerbaijani, Bahasa Indonesia, Bajuni, Balochi, Basque, Bemba, Bosnian, Bulgarian, Burmese, Catalan, Cebuano/Visayan, Chechen, Coorge, Creole, Croatian, Czech, Danish, Dari, Doric, Duri, Edo/Bini, Esan, Estonian, Ewe, Faroese, Fijian, Finnish, Flemish, Frisian, Gaelic (Irish), Georgian, Greek, Gujarati, Gurani, Hakka, Hausa, Hebrew, Herero, Hokkien, Ibo/Igbo, Icelandic, Idoma, Isekiri, Japanese, Jju, Jola, Jula, Kagoro, Kalabari, Kannada, Kashmiri, Katchi/Kutchi, Khmer, Kikuyu, Kinyarwanda, Kirundi, Konkani, Korean, Lingala, Luganda, Malagasy, Maltese, Mandinka, Marathi, Memmoni, Mirpuri, Moldavian, Mongolian, Ndebele, Nepalese, Northern Sotho, Norwegian, Nyanja/Chichewa/Chewa, Romanian, Romany, Rugika, Serbian, Serbo-Croatian, Setswana, Shanghainese, Silheti/Sylheti, Sindhi, Sinhalese, Slovene, Soninke, Sourashtra, Swati, Swedish, Telugu, Tibetan, Tigrinya, Tiv, Tonga, Tongan, Tswana, Tulu, Turkmani, Ukrainian, Urhobo, Uzbek, Vietnamese, Welsh, Wolof, Xhosa, Yoruba, Zulu.

Source: Pupils in Scotland, 2008.

Figure 3.6.2 Pupils in Scotland for whom English is an additional language, 2006–2008



Source: Pupils in Scotland, 2006, 2007, 2008.

NHS Health Scotland records requests for foreign language downloads and requests for health promotion materials in languages other than English. In the quarter April to June 2009, 1,121 requests were received. More than half (57%) were for Polish-language materials; the other requested languages were Chinese (13%), Urdu (10%), Bengali (6%), Lithuanian (4%), Russian and French (3% each), with seven foreign languages, three audio, three Braille and one large-print request accounting for the remainder of the requests.

Age and sex

The age and sex of people in Scotland whose first language is not English is not directly available. Applying the results from a study in England gives an estimate of 47,023 people from South Asia and China who cannot speak English (Table 3.6.2). These results apply to established ethnic minority groups that accounted for 64% of Scotland's ethnic minority population in 2001. The proportion of individuals unable to speak English increases with age, though the absolute numbers are greatest in the younger age groups. Minority ethnic women are less likely to speak English than men.

Table 3.6.2 **Percentage and estimated number of people who speak little or no English by age and sex, Scotland, 2007**

	% of individuals who speak little or no English		Estimated number in population in 2007	
	Men	Women	Men	Women
Indian				
16–34	2.9	5.3	3216	2797
35–54	6.0	14.6	1997	1806
55+	20.9	45.2	974	774
Pakistani				
16–34	9.8	15.8	5758	5941
35–54	15.1	40.1	3561	3429
55+	35.3	67.8	1480	1132
Bangladeshi				
16–34	14.8	31.2	415	350
35–54	36.2	75.9	281	175
55+	65.6	91.1	96	55
Chinese				
16–34	9.3	6.3	3311	3246
35–54	26.0	29.8	2232	2429
55+	57.1	61.2	791	777

Sources: Gill *et al.*,¹¹ General Register Office for Scotland.

Deprivation

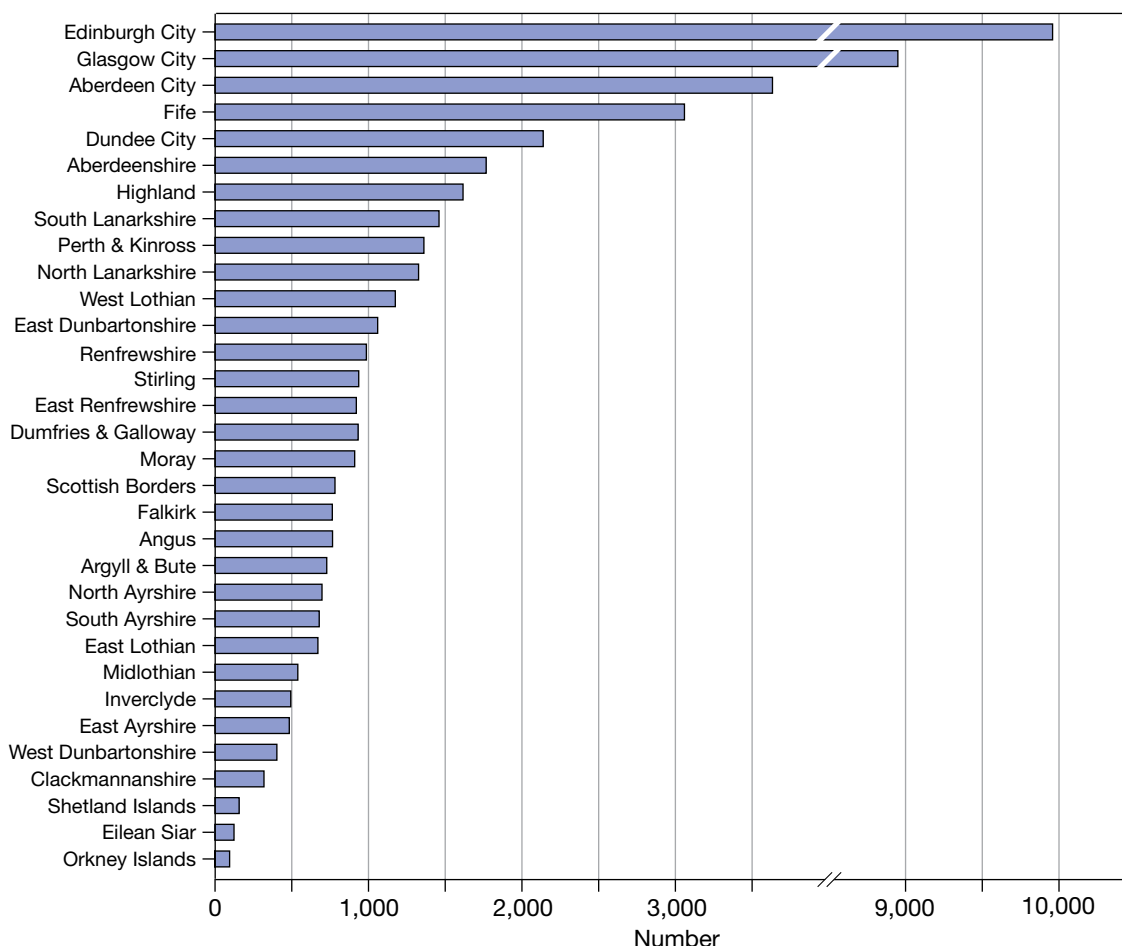
A report commissioned by the Department for Education and Employment⁵ highlighted anecdotal evidence to suggest that unemployment in the UK among people whose first language is not English ranges between 50% and 90%. In Scotland, this is likely to have changed in recent years given the large influx of migrants, most of whom are in paid employment (see section 3.8, Migrants). Those who are in work are typically employed at a lower level than justified by their qualifications and experience and, as a consequence, they suffer from poverty that exceeds the levels of the English-speaking population by a factor of between two and four.⁵ It is unknown whether non-English speakers in Scotland are disproportionately resident in areas of multiple deprivation.

A report by the Royal National Institute for the Deaf (RNID), *Deafness Employment and Discrimination*, is quoted as suggesting that deaf and hard-of-hearing people face widespread discrimination in the workplace.¹² The research showed that deaf or hard-of-hearing people are two and a half times more likely to be unemployed than a hearing person. Those between the ages of 25 and 45 are four and a half times more likely to be unemployed. Even when deaf people are successful in obtaining employment, many (68% of the sample) feel that their communication needs are not understood or met.¹²

Geography

A study for the Scottish Executive in 2004 estimated that 50,000 people in Scotland required English language support.³ Nearly two-fifths were in Edinburgh and Glasgow (Figure 3.6.3).

Figure 3.6.3 Estimates of demand for English support in Scotland by local authority, 2004

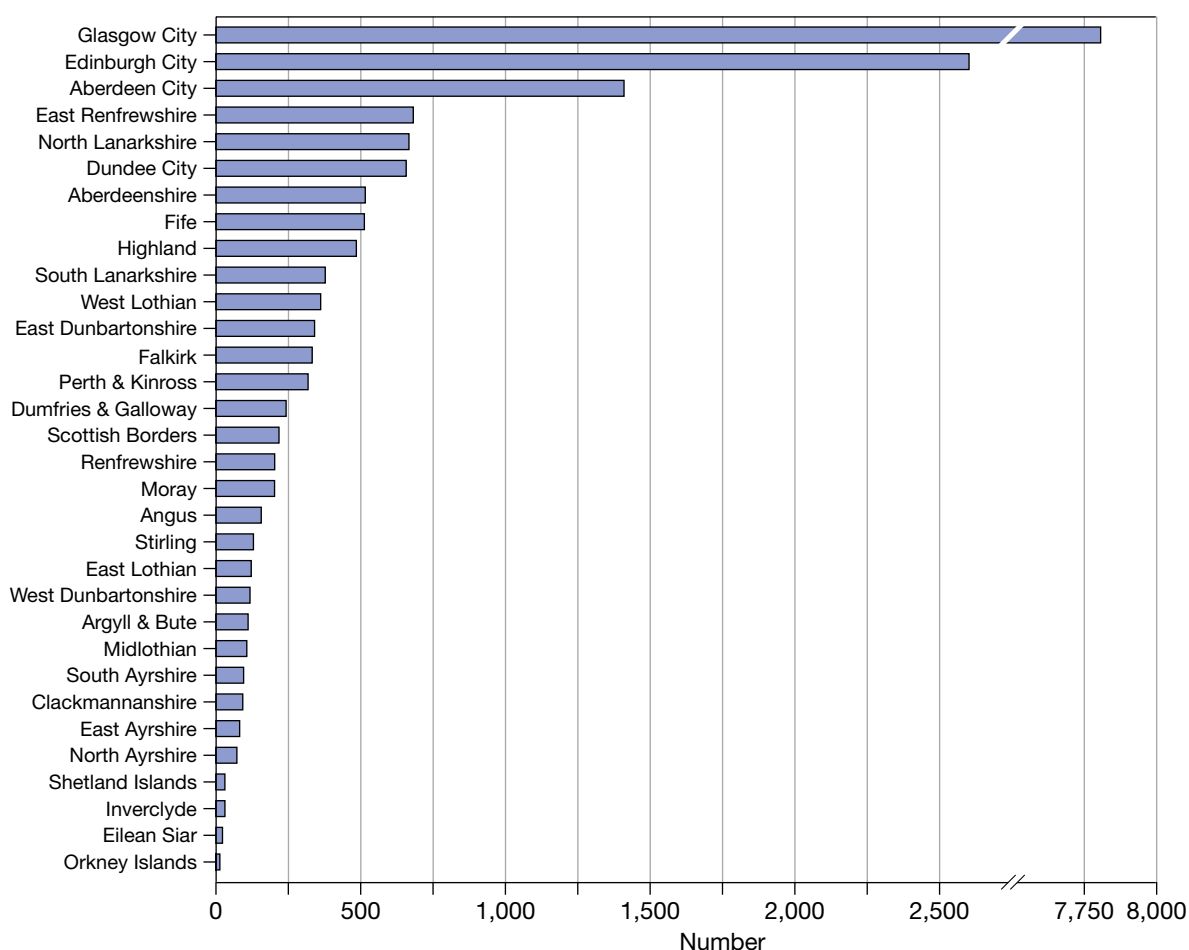


Source: Rice *et al.*³

Despite the limitations in using 2001 census data as the basis for the above estimations, a similar pattern – but with some distinct differences – emerges when using more recent local authority data from the 2008 Pupils in Scotland report⁸ (Figure 3.6.4). Although restricted to school-aged children, it is clear that the majority of pupils for whom English is an additional language live in the major cities of Glasgow, Edinburgh and Aberdeen. The fact that Glasgow City contains over 40% of the total number of pupils in Scotland with English as an additional language, corresponding to over 10% of the pupil population within the local authority, may reflect a combination of large numbers of asylum seekers (see section 3.2), non-white residents (see section 3.5) and migrants (see section 3.8) in this area.

There are some differences in the relative ordering of local authorities using the two different approaches of Figure 3.6.3 and Figure 3.6.4. Generally these are minor, but the position of Edinburgh is peculiar. We do not know if this reflects imprecision in the estimates, the different basis of the estimates or some particular local factor.

Figure 3.6.4 Pupils with English as an additional language by local authority, 2008



Source: Pupils in Scotland, 2008.

Some health challenges

Effective communication is fundamental to public health improvement and practice. Although few studies have been conducted to investigate the impact of language on health in Scotland, findings from English and international studies provide useful insights into the likely health challenges experienced by people who are not fluent in English. These suggest that they have lower access to health care,¹³ receive fewer preventative services and may have a poor experience of care (detering future contact).¹⁴ Lifestyle advice on diet, exercise and smoking cessation is less likely to be received,¹⁵ and children in non-English-speaking households are more likely to be overweight and to have only fair or poor dental health.¹⁶ The extent to which these findings apply in Scotland is unknown. Limited literacy, a particular problem for people whose first language is not English,¹⁷ may explain some of these adverse health effects (see section 3.7, Literacy).

In a RNID report (cited in ref. 11), over half of BSL users surveyed had to rely on friends and family to interpret for them during appointments. Only 8% of requests for an interpreting service originated from health care professionals themselves.

Many people whose first language is not English are migrants, asylum seekers, refugees or from ethnic minority communities, so it seems plausible that some of the health challenges faced by non-English speakers will be similar to those of these population groups. They

are covered in other sections of this report. Although these groups can experience the full spectrum of health problems, mental health problems are common and particularly challenging given the importance of communication in their diagnosis and treatment.¹⁸ Language is considered to be the largest obstacle to effective mental health service delivery to people who have difficulties with English.¹⁹

Health improvement opportunities

For people in Scotland who cannot speak English fluently, the primary requirement is to enable them to do so, providing the gateway to inclusion and opportunity.¹ Substantial numbers of people in Scotland are learning English – over 9,000 were enrolled in classes in 2003/04.³ This provides an excellent opportunity for health promotion literature and scripts to be used as language teaching materials – with the potential for health benefit as well.

The inability to speak English fluently is a real barrier to engagement with health promotion and health care. Given the diversity of the non-English-speaking population, and its dispersal across Scotland, innovative ways to facilitate communication are needed, such as telephone-based simultaneous translation (video-based for BSL), distribution of materials in different languages on the internet, and training in communication strategies to use with deaf people and non-English speakers.^{11,12,20} Provision of interpreters has been shown to increase use of preventative services.²¹

Conclusion

Epidemiological studies, population surveys and administrative data underpin public health intelligence. The absence of reliable information on non-English speakers and BSL users from these sources, and the difficulty of collecting it consistently across varying cultures,²² makes it impossible to assess how effectively needs are being met on a consistent basis across Scotland. If people for whom English is an additional language are not visible in basic data collection, the chances of understanding, and hence improving, their health is limited. The inclusion of a language question in the 2011 census is a vital step to improve basic knowledge.²³ Capturing language assistance needs in routine health data would improve health service delivery and, as a by-product, provide better and more timely statistical information.

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All web links were verified as working on 17 September 2009.

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3.7 Literacy

Key points

- One in five of the adult population (aged 16–65) in Scotland is estimated to have poor literacy.
- Men tend to have stronger numeracy and document reading skills than women, whereas women are better at prose reading.
- Older people are more likely to have low literacy skills than younger people.
- People with limited literacy skills are most likely to live in socially excluded areas, be on a low income and be in a manual social class.
- Among those with poor literacy skills, physical and mental wellbeing is lower, unhealthy behaviours are more common and the risk of earlier mortality in old age is higher. Understanding health information, navigating health care, engaging in self-care and participating in informed decision-making are all challenges for people with poor literacy.
- Developing literacy as an asset for health, and for living, means starting with children and the circumstances of their lives that promote poor literacy. Literacy interventions to improve health in adults show mixed results.
- Available information on literacy in Scotland is now over a decade old. There is no systematic information on health literacy in Scotland, and applying data from the UK as a whole gives possibly 'optimistic' results. Better information on these core skills is needed.

Definitions

Literacy simply means the ability to read and write.¹ It also includes speaking and listening. Numeracy – the ability to understand and use numerical, graphical and mathematical information² – is often also encompassed under the umbrella term 'literacy'. Further, literacy skills are flexible and complex, existing in specific contexts, and their adequacy can be judged only in line with the values associated with these contexts.³ Taking this into account, an operational definition of literacy was proposed by the United Nations Educational, Scientific and Cultural Organization (UNESCO) as 'the ability to identify, understand, interpret, create, communicate and compute, using printed and written materials associated with varying contexts. Literacy involves a continuum of learning in enabling individuals to achieve their goals, to develop their knowledge and potential, and to participate fully in their community and wider society.'¹ In Scotland, the generally accepted definition of literacy is an 'ability to read and write and use numeracy, to handle information, to express ideas and opinions and solve problems, as family members, workers, citizens and lifelong learners'.³

The majority of information presented in this section uses Scottish data from the International Adult Literacy Survey (IALS),⁴ which defined literacy as ‘using printed and written information to function in society, to achieve one’s goals and to develop one’s knowledge and potential’.⁴ The survey measured three dimensions of literacy:

- Prose literacy: the knowledge and skills required to understand and use information from texts such as newspaper articles and passages of fiction. The texts have a typical paragraph structure.
- Document literacy: the knowledge and skills required to locate and use information contained in various formats such as timetables, graphs, charts and forms. The texts have a varied format, use abbreviated and/or informal language and use a variety of devices and visual aids to convey meaning, such as diagrams, maps or schematics.
- Quantitative literacy (i.e. numeracy): the knowledge and skills required to apply arithmetic operations, either alone or sequentially, to numbers embedded in printed materials, such as calculating savings on items advertised in a sale or working out the interest required to achieve a desired return on an investment.

Scores on each of these scales were grouped into five literacy levels: levels 1 and 2 are those of most interest. Level 1 scores show difficulty in reading, writing and using everyday maths. Level 2 scores show a need for information to be expressed in clear, simple terms.⁵

Introduction

Literacy is much more than an ability to read, write and count. It affects people’s ability to make sound, informed decisions in the context of their everyday lives. Proficiency in literacy is therefore considered to be something to which everyone is entitled, a fundamental right that allows us to participate more fully and confidently in the community and wider society.¹ This, of course, includes health, and an increasing concern with health literacy – the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions⁶ – emphasises the wider impacts of limited literacy for health improvement.

Population

The Scottish cohort of the 1996 IALS found that 23% of adults (aged 16–65) in Scotland had very low levels of literacy and numeracy.⁷ Updating this to 2007, using age-specific rates advanced by one decade to allow for a clear cohort effect in the oldest age group, gives an estimate of nearly 660,000 adults in Scotland with poor literacy ([Table 3.7.1](#)). This is 19% of the population aged 16–65. Analysis of a Scottish cohort of 34-year-olds uses a different method and gives levels of literacy problems (1.5 million people) and numeracy problems (2.9 million) ‘at a level to impact on their employment opportunities and life chances’⁸ which, for literacy at least, is fairly consistent with our estimate for levels 1 and 2 in 2007 from the IALS.

Table 3.7.1 Population of adults in Scotland (aged 16–65) by literacy level

Level	1996	2007		Definition
	%	<i>N</i>	%	
1	23	658,219	19	People with very poor skills, who may, for example, be unable to determine the correct amount of medicine to give a child from information printed on the package
2	31	1,069,862	31	Can deal only with material that is simple, clearly laid out, and in which the tasks involved are not too complex. It denotes a weak level of skill, but more hidden than level 1. It identifies people who can read, but test poorly. They may have developed coping skills to manage everyday literacy demands, but their low level of proficiency makes it difficult for them to face novel demands, such as learning new job skills
3	30	1,121,699	32	Considered a suitable minimum for coping with the demands of everyday life and work in a complex, advanced society. It denotes roughly the skill level required for successful secondary school completion and college entry. Like higher levels, it requires the ability to integrate several sources of information and solve more complex problems
4/5	16	613,379	18	People who demonstrate command of higher-order information processing skills
Total	100	3,463,158 ^a	100	

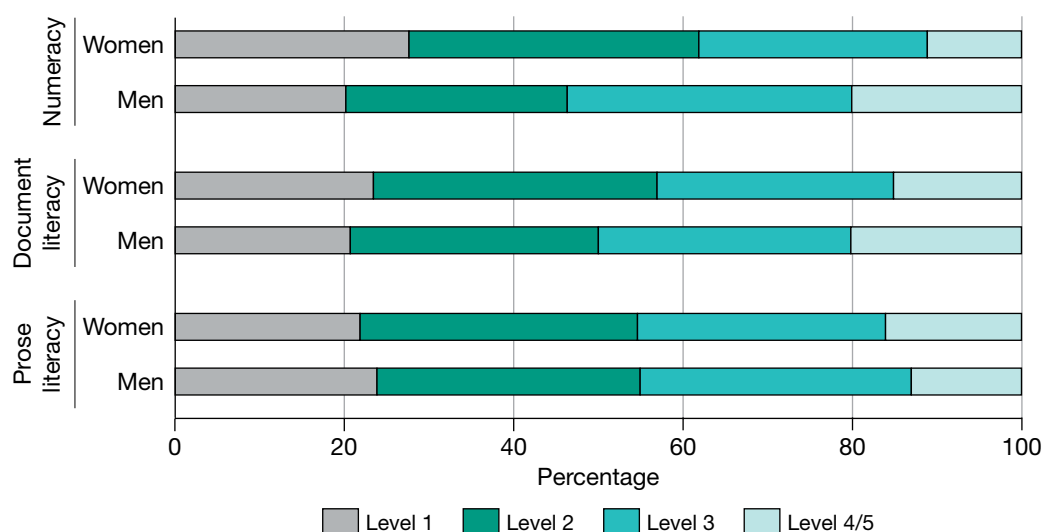
^aSums to 30,455 less than General Register Office for Scotland 2007 mid-year population estimate for 16- to 65-year-olds because of using published rounded figures in our calculations.

Source: Adult Literacy in Scotland: Analysis of Data from the 1996 Adult Literacy Survey, 2001;⁴ General Register Office for Scotland; Organization for Economic Co-operation and Development: Adult Literacy.

Age and sex

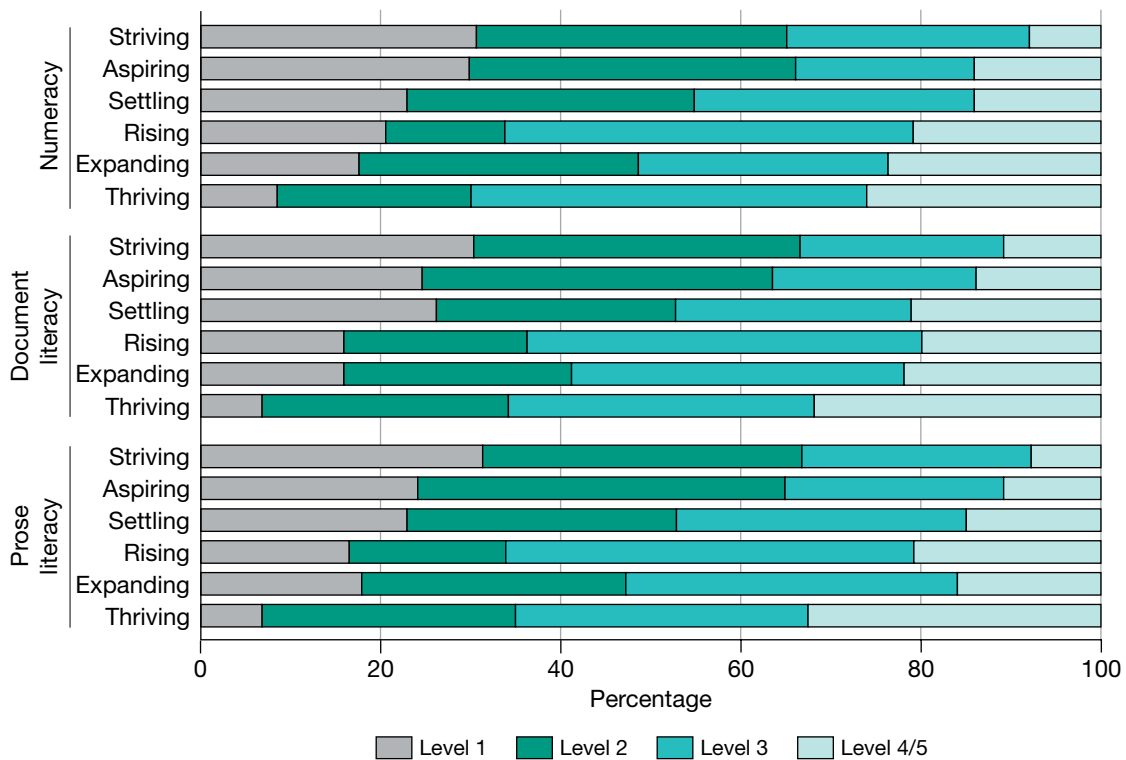
Women tend to perform less well than men on numeracy and document reading tasks but are better at prose reading (Figure 3.7.1). People aged 56–65 are more likely to have low literacy skills than younger people (Figure 3.7.2). This appears to be a cohort effect, perhaps reflecting disrupted education in children at school during wartime and the austerity of the later 1940s.

Figure 3.7.1 Literacy level among people aged 16–65 by sex, Scotland, 1996



Source: Adult Literacy in Scotland: Analysis of Data from the 1996 Adult Literacy Survey, 2001.⁴

Figure 3.7.2 Literacy level among people aged 16–65 by age, Scotland, 1996



Source: Adult Literacy in Scotland: Analysis of data from the 1996 Adult Literacy Survey, 2001.⁴

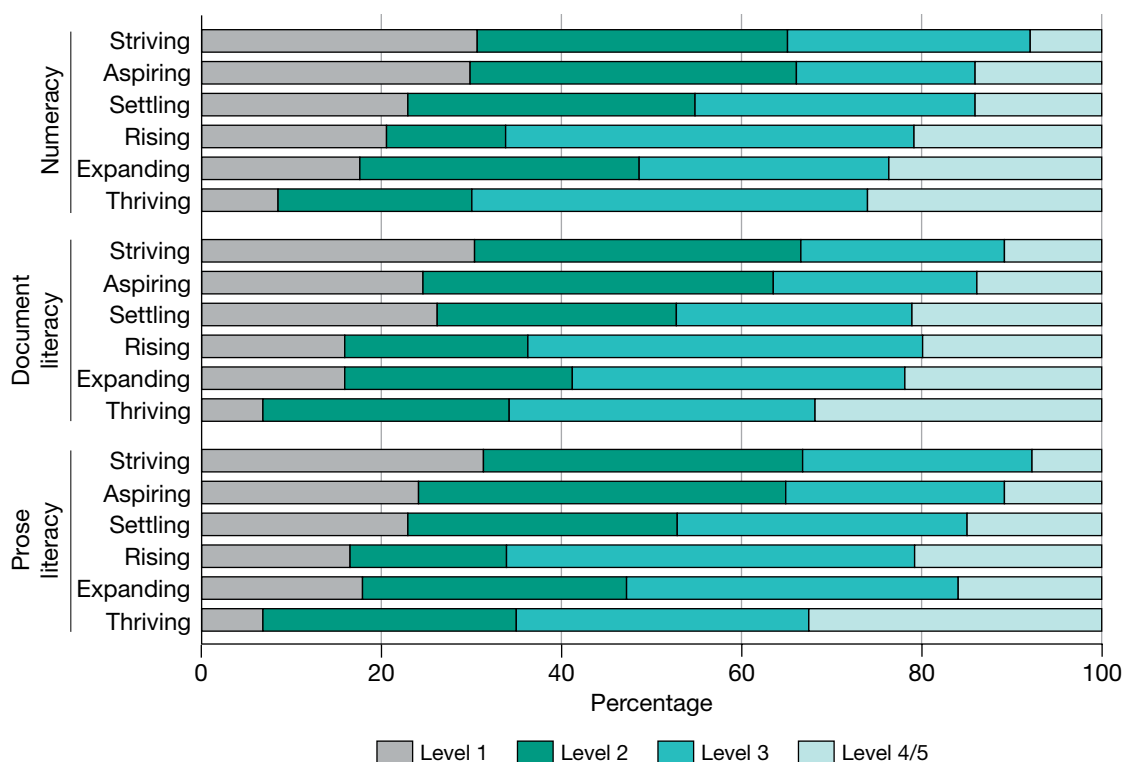
Deprivation

People with limited literacy and numeracy skills are most likely to be found in socially excluded areas (Figure 3.7.3). One-third of adults living in areas classified as ‘striving’, which includes council estates and multiethnic low-income areas, have low literacy and numeracy skills, compared with 14% in the three most affluent categories of the ACORN^v classification.⁴

Besides area deprivation, literacy and numeracy are also strongly associated with social class, a measure of individual socio-economic status (Figure 3.7.4). People in manual occupational classes have lower literacy than those in non-manual classes. Seven in ten people at the lowest level of literacy are in manual social classes, which account for only four in ten of the population aged 16–65.^{4,9} The strongest predictors of being at the lowest literacy level are low income and being in a manual social class.⁴

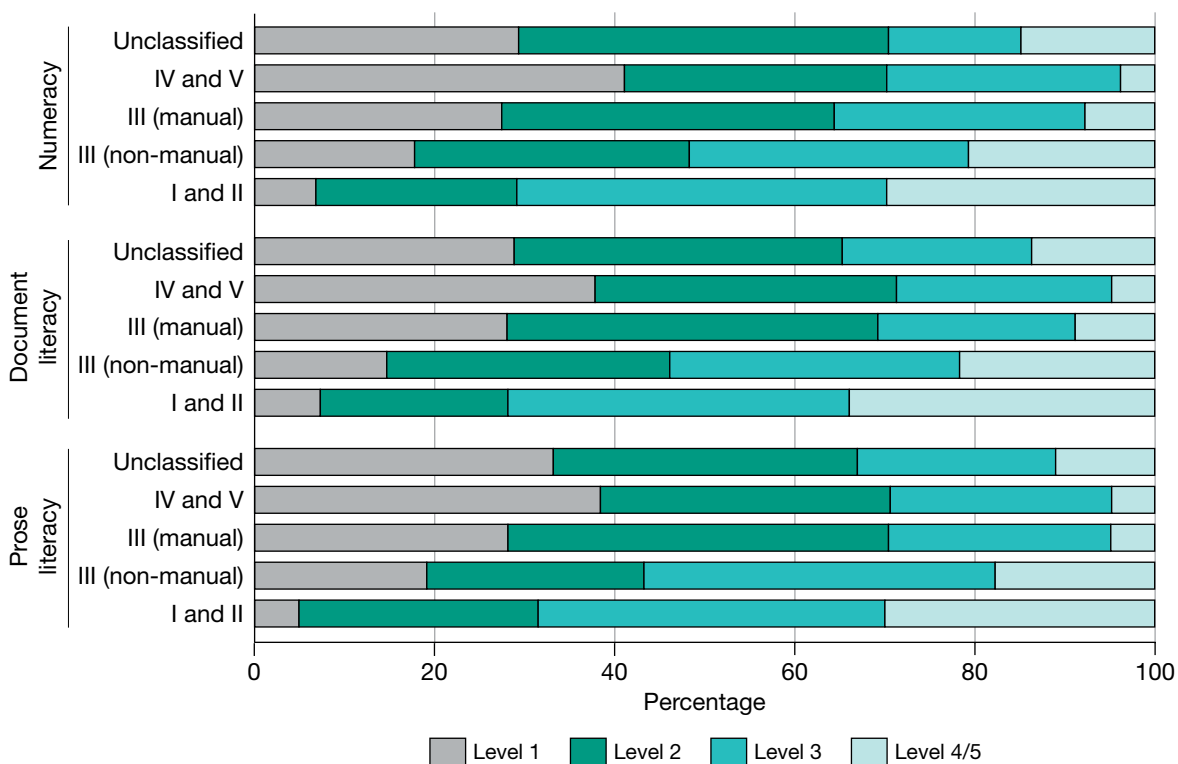
^v ACORN stands for ‘A Classification of Residential Neighbourhoods’. Although superseded by new classifications in 2005, the categories of the original ACORN classification system contained the following groups. Thriving: wealthy achievers, suburban areas; affluent greys, rural communities; prosperous pensioners, retirement areas. Expanding: affluent executives, family areas; well-off workers, family areas. Rising: affluent urbanites, town and city areas; prosperous professionals, metropolitan areas; better-off executives, inner-city areas. Settling: comfortable middle-agers, mature home-owning areas; skilled workers, home-owning areas. Aspiring: new home owners, mature communities; white-collar workers, better-off multiethnic areas. Striving: older people, less prosperous areas; council estate residents, better-off homes; council estate residents, high unemployment; council estate residents, greatest hardship; people in multiethnic low-income areas.

Figure 3.7.3 Literacy level among people aged 16–65 by ACORN area classification, Scotland, 1996



Source: Adult Literacy in Scotland: Analysis of data from the 1996 Adult Literacy Survey, 2001.⁴

Figure 3.7.4 Literacy level among people aged 16–65 by social class, Scotland, 1996



Source: Adult Literacy in Scotland: Analysis of data from the 1996 Adult Literacy Survey, 2001.⁴

Geography

There is currently no available information regarding the literacy of people in Scotland by geographical location. There is a suggestion that slightly more people in the Central Belt have higher literacy and numeracy skills.⁸

Some health challenges

It appears obvious that low levels of literacy will impact negatively on people's health, and research confirms this.¹⁰ Only one analysis has been undertaken in Scotland. It showed that poor literacy and numeracy was associated with poor self-assessed physical and mental wellbeing, smoking and high alcohol consumption at age 34.⁷ This is supported by UK analysis of the same cohort and by wider data.¹¹ However, analysis often does not allow for the effect of socio-demographic characteristics which are known themselves to be strong predictors of health status.

Studies investigating the impact of poor literacy on health appear rare. However, evidence on a wide range of health outcomes is available from studies investigating *health literacy*. This is defined as individuals' 'capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions'.¹² Poor health literacy is associated with older age, being male, lower educational attainment and lower income.¹³ People with low levels of health literacy are less likely to be aware and make use of screening and preventative services.¹⁰ They have been found to have worse disease self-management¹⁰ and not to know much about their chronic disease.¹⁴ Qualitative research has shown that people with limited health literacy often experience practical difficulties when interacting with the health care system.¹⁵ Communication between health services and individuals with low health literacy is often inadequate and educational materials – aimed at increasing health-related knowledge, attitudes and motivations – are mostly difficult to understand for people who have impaired health literacy.¹⁶

Poor health literacy is associated with poorer self-rated health^{10,13,17} and significantly lower physical and mental wellbeing.¹⁸ It is also associated with poorer health behaviours. Studies have shown associations with lower fruit and vegetable consumption and with being a smoker in UK adults¹³, with smoking in adolescent boys and girls in Australia¹⁹ and with low breastfeeding in US women.²⁰ In elderly populations, limited health literacy has been associated with smoking, alcohol consumption and obesity in some but not all studies.^{21,22} Older people are most likely to be health illiterate⁶ and the risk of death for those who are is almost twice that of those with adequate literacy.²¹ (Most of these studies took account of other factors that could influence health but some did not and might overstate the causal importance of literacy.)

It can be assumed that poor literacy hinders health literacy, but poor health literacy does not necessarily mean poor literacy.²³ The prevalence of health literacy has yet to be measured in Scotland. Logically, one would expect health literacy to be poorer than literacy, as basic literacy is so fundamental to most learning and understanding. However, a study of health literacy in British adults suggests that only around 11% of adults aged 18–90 have poor health literacy.¹³ This is perhaps an optimistic finding, and further work is needed that simultaneously examines the prevalence of literacy *and* health literacy and their separate and joint effects on health outcomes.

Opportunities for health improvement

Major EU policy initiatives have highlighted the importance of providing health information in order to disseminate knowledge to everyone, in the belief that this will enable people to make more informed choices and adopt lifestyle behaviours conducive to good health.²³ Indeed, health communications have been a strong and consistent element in health improvement in Scotland since at least the early 1990s.²⁴ Without the necessary skills to obtain, understand and utilise such information, it is difficult for people to effectively manage their health, even though they are expected to bear the personal responsibility of making sound health decisions.²⁵

A strategy on adult literacy and numeracy in Scotland was published in 2001.³ This is currently being refreshed.²⁶ A range of projects on health and literacy are supported through the strategy.²⁷

The link between lower socio-economic status and poor literacy can be traced back to childhood.²⁸ According to Scottish data from the 2004 survey of the 1970 British Cohort Study, individuals with the poorest grasp of literacy and numeracy in adulthood are likely to have had a relatively disadvantaged home life in childhood, measured by various socio-economic indicators.⁷ This adds to the many reasons why a focus on improving life circumstances in childhood is important for the future health and wellbeing of the population.⁸ This must include parents, perhaps especially mothers,²⁹ as well as children.

Reviews of literacy interventions to improve health paint a mixed picture of effectiveness.^{10,30} Replacing standard text-based materials with easy-to-read brochures, videotapes and verbal presentations has been shown to sometimes have an impact on health knowledge, but this has usually not been tracked through to health outcomes in studies which are often of poor quality and conducted in a North American setting.³⁰

Health literacy can be viewed as a risk (for poor health care use or self-care) or as an asset for healthy living.¹² The former perspective, at least in terms of developing interventions, appears more common in practice. A truly public health approach would place more emphasis on developing literacy as an asset for health, and – more generally – for an empowered population.²³

Conclusion

There are many people with low literacy (including numeracy) skills in Scotland. Data on the actual number are more than a decade old. A new survey is currently being undertaken, and the results will probably be published while this report is in press.³¹ Such data are essential to identify how successful recent interventions have been in changing literacy at a population level and how big a task remains. There are no data on health literacy in Scotland and, perhaps oddly, poor health literacy appears to be less common than poor general literacy. Given the current emphasis on social marketing to achieve health behaviour change, better information on the core skills for engaging with health messages is needed.

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All web links were verified as working on 17 September 2009.

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3.8 Migrants

Key points

- Total net migration to Scotland between 2002/03 and 2007/08 totalled 122,110 people, an average of 20–25,000 people a year.
- This recent situation is a marked departure from historical trends. In the 1980s and 1990s, Scotland lost c. 6,800 people a year to migration.
- Cumulative figures suggest that almost 236,000 foreign nationals were issued with a National Insurance number to work in Scotland between 2002 and 2008. Under the Worker Registration Scheme, 101,000 people from the A8 countries^{vi} registered to work in Scotland between 2004 and 2008.
- Poles are the single largest group of recent migrants to Scotland, making up nearly one-third (31%) of foreign nationals coming to work in Scotland since 2002.
- Migrants have a relatively young population profile: 83% of working-age migrants were aged 18–34, compared with 35% of the Scottish working-age population.
- Low pay and overcrowding are the main deprivation-related characteristics of migrants.
- New migrants to Scotland are concentrated in the cities (especially Edinburgh and Aberdeen) and in some rural areas (especially the Highlands and Perth and Kinross). Other than Glasgow, they have not come in large numbers to west central Scotland.
- Health challenges for migrants include risk of mental health problems and poorer mental wellbeing, health behaviours and access to services.
- Health improvement opportunities for recent migrants are less obvious than for some other population groups because of limited information. Working with migrants and local communities to improve economic and social integration is likely to be beneficial for migrants' mental health. Specific consideration in health promotion communications needs to be given to language, channels and settings.
- Most of what is known about migrants comes from limited national data and small-scale local studies. Major surveys will need to record migration status if a more in-depth understanding is to develop.

^{vi} The A8 countries are Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia. Nationals from these countries have been allowed access to the UK labour market since May 2004. From January 2007, nationals from a further two countries (Bulgaria and Romania) have been allowed access to the UK labour market on a more restricted basis.

Definitions

The UN Convention on the Rights of Migrants defines a migrant worker as a ‘person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national’.¹ From this a broader definition of migrants follows: ‘The term “migrant” ... should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of “personal convenience” and without intervention of an external compelling factor.’¹

The Department of Work and Pensions (DWP) – in terms of statistics – defines migrant workers as migrants newly arrived in the UK who have applied for a National Insurance number. Until May 2009, migrants from the so-called A8 accession countries to the European Union had to register if they planned to work for more than one month in the UK. After 12 months’ continuous employment they no longer had to register and could gain a residency permit. The Home Office Worker Registration Scheme was discontinued from May 2009.²

Introduction

Scotland has always attracted migrants. Immigration from Ireland for much of the nineteenth and early twentieth centuries was followed by immigration of Italians and Jews between the 1880s and the 1920s and then, from the 1950s, by the immigration of Asians from Pakistan, India, Bangladesh, Uganda and China.³ Since 2002, the expansion of the European Union has brought a new cohort of economic migrants to Scotland from the countries of Central and Eastern Europe – the European Union accession countries.

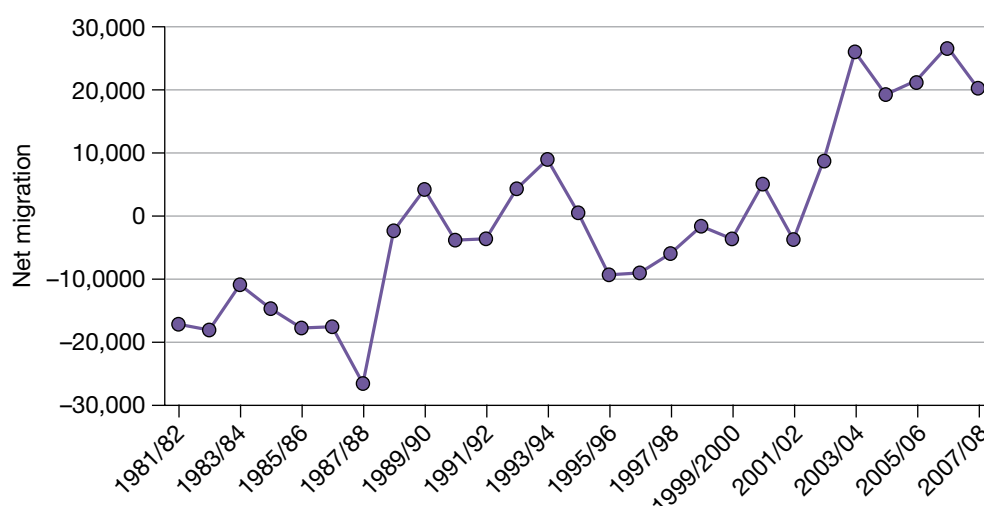
As migrants settle and become simply part of the Scottish population, the health issues they face and the health improvement opportunities change to those associated with aspects of their lives other than the fact of migration. This can include continuing discrimination for reasons of religion, skin colour or cultural differences and an intergenerational socio-economic legacy from having initially occupied the lowest rungs of the economic ladder.^{4,5} This chapter focuses on *migration* and on the most recent wave of migrants to Scotland, from 2002 onwards.

The General Register Office for Scotland has also published local area migration reports, covering all local areas in Scotland.⁶

Population

Between 2002/03 and 2007/08, net migration to Scotland totalled 122,110 people.⁷ This represents a departure from historical trends and even from the position as recently as the 2001 census.⁸ In the 21 years between 1981/82 and 2001/02, Scotland lost more people through migration than it gained: an average annual net outflow of 6,800 people. However, since 2001/02, this trend has reversed, with net in-migration around 20,000–25,000 annually between 2003/04 and 2007/08 (Figure 3.8.1).

Figure 3.8.1 Annual net migration flows to Scotland, 1981/82 to 2007/08



Source: General Register Office for Scotland.

For the period 2002/03 to 2007/08, net migration to Scotland came in broadly similar numbers from overseas and from the rest of the UK (Table 3.8.1).

Table 3.8.1 Composition of annual net migration flows to Scotland, 2002/03 to 2007/08: overseas and rest of UK

Net migration	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Total ^a
From rest of UK	7,043	15,522	12,507	8,922	8,849	11,509	69,048
From overseas	4,100	11,700	7,300	12,700	16,800	7,700	54,257

^aFigures do not sum to total migration, because they exclude armed forces data and because of rounding.

Source: General Register Office for Scotland.

Focusing on those of working age from overseas, between January 2002 and December 2008, 235,930 National Insurance numbers (NINOs) were issued to foreign nationals to work in Scotland, 99,500 to nationals from the A8 countries. (Individuals can be issued with two NINOs, although the DWP states that one of the numbers would then be cancelled.)⁹ Between May 2004 and December 2008, 101,010 migrants from the A8 countries registered in Scotland under the WRS. Neither figure will capture the true number of migrants in Scotland. An unknown number of migrants either have no NINo or are not registered under the WRS. It is impossible to precisely quantify the numbers involved, but a survey of A8 migrants in Glasgow in 2007 found that 32% were not registered with the WRS.¹⁰ WRS and NINo capture only the 'inflow' of migrants and take no account of 'outflow' (migrants returning home or moving to other parts of the UK). Furthermore, it has been estimated that there were 373,000 to 719,000 migrants in the UK irregularly in 2007 (plus their 44,000–144,000 UK-born children), 70% of whom lived in London.¹¹

Poles are the largest single group of economic migrants, constituting nearly one-third (31%) of foreign nationals issued a NINo to work in Scotland since 2002. There are also appreciable numbers of economic migrants from India, Australia and many other countries (Table 3.8.2). The latest available statistics (to December 2008) show that only 2,320 people from Bulgaria and 1,780 from Romania have been issued a NINo to work in Scotland since 2007.¹²

Table 3.8.2 **National Insurance numbers issued to foreign nationals to work in Scotland, January 2002 to December 2008: top ten nationalities**

	Number	As % of all issued a NINo
Poland	73,320	31.1
India	15,100	6.4
Australia	10,190	4.3
China	8,260	3.5
Republic of Ireland	7,900	3.3
Slovak Republic	7,320	3.1
Spain	6,740	2.9
France	6,390	2.7
Pakistan	6,260	2.7
Germany	5,460	2.3

Source: Department for Work and Pensions 100% extract from the National Insurance Recording System.

As noted already, the available data have gaps and deficiencies, with different sources constructed on different bases and giving different figures. This means that many of the figures are open to question and varying interpretations. For example, in 2008 it was suggested that the number of Poles in Scotland was nearly three times higher (86,000) than the official estimate (31,000).¹³

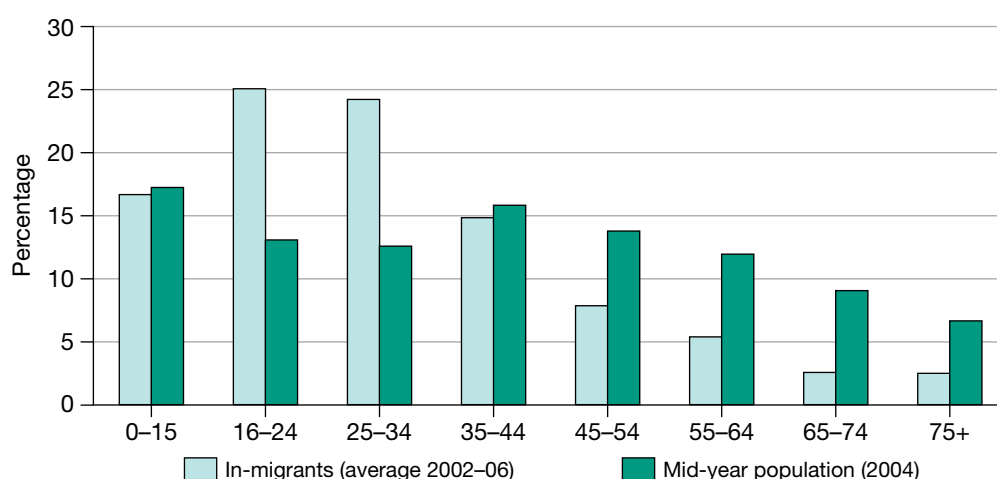
Age and sex

Migrants are younger than the indigenous population. In the period 2002–06, half of all in-migrants to Scotland were aged 16–34 compared with one-quarter of the population as a whole. For the older age group, the pattern reverses: only 18% of in-migrants were aged 45+ compared with 41% in the population as a whole (Figure 3.8.2). It should be remembered that *emigrants* from Scotland are also young – in 2007/08, two-thirds of those leaving Scotland either for overseas or for other parts of the UK were under the age of 35.

The comparison can be drawn more tightly by considering only the working-age population (aged 16–64) with a NINo registration. Between 2002 and 2008, 83% of economic migrants entering Scotland were aged 18–34, compared with 35% of the Scottish population.

Men are slightly more likely than women to be economic migrants to Scotland: over the period January 2002 to December 2008, 126,650 migrants were men and 109,280 were women.

Although most economic migrants are single and without dependants, there is some recent evidence that this position is changing. According to the most recent WRS report, 8% of A8 migrants had dependants and the average number of dependants living with each migrant in the UK was 1.6 (57% under the age of 17).¹⁴ A survey of A8 nationals by Citizens Advice Scotland found that a higher proportion (22%) had at least one child.¹⁵

Figure 3.8.2 **Age of in-migrants compared with total resident population, Scotland, 2002–2006**

Source: General Register Office for Scotland 2004 mid-year population estimates, and in-migration estimates.

Deprivation

Although almost all the recent economic migrants to Scotland are in employment, they tend to work in low-paid occupations (such as agriculture, factory work, food processing and hospitality and catering).¹⁶ Half (53%) of migrants who arrived in Scotland after 2002 were in jobs paying less than £7 an hour compared with 33% of those who had always lived in Scotland or who arrived in Scotland before 2002.¹⁷

There is some Scottish evidence of exploitation of younger migrants, including pay levels below the national minimum and inappropriate ‘deductions’ from pay packets.¹⁸ One-third (36%) of enquiries to Citizens’ Advice Bureaux by A8 nationals concerned ‘in work’ benefits, with migrants living in rural Scotland more likely to enquire about these issues.¹⁵ Another aspect of deprivation is overcrowded housing: an estimated 10–13% of migrants report this as an issue.^{19,20} In some parts of Scotland, such as Aberdeen, there is evidence that this is being partly alleviated by migrants accessing social housing in low-demand areas.²¹

Those migrants who choose to become settlers are likely to develop an economic profile more similar to the existing Scottish population, and to move, for example, into a wider range of neighbourhoods.

Geography

In absolute terms, the greatest numbers of economic in-migrants in Scotland are concentrated in Edinburgh, Glasgow, Aberdeen and Highland – more than one-quarter (26%) in Edinburgh alone. As a percentage of the local working-age population, a rather different pattern emerges (Table 3.8.3). Economic in-migrants are twice as common in Edinburgh (19% of the working-age population) and Aberdeen (18%) as in Glasgow (11%). Outside Glasgow, the relative level of economic in-migration is more limited in west central Scotland. (Note that the data show only cumulative in-migration in the period and make no allowance for any out-migration.) Data from the WRS show a similar picture of concentration in Edinburgh and north of the Tay.²²

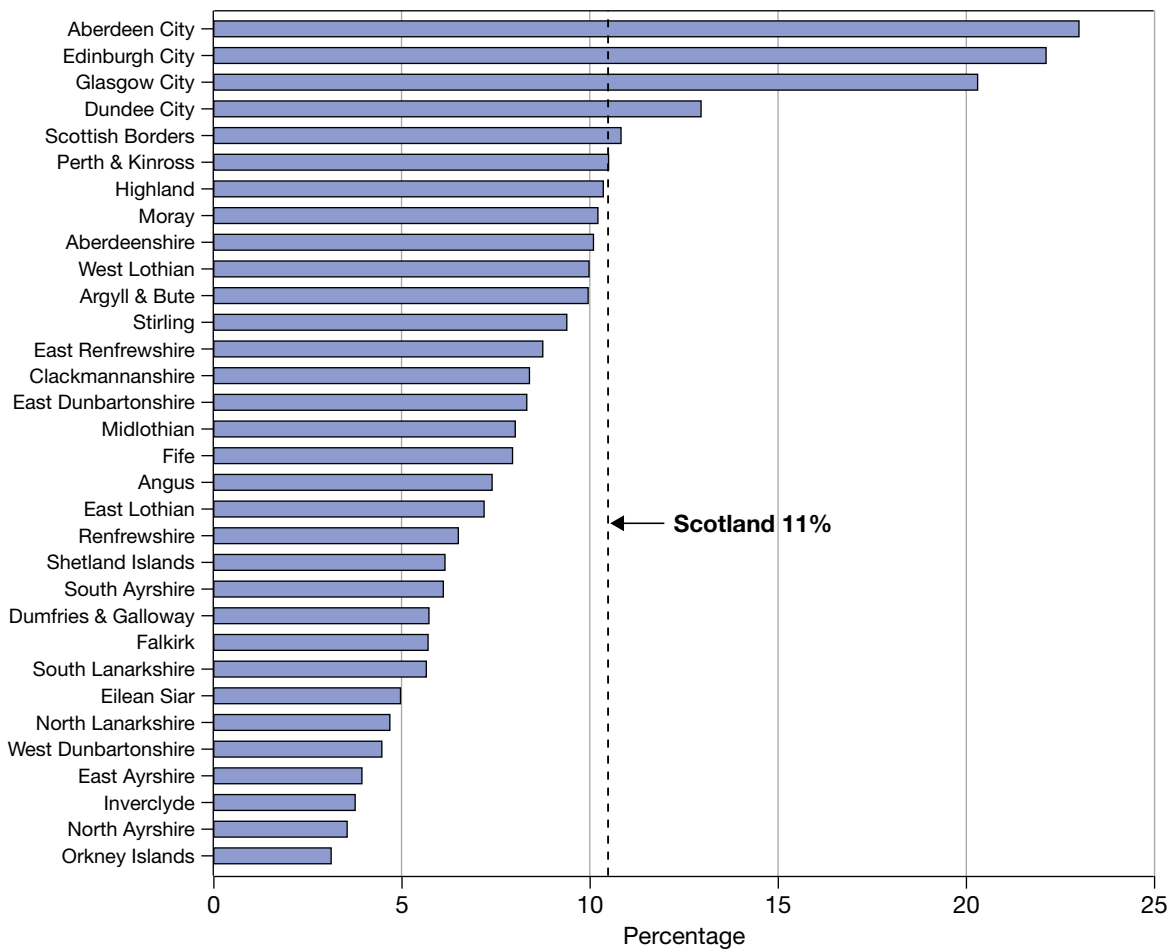
Table 3.8.3 **National Insurance numbers (NINos) issued to foreign nationals to work in Scotland, January 2002 to December 2008, by local authority of residence: number, percentage of total NINos; as percentage of local population aged 16–59/64**

	Number	% of total NINos		% local population
Edinburgh	61,510	26.1	Edinburgh	19.2
Glasgow	42,490	18.0	Aberdeen	17.6
Aberdeen	24,540	10.4	Perth and Kinross	13.2
Highland	12,590	5.3	Glasgow	10.8
Perth and Kinross	11,340	4.8	Highland	9.5
Fife	9,350	4.0	Dundee	9.5
Dundee	8,430	3.6	Stirling	6.7
Aberdeenshire	8,280	3.5	Argyll and Bute	6.7
West Lothian	5,910	2.5	Angus	6.4
North Lanarkshire	5,440	2.3	Shetland Islands	5.7
South Lanarkshire	4,310	1.8	Aberdeenshire	5.6
Renfrewshire	4,190	1.8	West Lothian	5.5
Angus	4,180	1.8	Scottish Borders	5.2
Stirling	3,660	1.6	Moray	4.7
Argyll and Bute	3,550	1.5	Fife	4.2
Scottish Borders	3,430	1.5	Renfrewshire	4.0
Dumfries and Galloway	2,940	1.2	East Lothian	3.5
Moray	2,480	1.1	Dumfries and Galloway	3.4
Falkirk	2,450	1.0	Eilean Siar	3.3
South Ayrshire	2,040	0.9	Inverclyde	3.3
East Lothian	2,010	0.9	Orkney Islands	3.1
North Ayrshire	1,730	0.7	South Ayrshire	3.1
Inverclyde	1,630	0.7	North Lanarkshire	2.7
Midlothian	1,130	0.5	Falkirk	2.6
East Dunbartonshire	1,120	0.5	Clackmannanshire	2.4
West Dunbartonshire	1,020	0.4	Midlothian	2.3
East Renfrewshire	900	0.4	South Lanarkshire	2.2
East Ayrshire	860	0.4	North Ayrshire	2.1
Clackmannanshire	770	0.3	West Dunbartonshire	1.8
Shetland Islands	760	0.3	East Dunbartonshire	1.8
Eilean Siar	510	0.2	East Renfrewshire	1.7
Orkney Islands	370	0.2	East Ayrshire	1.2
Scotland	235,920	100.0	Scotland	7.3

Source: General Register Office for Scotland 2008 mid-year population estimates; Department for Work and Pensions 100% extract from National Insurance Recording System.

Edinburgh, Aberdeen and Glasgow (which have the lowest *overall* birth rates) had the highest proportion of live births to mothers born outside of the UK, though the high percentage of births to non-UK mothers in parts of rural Scotland is also worth noting (Figure 3.8.3). Births and NINos give two different windows onto the pattern of in-migration, neither giving a complete view.

Figure 3.8.3 **Percentage of live births where mother was born outside of UK by local authority, Scotland, 2007**



Source: General Register Office for Scotland.

Some health challenges

The majority of the migrant population in Scotland are young, educated adults in relatively good physical health.² This creates a distinct variety of health challenges.

Mental and social health problems are an issue for many migrants. Many economic migrants are working long and irregular hours in low-paid jobs for which they are overqualified.^{2,23} While they are generally well integrated into their employment, their positions offer little opportunity for advancement. Overcrowded accommodation,¹⁰ which they may be reluctant to report for fear of losing the tenancy,²⁴ can create stresses from lack of private space. Outside of work, some migrants, particularly if lacking English skills, feel socially isolated from their local communities, especially in rural areas, and some have experienced racial abuse or violence.^{2,19,25} The degree of social integration and experience of abuse appears to vary across Scotland.^{21,26} The Scottish Social Attitudes Survey has shown a potential for ill-feeling to develop between migrant workers and, particularly, young unqualified Scots based on the latter's perception of economic competition.²⁷ Cultural dissonance may also contribute to a sense of not belonging.²⁸ In combination, these various stresses may contribute to lower wellbeing and possible mental health problems.²⁹

In general, physical health is likely to be similar between migrant workers and the general population of the same age but there may be some differences, partly reflecting the characteristics of the source population or aspects of migrant circumstances. For example, smoking levels among Polish economic migrants in Dublin were found to be higher than among the local population.³⁰ Whether this applies in Scotland is unknown, but to the extent that it derives from the high male smoking prevalence in Poland it is likely that it does.³¹ Economic migrants in Scotland are concerned about sexually transmitted infections and fertility control, reflecting age and circumstances.²³

GP registration among economic migrants in Scotland is low and their use of services limited, with some reports of a preference to return to their home country for treatment.² Knowledge of the NHS system is limited, and those who do use it appear to face barriers in accessing particular services, notably relating to mental health, sexual and maternal health and substance misuse.²³ Language barriers are a recurring issue in the literature (see section 3.6, Language).

The demographic pattern of migrants to Scotland may be changing from a 'typical' profile of young single people without dependants towards one in which families are reunited or form after migration.¹⁵ The needs of those who decide to settle in Scotland may change (e.g. towards accessing maternity services).²⁶ There were 6,349 live births in Scotland in 2007 to mothers born outside the UK – just over one in ten of all births. This is double the number of 3,240 in 1997 (1 in 20). The largest increase was seen among babies born to Polish mothers, from 11 to 934 births. In 2007, the largest numbers of births to non-UK-born mothers in Scotland were to mothers born in pre-2004 EU countries (1,100), the A8 accession countries (1,204) and South Asian countries (1,048).³²

On the other hand, as language skills improve and wider social integration develops, those settling will become more like the existing population in their health behaviours and service contacts. There is, though, great uncertainty about how many recent economic migrants will settle in Scotland for the long term,² and the high estimates in newspapers of just a few years ago³³ might look optimistic in the current recession.³⁴

Health improvement opportunities

It is difficult to see opportunities clearly when the nature and scale of challenges is unclear.

Scottish Government policy is to attract and retain migrants. This 'welcoming' policy appears to have had a positive impact on attitudes towards migrants in Scotland, but there is still clear evidence of hostility, abuse and discrimination.² More generally, poor integration has a potential mental health impact and therefore local work that builds a human face to the national political welcome has potential benefits. In areas where migrants are filling a population gap, particularly in rural areas, better integration will also benefit the host population.²

Health behaviour initiatives aimed at younger adults in Scotland will have some reach towards migrants but might miss many or even most. Specific consideration needs to be given to language, communication channels and settings. For example, those in particular settings (e.g. in contact with homeless advice agencies) may be more likely to have health problems.²⁰ Such a 'segmentation-minded' approach needs to be extended to aspects of migrant experience relevant to health on which we have little information for Scotland, such as gender.³⁵

Conclusion

Timely, local data on the characteristics of migration are limited, although migration statistics are improving.³⁶ Many potential sources of information on migrants, such as national surveys, do not ask about migrant status and/or use samples that are too small to provide useful information.² Much of what we know about migrants comes from small-scale local studies which provide insights of value but whose representativeness is often uncertain. Major surveys will need to record migration status if we are to develop both robust and in-depth understanding.

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3.9 Poverty

Key points

- In 2007/08, 860,000 people in Scotland, one in six of the population, were living in relative poverty.
- The greatest number of poor people are of working age, though higher proportions of children and pensioners are poor.
- Poverty levels were declining for children and pensioners up to 2004/05, after which they stabilised. During the same period, poverty among working-age adults fluctuated without any real change.
- Poverty is geographically concentrated: in west central Scotland, in urban areas and in deprived communities. However, three-quarters of people in relative poverty in Scotland live outside the 15% most deprived areas, and there is a rural bias to low pay.
- Benefit levels are low relative to the national profile of incomes.
- Employment can make an important contribution to reducing poverty. It is more effective where all the adults are working in a household (with at least one full-time) and pay levels are above £7 an hour. Low pay remains an important barrier to tackling poverty.
- Childhood poverty increases the risk of health problems both in infancy and in childhood, with continuing effects throughout life and into the next generation. Poverty is strongly associated with some health risk factors, such as smoking, diet and obesity in women. For others (such as physical activity and alcohol) the association is more complex. Poor people (especially young adults) have poorer mental health, worse self-rated health and higher levels of mortality.
- In countries where welfare regimes are more generous, health inequality is lower and economic recession has a less adverse impact. There is little appetite for such an approach in Britain. Health improvement projects can act to ensure maximum benefit take-up by those with whom they are working. Local services and projects can pursue measures to reduce the cost of healthy behaviours. As a major employer, the NHS can support employability initiatives.
- There is substantial information on poverty in Scotland. It is used extensively by government and civic society. It is insufficient alone to bring about change.

Definitions

There are two official definitions of poverty in Scotland. Each can be calculated before or after housing costs are deducted from total household incomes (including housing benefits). More detailed information is available from the Scottish Government website.¹

- Relative poverty: individuals living in households whose income (after taxes and adjusting for family size) is below 60% of UK median income for that year. This was

£236 a week for a couple with no children in 2007/08. Over time, this measures whether the relative gap between the poorest and the rest of society is growing, shrinking or remaining static. When the Scottish Government talks about reducing poverty, it means relative poverty before housing costs have been deducted (but after housing benefits have been added in).

- Absolute poverty: individuals living in households whose income (after taxes and adjusting for family size) is below 60% of the (inflation adjusted) Great Britain median income in 1998/99. This was £203 per week for a couple with no children in 2007/08. Over time, this measures whether the poorest are seeing their incomes increase after taking account of changes in the cost of living.

In addition, there is a third measure of poverty specifically for children, which combines material deprivation (whether people can afford to buy essential items and participate in leisure or social activities) and low income (below 70% of median income). In 2007/08, 15% of children in Scotland were poor according to this measure.¹

Introduction

At root, poverty is caused by a lack of money. In 2000, our predecessor Committee found that poverty could only be tackled with quality work and generous wholehearted benefits for those unable to work. This remains the case.²

In modern Scotland, the concept of poverty is a contentious one. Just under two-thirds (63%) of Scottish adults believed there was 'quite a lot' of poverty in Scotland in 2006, whereas 33% thought there was 'very little real poverty'. There is also debate about the causes of poverty in Scotland: 42% believe it to be an inevitable part of modern life, 21% due to laziness/lack of willpower on the part of individuals, and 21% due to injustice in society.³ Scottish public attitudes towards poverty remain fairly strict: 93% of people in Scotland think someone is poor if they do not have enough to eat and live without getting into debt, but only 26% define poverty as having enough to buy the things really needed but not enough to buy the things most people take for granted.³

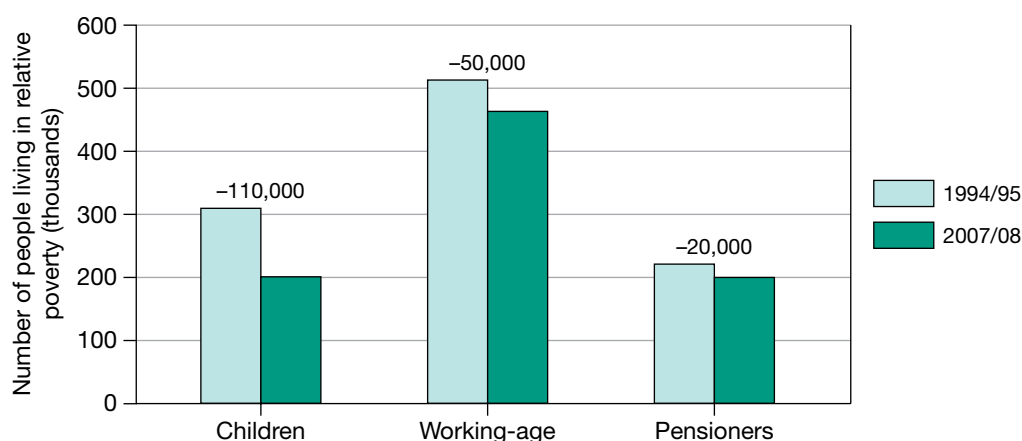
This section follows the official definition of 'poverty' as living below the 60% *relative income* threshold before housing costs have been deducted. It also draws on social security benefits data.

Population

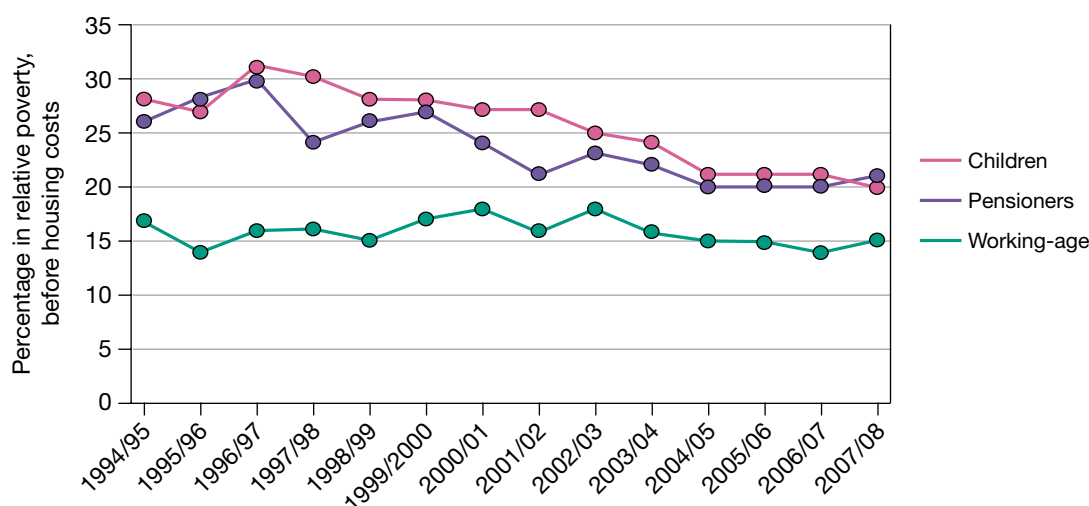
In 2007/08, 860,000 people in Scotland were living in relative poverty: 200,000 children, 460,000 working-age adults and 200,000 pensioners (Figure 3.9.1). One in six of the population (17%) were in relative poverty: 20% of children, 15% of working-age adults and 21% of pensioners.

In 1994/95 more than a million people in Scotland were living in relative poverty. By 2007/08 this had fallen to 860,000. In all, there were 180,000 fewer people living in poverty: the majority of the reduction was concentrated among children (Figure 3.9.1).

The trend in poverty between 1994/95 and 2007/08 differed by age group (Figure 3.9.2).

Figure 3.9.1 **Relative poverty, Scotland, 1994/95 to 2007/08**

Source: Poverty and Income Inequality in Scotland, 2007/08.¹

Figure 3.9.2 **Proportion of children, working-age people and pensioners living in relative poverty, Scotland, 1994/95 to 2007/08**

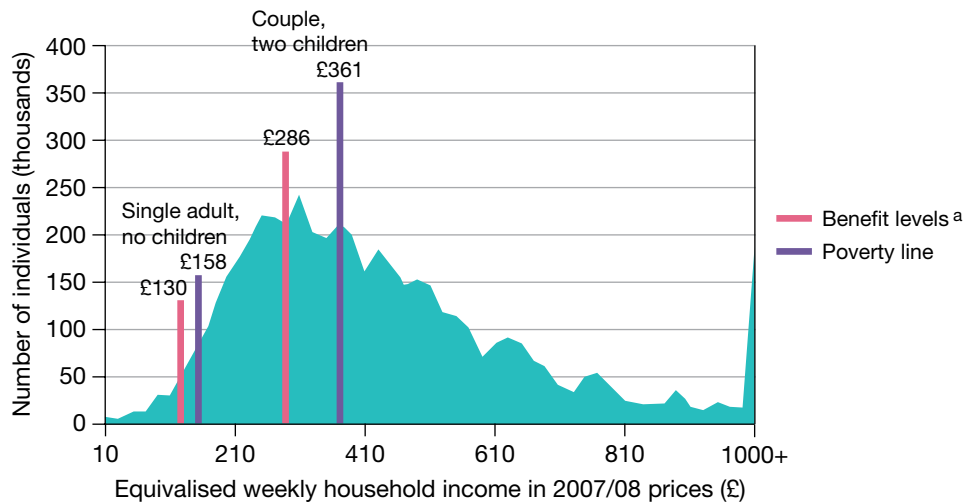
Source: Poverty and Income Inequality in Scotland, 2007/08.¹

- The proportion of children in relative poverty fell (from 28% to 20%).
- The proportion of pensioners in poverty also fell (from 26% to 21%).
- The proportion of working-age people in poverty fluctuated without any sustained trend.

Progress for all age groups has shown little change since 2004/05, raising a question over the ability of current measures to achieve the Scottish Government's target to eradicate child poverty by 2020.⁴

Poverty definitions and social security benefits for different types of household need to be considered against the overall profile of household income in Scotland (Figure 3.9.3). In 2007/08, the median income after tax and before housing costs for all households in Scotland was £392 per week (£20,384 per year). That is, half of the population lived in households with an income below this level. Two-thirds of the population had an income higher than the level of income and housing benefits received by a couple with two children; 93% had an income higher than the benefits received by a single adult with no children.

Figure 3.9.3 **Poverty lines and benefits received by selected household types compared with weekly income of people in all households after tax and before housing costs, Scotland, 2007/08**



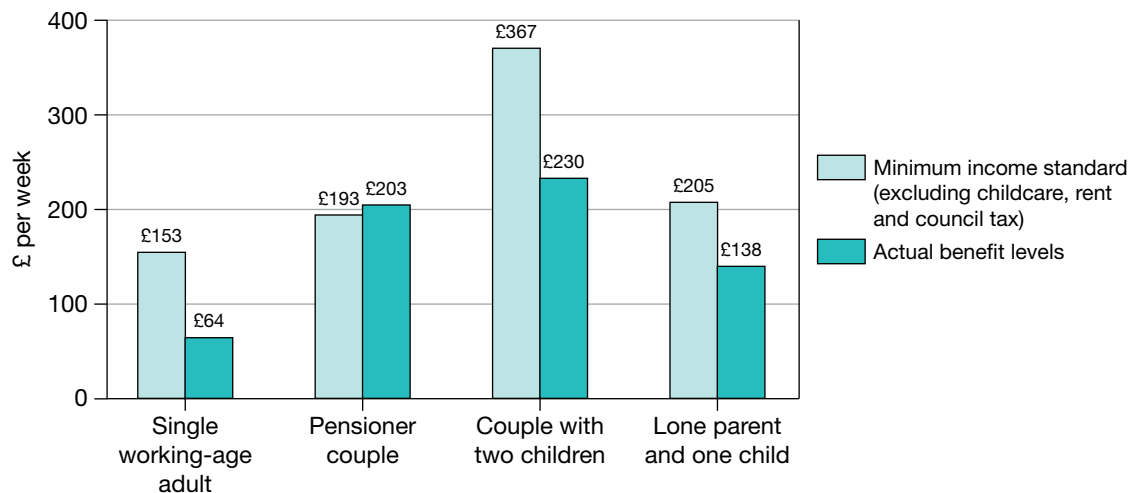
^aBenefit levels show weekly income support payments to *single adult, no children* and *couple, two children* households plus all-claimants average weekly amount of housing and council tax benefit paid in Scotland, May 2007 (£69). Housing benefit/council tax benefit figures are approximations only since the actual amount paid will vary according to household circumstances.

Sources: Department for Work and Pensions: Household Below Average Income 2007/08; Abstract of Statistics for Benefits, National Insurance Contributions, and Indices of Prices and Earnings, 2008; Housing & Council Tax Quarterly Summary Statistics, May 2007.

A completely different approach to the definition of poverty comes from work by the Joseph Rowntree Foundation. This defines a minimum income standard (MIS) regarded by groups chosen to represent people at different life stages and with different household circumstances as necessary to achieve a minimum standard of living in Britain.⁵ The figures are for Britain but provide a reasonable guide to the situation in Scotland.

Figure 3.9.4 compares the MIS with benefit levels for different household types in 2009. Benefit levels fall substantially short of the MIS for all except pensioner households.

Figure 3.9.4 **Minimum income standard compared with out-of-work benefit income, Great Britain, April 2009**



Source: Hirsch *et al.*⁶

Table 3.9.1 shows the gross earnings required to meet the MIS. These figures can be considered alongside three further points:

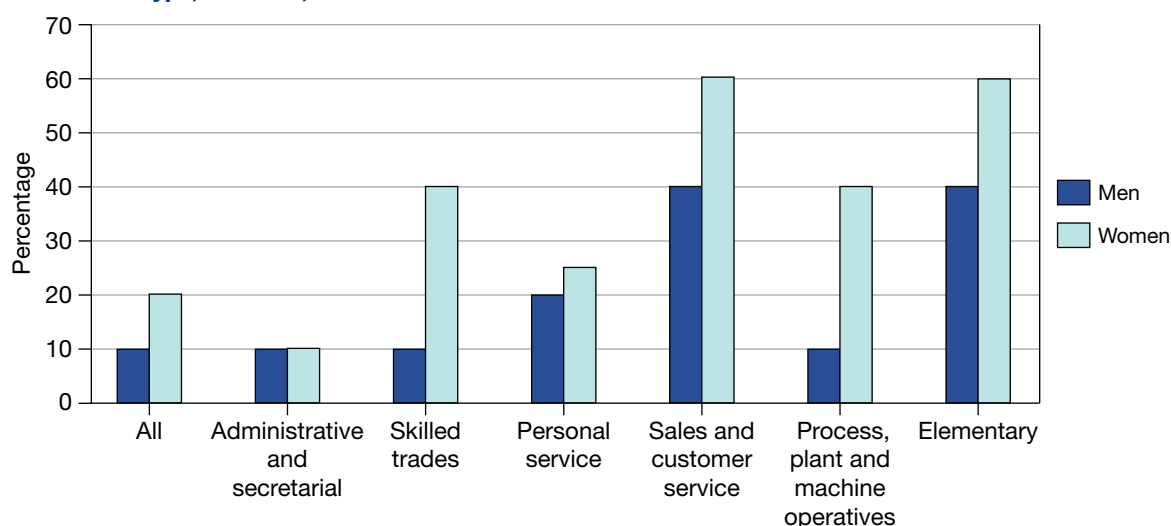
- The statutory minimum wage. The adult rate (22+) is £5.80 an hour from October 2009. (Those under the age of 22 receive less.) This is below the hourly wage necessary to meet the MIS for all three groups.
- The concept of a living wage. The Poverty Alliance (and others)^{7,8} propose that a level of £7 an hour might reasonably be considered a living wage – close to the MIS required for single working-age adults and for a couple family if both parents were working.
- Low pay and in-work poverty. The Poverty Alliance argues that around 700,000 employees in Scotland were low paid in 2008.⁹ An estimated 20% of female and 10% of male employees were paid less than £7 per hour, with high concentrations in particular occupational groups (Figure 3.9.5).

Table 3.9.1 **Gross weekly earnings required to meet the minimum income standard, April 2009**

	Single working-age adult	Couple with two children (single earner; no child care)	Lone parent and one child with child care
MIS (including rent and council tax)	220	460	427
Gross earnings required	266	530	232
Hourly wage needed for 37.5-hour week	7.09	14.13	6.20

Source: Hirsch *et al.*⁶

Figure 3.9.5 **Estimated percentage of employees paid less than £7 an hour by sex and selected occupation type, Scotland, 2008**

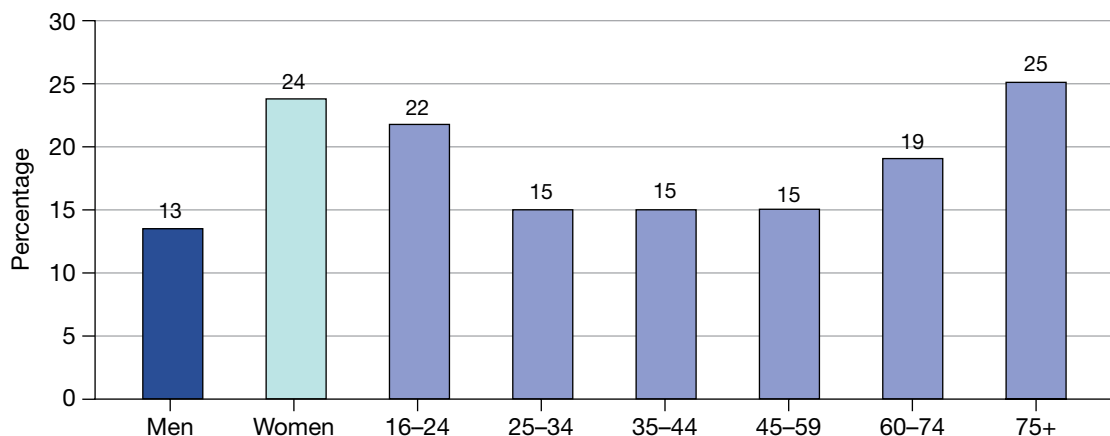


Source: Office for National Statistics Annual Survey of Hours and Earnings 2008.

Age and sex

Poverty in Scotland is unevenly distributed by age and gender. People living in female-headed households, young adults and the oldest pensioners are at greater risk of poverty (Figure 3.9.6). Higher levels of female poverty reflect a greater concentration in part-time, low-paid jobs (partly because of caring responsibilities) and longer life expectancy but lower pension entitlements.⁹

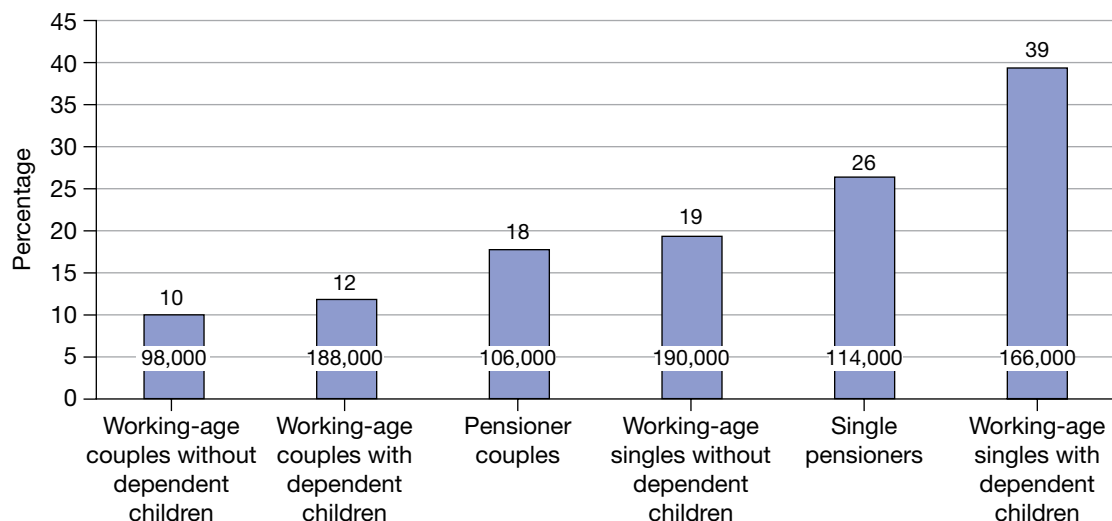
Figure 3.9.6 **Poverty rate (%) by sex and age band, Scotland, 2007/08**



Source: Department for Work and Pensions Household Below Average Income 2007/08.

Household type reflects life stage, which can be a more sensitive measure of circumstances than simply age. Lone parents and single pensioners are at greatest risk of living in poverty, but the largest absolute number of people living in poverty are single working-age people without children (Figure 3.9.7).

Figure 3.9.7 **Percentage and absolute number of people living in poverty by family type, Scotland, 2007/08**



Source: Department for Work and Pensions Household Below Average Income 2007/08; absolute numbers rounded to nearest 1000.

Deprivation

Compared with people living in the rest of Scotland, people living in the 15% most deprived areas were more than twice as likely to be living in relative poverty in 2007/08 (32% against 15%).¹⁰ However, in absolute terms, three-quarters of the poor in Scotland lived outside the 15% most deprived areas.¹⁰

Geography

In 2007/08, people living in urban areas were more likely to be living in relative poverty compared with those in rural areas (18% against 14%).¹⁰ However, poverty related to *low pay* appears to have a rural bias in Scotland. Using a threshold of £7 an hour as a definition of low pay, the proportion of employee workers who are low paid is highest in Clackmannanshire, Highland, Dumfries and Galloway and the Borders.¹¹

At local authority level, tax credit and benefit claimant data from HM Revenue and Customs can be used to indicate levels of child poverty. The estimated number of poor children on this measure is higher than is derived using estimates of total household income. In eight local authorities, more than 50% of children are living in poverty (Figure 3.9.8). Only in four local authorities is it fewer than one-third.

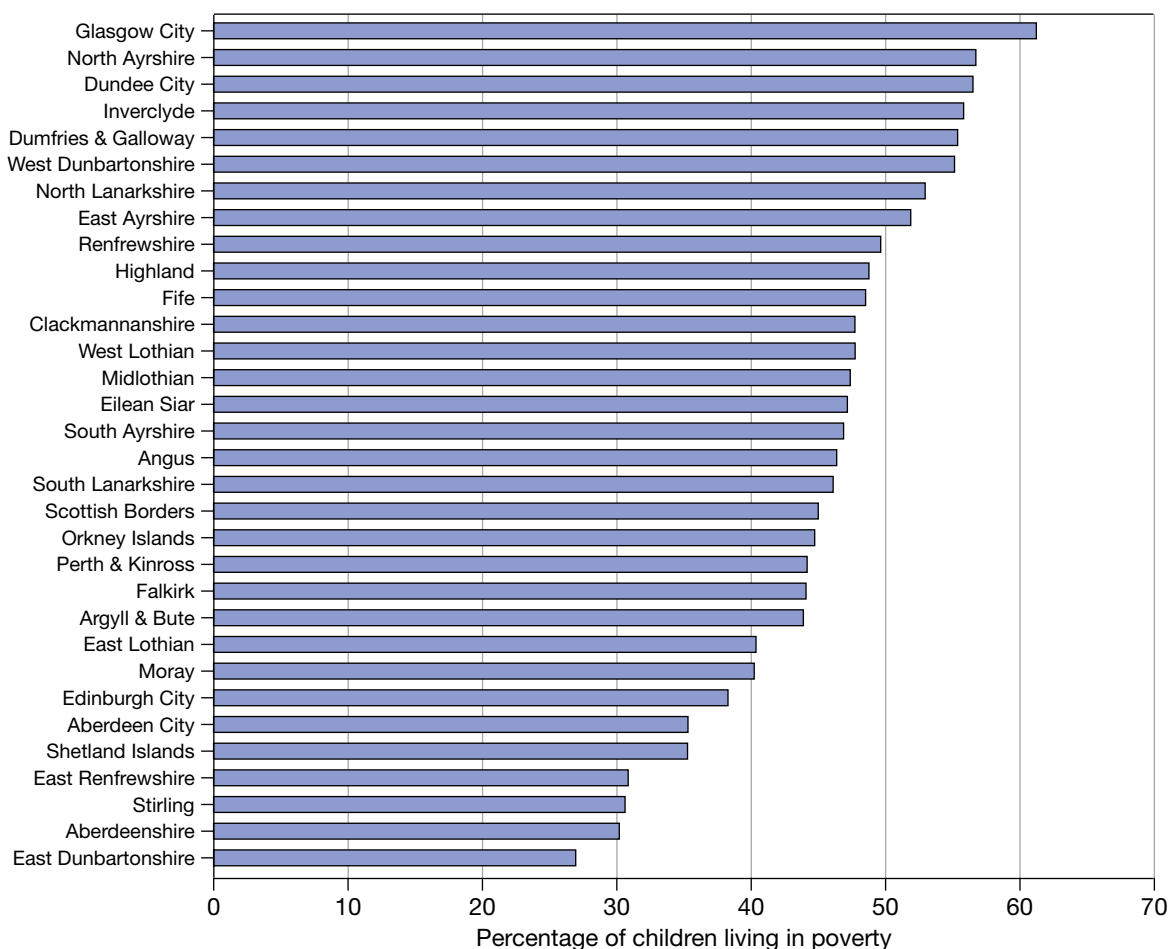
Some health challenges

Poverty taints health throughout the life course and tracks across generations: children from poor households are more likely to become parents in poor households.¹² Babies born into poverty are twice as likely to die before their first birthday as babies not from poor households, and their risk of 'sudden infant death' is ten times higher. Three-year-olds in families with an annual income of less than £10,400 are more than twice as likely to suffer life-limiting chronic illness and twice as likely to suffer from asthma as those in households with an annual income of more than £52,000. Children from poor families are nearly three times as likely to experience mental and behavioural problems as those from more affluent backgrounds.¹²

The Growing Up in Scotland survey found that children in low-income households had higher mean scores on the difficulties section of the Strengths and Difficulties Questionnaire.¹³ Babies, but not toddlers, were more likely to have had one or more accidents in the last year if they lived in a low-income household.¹³ And children in low-income households in Scotland were more likely to have a long-standing illness/disability.¹³

Although there is some evidence of equalisation of health measures among adolescents from different backgrounds,¹⁴ poverty is still important in determining future health prospects for this age group. In 2006, 15-year-olds in receipt of free school meals were, compared with those not receiving free school meals, more likely to report that they had ever been drunk (80% versus 72%), that they had taken drugs in the last month (19% versus 12%) and that they smoked (30% versus 20%).^{15,16} In addition, adults who experienced poverty in adolescence are more likely to be poor in their early 30s, with the association stronger than that seen for childhood poverty.¹⁷

Figure 3.9.8 **Proportion of children (aged 0–19) living in low income households by local authority, 2008/09**



Source: HM Revenue and Customs Child and Working Tax Credits Statistics, Geographical analyses, April 2009; General Register Office for Scotland mid-year population estimates for 2008.

Some adult health behaviours in Scotland, such as smoking or having a diet low in fruit and vegetables, are strongly patterned by relative poverty, with a clear gradient from high-income households, with a higher prevalence of healthy behaviours, to low-income households.¹⁸ Decreases in income make it more difficult for people to eat healthily.¹⁹ In the case of some health behaviours, however, the relationship is more complex, with no or inconsistent associations between income and behaviour. Obesity (defined as a body mass index of 30+) is associated with household income differently for men and women. The prevalence of obesity is lower among women whose household income is high, whereas for men it is lower if their household income is low.¹⁸ Regarding alcohol consumption, those in higher income groups appear to be more likely to exceed weekly drinking limits.²⁰ Given that alcohol-related harm – death and hospital admission – is highest among the least well-off in Scottish society,²¹ this merits further exploration.

Living in relative poverty reduces the capacity of individuals to flourish mentally. Adults in the poorest quintile of the population of the UK are twice as likely to develop mental illness as those on average incomes.²² In Scotland, the prevalence of common mental health problems is more than twice as high in adults living in low-income households as in high-income households, with the gradient most pronounced for women.¹⁸ This might occur through a sense of frustration and anxiety when people are unable to afford things others

take for granted (even if they are working full-time), have constrained opportunities for 'escape' (e.g. meeting friends or taking a break), have worries about debt and the future or feel stigmatised for being poor.²³

Health improvement opportunities

Child poverty and pensioner poverty in Scotland has fallen over the last decade, though the rate of progress had stalled even before the onset of the recession. According to the WHO, among rich nations, 'countries with more generous social protection systems tend to have better population health outcomes'.²⁴ There is strong evidence that more generous welfare regimes can help promote mental wellbeing and maintain the health of the unemployed (as measured by self-reported health and distress).²⁵⁻²⁸ Britain does not have a generous social security system by comparison with countries such as Germany, where health inequalities are lower and the health impacts of economic adversity are less severe both personally and nationally.^{28,29} However, there is little evidence of public or political appetite for a more generous egalitarian approach in Britain. On the contrary, public support for redistribution and sympathy for the poor declined between the mid-1990s and 2006.³⁰

Health improvement projects, especially those rooted in local communities such as Keep Well, can improve incomes directly by ensuring full take-up of social security entitlements for those not in employment or on low pay.³¹

For working-age people, employment is often seen as the best route out of poverty.³² However, being in work does not automatically protect against poverty: 40% of working-age people in poverty in Scotland live in a household where at least one person works.³³ Part-time workers (especially women) and those working in certain industries (hospitality, tourism, agriculture) are especially vulnerable.^{34,35} In the longer term, investment in skills and the availability in all parts of the country of a variety of employment opportunities might be the best way to mitigate the health problems associated with working age and child poverty.³⁶ As a major employer, the NHS can play a part by promoting and supporting employability initiatives.³⁷

Local services and projects can pursue measures that reduce the cost of engaging in healthy activities, e.g. free swimming sessions, healthy food co-operatives.³⁸ There is also a financial benefit to individuals from some behaviour changes, though the rationale for the NHS supporting people to change behaviours such as infant bottle feeding or smoking is to improve health not to reduce personal expenditure.

Such actions can reduce some of the material disadvantage of being poor. Health projects run using community development models can also have some local impact on the poverty of power that accompanies material poverty.³⁹

Conclusion

A variety of data sources are available on poverty in Scotland.⁴⁰ These are extensively used by the government and by civic society. However, information alone is insufficient to bring about change in the absence of popular support, and hence of political voice, for more egalitarian policies.

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All web links were verified as working on 17 September 2009.

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3.10 Prisoners

Key points

- In 2007/08, the average daily population in Scottish prisons totalled 7,376, the highest annual level ever recorded.
- Over the ten-year period 1998/99 to 2007/08, the average daily prison population increased by 22%. The female prison population increased more quickly than the male.
- 95% of prisoners in Scotland are men.
- Almost 90% of the prisoner population in Scotland is under age 45.
- People in prison are likely to come from the most deprived areas of Scotland.
- Prisoners have higher levels of a range of physical health and addiction problems. Almost half are likely to have an alcohol problem; four-fifths are smokers, and almost seven in ten have used drugs in the 12 months prior to entering prison.
- There is a considerable burden of mental health problems in Scottish prisons.
- Some health behaviours may deteriorate in prison, although many prisoners are able to obtain help with addictive behaviours and mental health problems.
- Prison presents a setting with substantial health promotion opportunities, though for maximum effect this needs to go hand in hand with improvement in post-release care and in the health-enhancing capacity of the environments and cultures from which prisoners come and to which they return on release.
- A start has been made on developing information on prisoner health. The challenge is to build on this to improve understanding of and action on prisoner health.

Definitions

A prisoner is a person who has been legally committed by a court of law to a penal establishment – a place in which individuals are physically confined and usually deprived of a range of personal freedoms. There are two main types of prisoners: remand and sentenced. *Remand prisoners* have not been convicted of any offence but are detained in custody until the charges against them have been heard. This is because they have been denied, refused, or are unable to meet, conditions of bail. *Sentenced prisoners* have been convicted of an offence and directed by a court to spend time in prison.

Introduction

Most prisoners in Scotland are young, white men who come from the more deprived areas of Scotland. They display, to a far greater extent than the general population, patterns of behaviour that are known to be harmful to health, intersecting with complex health problems such as mental illness and blood-borne viruses.¹ Graham’s major assessment of prison health in Scotland states: ‘Prisoners in Scotland are a unique population.’² It follows that they – and the prison setting – present both unique health challenges and unique health improvement opportunities.

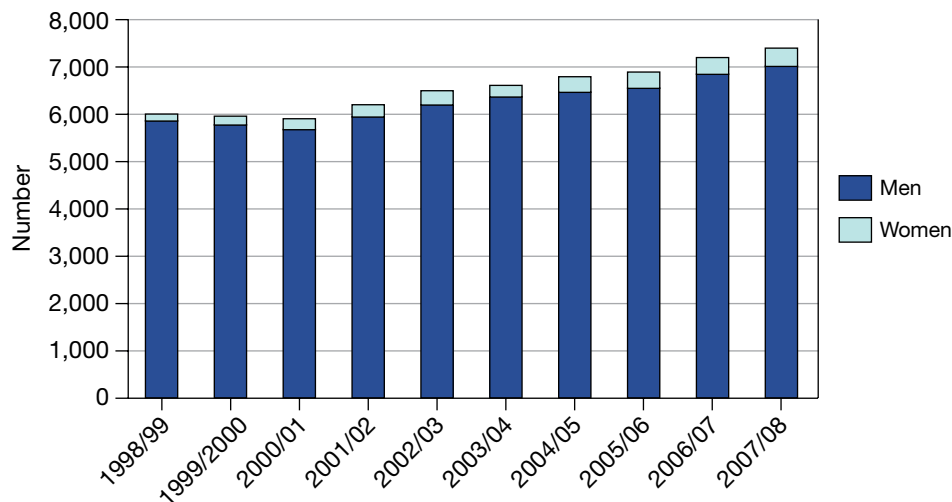
The concept of prison as a setting for health promotion has been acknowledged both nationally and internationally.³ It has been suggested that prisons can make a major contribution to improving the health of some of the most disadvantaged and excluded individuals in society,^{4,5} and so help to tackle health inequalities, though some commentators see this as problematic.^{6,7} This chapter describes the prisoner population in Scotland and the major health improvement challenges and opportunities it presents.

Population

In 2007/08, the average daily population in Scottish prisons was 7,376, the highest annual level ever recorded. Of these, 7,005 (95%) were men and 371 (5%) were women. Over the ten-year period 1998/99 to 2007/08, the average daily prison population increased by 22% (Figure 3.10.1). The female prison population increased by 87%: over four times the 20% growth experienced in the male prison population.

Of the average daily prisoner population in 2007/08, 5,816 (79%) were under sentence and 1,560 (21%) were on remand. Young offenders (aged 16–21) accounted for 14% of the average daily prison population and they were more likely to be on remand (34%).

Figure 3.10.1 Average daily population in penal establishments, Scotland, 1998/99 to 2007/08

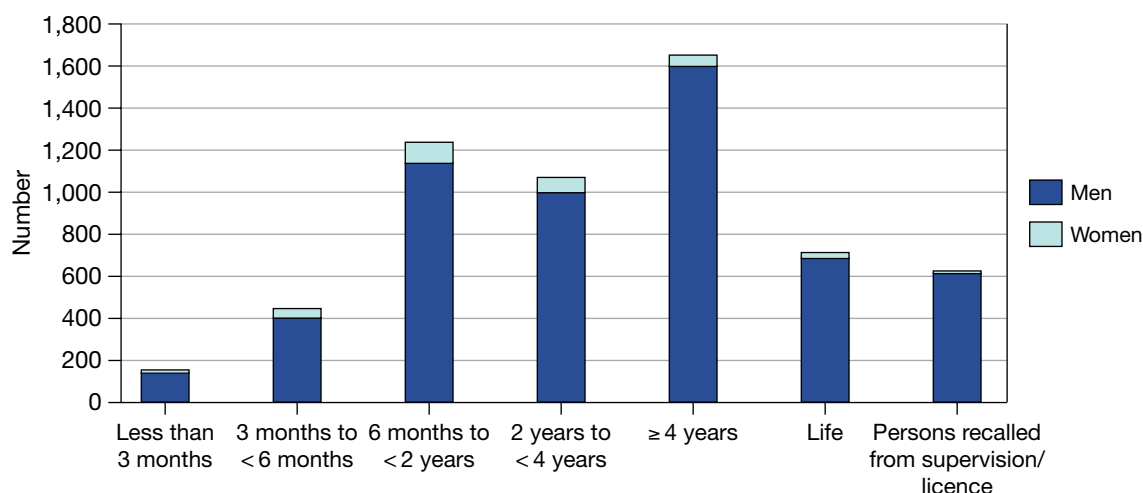


Source: Prison Statistics Scotland, 2007/08.

The number of long-term prisoners – those sentenced to four years or more (including life sentences and recalls) – averaged 2,960. The number of short-term prisoners, serving sentences of less than four years, was 2,855 (Figure 3.10.2).

The most common causes of imprisonment are non-sexual crimes of violence. Serious assault and attempted murder is the main crime for 16% of sentenced prisoners, homicide for 14% and drug-related crimes for a further 14%.⁸

Figure 3.10.2 Average daily population in penal establishment by length of sentence, Scotland, 2007/08



Source: Prison Statistics Scotland 2007/08.

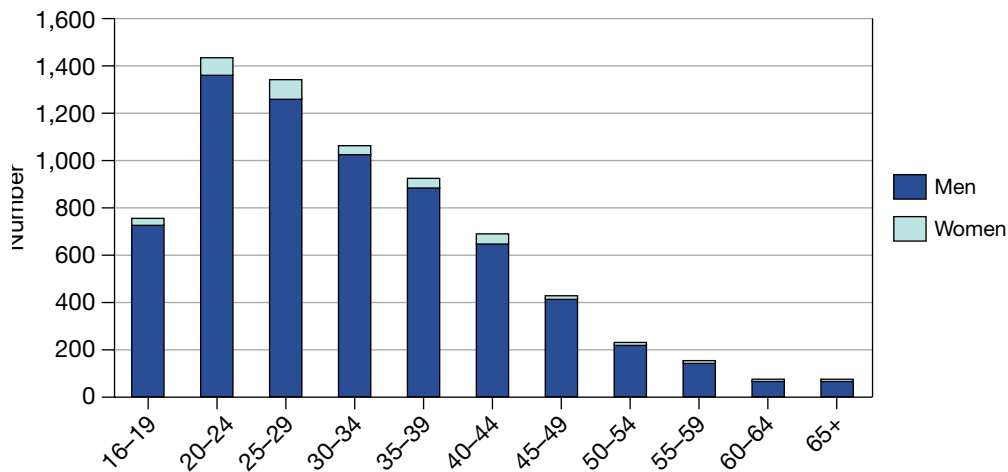
Age and sex

The prisoner population in Scotland predominantly consists of young men (Figure 3.10.3). Almost 90% of the total prisoner population is under the age of 45, nearly two-thirds under age 35. Based on the prisoner population aged 16–44 in mid-2007, and mid-2007 estimates of people of the same age in the general population, the imprisonment rate in Scotland for men is 590 per 100,000 compared with 31 per 100,000 for women.^{8,9}

Deprivation

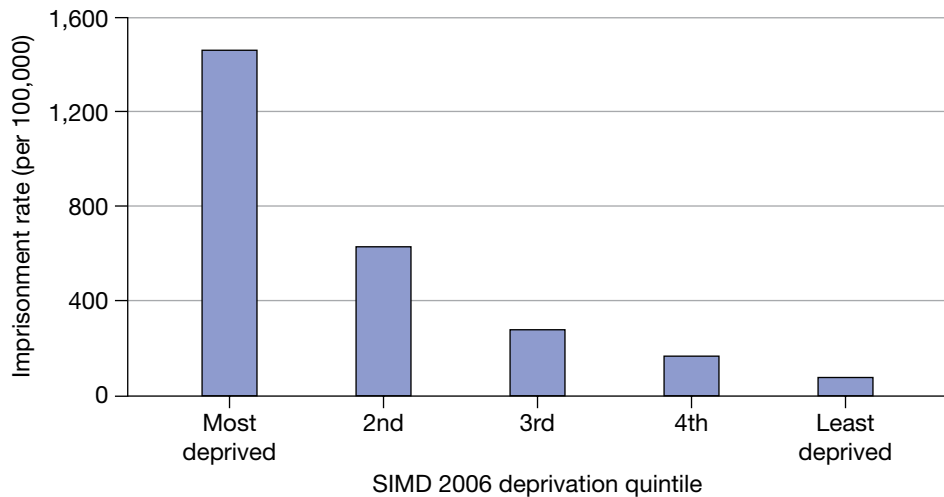
People in prison are more likely to come from deprived areas (Figure 3.10.4). At all ages up to about 60 (at which point numbers become very small) there is a strong and consistent association between imprisonment rate and deprivation.¹⁰ Based on data from 2003, it has been estimated that each year about one in nine men aged 22–24 from the most deprived 27 wards in Scotland (2.2% of all wards) will spend some time in prison.¹⁰

Figure 3.10.3 Average daily population in penal establishment by age and sex, Scotland, 30 June 2007



Source: Prison Statistics Scotland 2007/08.

Figure 3.10.4 Imprisonment rate of men aged 16–44 (per 100,000), by deprivation quintile, Scotland, 30 June 2007

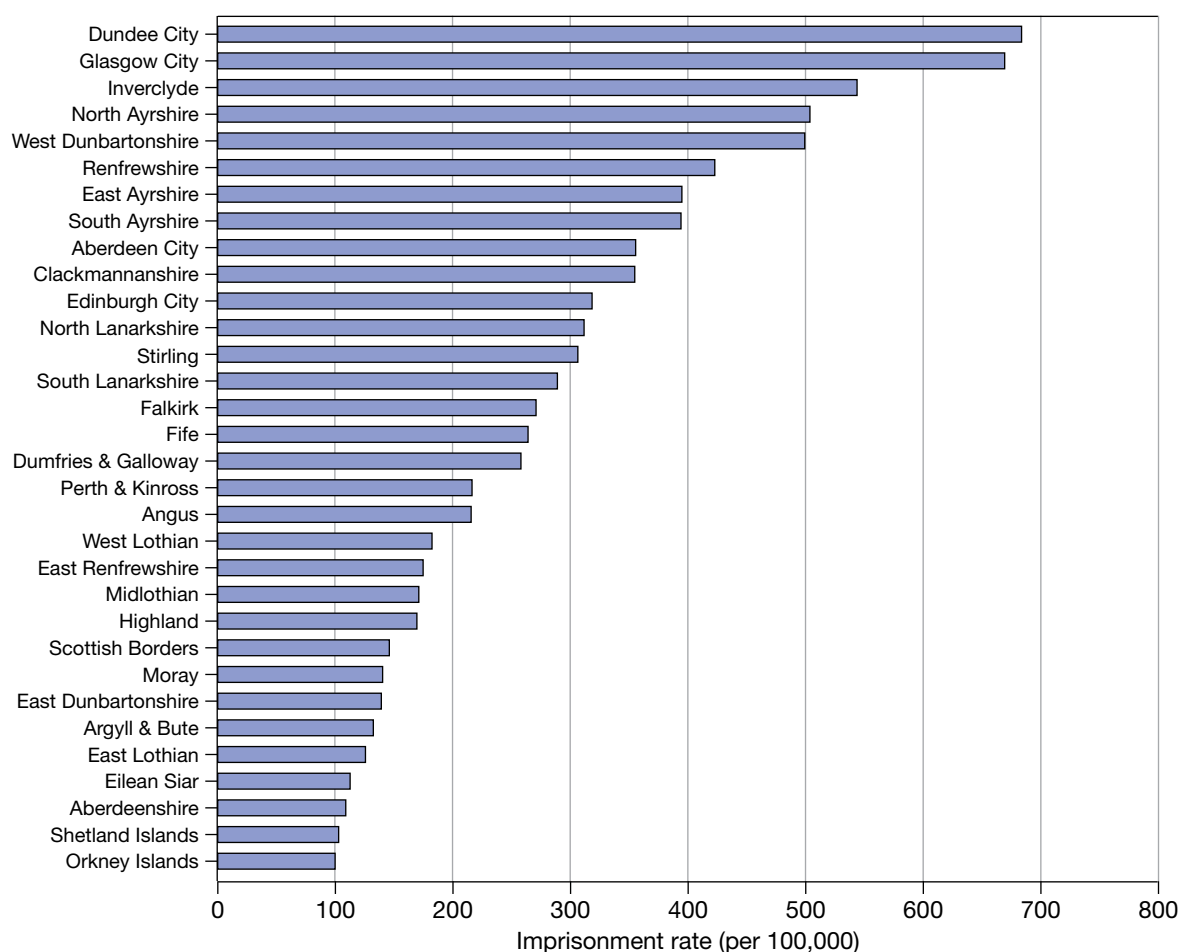


Source: Scottish Government Justice Analytical Services.

Geography

Glasgow City accounts for 21% of Scotland’s prisoner population despite having only 14% of Scotland’s male population aged 16–44. Dundee has the highest imprisonment rate in Scotland, although west central Scotland and Ayrshire account for seven of the ten local authorities with the highest imprisonment rates (Figure 3.10.5). Rural and suburban local authorities have the lowest rates.

Figure 3.10.5 **Imprisonment rate per 100,000 population (men aged 16–44) by local authority, Scotland, 30 June 2007^a**



^aThe numerator is all prisoners of all ages and both sexes. The denominator is the male population aged 16–44.

Source: Prison Statistics Scotland 2007/08; General Register Office for Scotland mid-year population estimates, 2007.

Some health challenges

Compared with the general population of men aged 16–44 (who are used hereafter as the baseline for comparison unless otherwise stated, as 82% of prisoners are men aged 16–44), prisoners have poor health on physical, mental and social dimensions.²

There are high rates of blood-borne viruses, asthma, epilepsy, prescribing for dyspeptic symptoms, sexually transmitted infections and dental decay.²

Substance use is common. The proportion of Scottish prisoners with an alcohol problem (45%)¹¹ is three times that of the general population (15%).¹² Four-fifths of prisoners (79%) are smokers compared with 33% of the general population.^{13,14} Nearly half (48%) of prisoners are either dependent on drugs or have a history of drug dependence.² Over two-thirds (69%) report using illegal drugs in the past 12 months (prior to entering prison),¹³ compared with 23% in the general population (men aged 16–44).¹⁵ One-quarter (26%) reported that they have used drugs in the past month in prison.¹³

Drug misuse figures are from self-reports by prisoners, but their veracity is confirmed by results from objective drug testing on a sample of prisoners each year. In 2007/08, 64% of those tested on entering prison were positive for illegal drug use, which is similar to the 69% self-reporting drug use in the past 12 months.^{13,16} One-quarter (26%) of those tested on release were positive for illegal drug use, similar to the rate of self-reported drug use in prison.²

Considerable overlap exists between the populations who have contact with mental health services and those who have contact with the criminal justice system.¹⁷ The scale of overlap is difficult to determine and depends on how 'mental health problems' are defined. *Prison Health in Scotland* reported that 14% of prisoners have a history of psychiatric disorders whereas 7% have a history of self-harm, including attempted suicide, though it notes that under-recording is likely, particularly given the high level of drug prescription for depression and psychosis within Scottish prisons compared with the general population.²

Many aspects of the prison environment are likely to be detrimental to mental health: these include overcrowding, lack of privacy, enforced solitude, the threat of violence, lack of meaningful activity, isolation from social networks and insecurity about the future.^{18,19} Notwithstanding this, around 70% of prisoners in Scotland in 2008 reported that they were dealing with their problems well, were optimistic about the future and felt relaxed at least 'some of the time'.¹³ But half of prisoners reported feeling interested in other people and feeling loved either 'none of the time' or 'rarely'.¹³

Many prisoners come from socially chaotic backgrounds.² Many have never worked, nor have their parents.¹ They are more likely to have been in the care system as children. They have a poor school record and few qualifications. They have low literacy. Their social networks normalise criminality. Women prisoners, particularly, are likely to have experienced physical, sexual and emotional abuse as children and adults.²⁰

One of the major challenges to improving prisoner health in a sustained way is that most return from prison to the same social and cultural environment in which they were embedded prior to receiving a prison sentence.¹⁰

Health improvement opportunities

One might, naively, assume that the controlled environment of prison would facilitate – perhaps even enforce through absence of choice – improved health behaviour. Such an assumption cannot be made. Over half of the smokers in prison smoke an increased amount while in prison; only one in five smokes less.²¹ Fruit and vegetable consumption is self-reported as much lower in prison than prior to entry,²¹ although the reported levels prior to entry appear exaggerated compared with the general population (men aged 16–44).¹² The prison service budget is very constrained and the usual prisoners' diet choices are poor,²² yet half of those responding to the prisoner survey in 2008 wanted to see fish and fruit more on the menu compared with one-third who wanted to see chips more.¹³ There is a clear opportunity here in that life in prison should, at least, not be less healthy than life 'outside'.

Many prisoners report having been offered help for addiction problems: 4,523 prisoners (18.5% of admissions) accepted and undertook an addictions assessment in 2007/08;¹⁶ 33% of all prisoners had been offered help for alcohol (21% had received treatment); 33% had been given the chance to attend smoking cessation services; and 40% were provided

with the opportunity to receive treatment for their drug use (35% received some form of treatment).²³ Six in ten prisoners (61%) who reported mental health problems indicated that they had been given the chance to receive help for their problems, and the majority of these reported that they had accepted the help on offer (89%).²¹ As with health improvement generally, it may be easier to deliver evidence-supported interventions that focus on individual behaviour change than to trigger deeper change in the environments and cultures that create the conditions for adverse behaviours to thrive.

A key challenge for a deeper process of change is to ensure that health and addiction services are integrated within prison and that through-care is effective across the country for those on release.² Beginning a process of individual change in prison can have limited impact if constantly undermined by prisoners returning to communities where the environment and culture prompt, even promote, relapse. The criminal justice statistics are stark: 50% of prisoners are reconvicted within two years of release.²⁴ There are no comparable statistics on health behaviours, but why should they be better?

Nonetheless, there is an appetite for health improvement interventions in prisons which, appropriately presented, could improve both health and future life chances by building confidence, hope and purpose.¹⁸ This makes it all the more regrettable that, of 13 health care standards for the Scottish Prison Service, the standard on health promotion has the second lowest level of achievement at under 70%² (though many of the other standards are also relevant to health improvement).

Although specifically writing about mental health, the words of Fraser *et al.* offer a vision applicable to prison health improvement more generally:

the importance of supporting, encouraging and initiating feelings of hope ...
Encouraging a realistic confidence that things can be better; that they can, in
most cases, recover and that they have a worthwhile future...¹⁸

Conclusion

A start has been made on developing information on prisoner health, particularly with the 2007 health needs assessment.² The challenge is to build on this to develop more robust and comprehensive routine health needs and care information, with in-depth work on particular areas such as mental health. This will provide better understanding of and action on prisoner health.

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All web links were verified as working on 17 September 2009.

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3.11 Religion and belief

Key points

- In 2001, people in Scotland reported their current religion as Church of Scotland (42%), none (28%), Roman Catholic (16%) and other Christian (7%). Muslims were the largest non-Christian faith group in Scotland – 0.8% of the population.
- Christians and Jews are older, on average, than those of other religions or of none.
- Hindus, Jews, Muslims and Sikhs are more concentrated in large urban areas than people of other faiths. Roman Catholics are more likely to live in large urban areas than other Christian denominations.
- There are some marked local differences across Scotland in the distribution of religions.
- Roman Catholics and Muslims are more likely to live in more deprived areas, with 55% of Roman Catholics and 47% of Muslims living in the most deprived two quintiles.
- A variety of differences in health and risk factors can be demonstrated in Scotland. For example, self-reported poor health and limiting long-term illness appear to be consistently higher among Muslims, Sikhs and Roman Catholics. Smoking rates are highest for Roman Catholics and those of no religion. Women of some faiths show heightened levels of mental distress not paralleled by male distress rates. The extent to which such patterns are directly attributable to or mediated by religion is an open question.
- Faith groups and settings may offer scope for health promotion alliances and interventions.
- There is relatively little information on health and religion or belief in Scotland. The agreed use of a standard question in all major surveys will lead to improved information.

Definitions

The definitions given by the Fair for All Religion and Belief Project¹ are:

- Religion: a common core of shared beliefs and rituals that ‘binds together’ a group of people in their obedience to or worship of a supernatural power considered to be divine (often referred to as ‘God’).
- Belief: a personal conviction or understanding about something, such as ‘is there any meaning to life?’. It is often accepted without necessarily any proof. Religions are beliefs, but so are agnosticism, atheism and humanism.

Within the NHS, the broader idea of the 'spiritual' has been embraced. It is defined as

a natural dimension of what it means to be human, which includes the awareness of self, of relationships with others and with creation ... Spiritual care is not necessarily religious. Religious care should always be spiritual. Spiritual care might be said to be the umbrella term of which religious care is a part.²

Most population statistics presented here are from the question on current religion in the 2001 census.³ For some health behaviours and measures of morbidity in this section, comparisons are made using the Scottish Health Survey 2003 for Christian denominations and the Health Survey for England 2004 for Muslims, Buddhists, Sikhs and Hindus, because of small sample sizes for these religions in the Scottish Health Survey.

Introduction

There is increasing interest in the interaction between religion and health. One review of the available evidence in the late 1990s suggested that 'religion, in a broad sense, represents a protective factor that offers a small but significant primary-preventative effect against morbidity in populations'.⁴ A number of explanations have been proposed for why this might be the case. Religion's strictures might influence health behaviours directly, typically to discourage or reduce those that might be a risk factor for health. Religion might also increase social health, by increasing the range and depth of social supports available in stressful situations (and thus limit the substitution of harmful means of coping).⁴ Regular engagement in religious activities may have a positive impact on health.⁵⁻⁷ Religion, or other beliefs or unorganised forms of spirituality, might provide an intrinsic source of peace, strength, contentment or wellbeing, for example by providing a lens through which sense is made of the world and by which an individual defines his or her place in it, with benefits to health.^{8,9}

It remains unclear to what extent the existing evidence base, mostly American in origin, can be applied to the Scottish population.^{vii}

There is some suggestion that census figures overstate the true level of religious adherence by including all levels of adherence from nominal to full commitment.¹⁰ To the extent that this is the case, it would also dilute the visibility in the statistics of any association between religion and health or other factors because nominal adherents are unlikely to be following the requirements of a faith as closely as are those with an active commitment.

Population

The 2001 census asked two voluntary questions on religion: 'What religion, religious denomination or body do you belong to?' and 'What religion, religious denomination or body were you brought up in?'¹¹ Ninety-five per cent of respondents answered the question on current religion. The most common religions were Church of Scotland, none, Roman Catholic and other Christian (Table 3.11.1). Muslims are the largest non-Christian religion in Scotland, but still constitute less than 1% of the population.

vii The 2006 World Values Survey reported that 71.6% of Americans thought that religion was very important or rather important in life compared with 40.7% of Britons (www.worldvaluessurvey.org).

Table 3.11.1 Population by current religion, Scotland, 2001

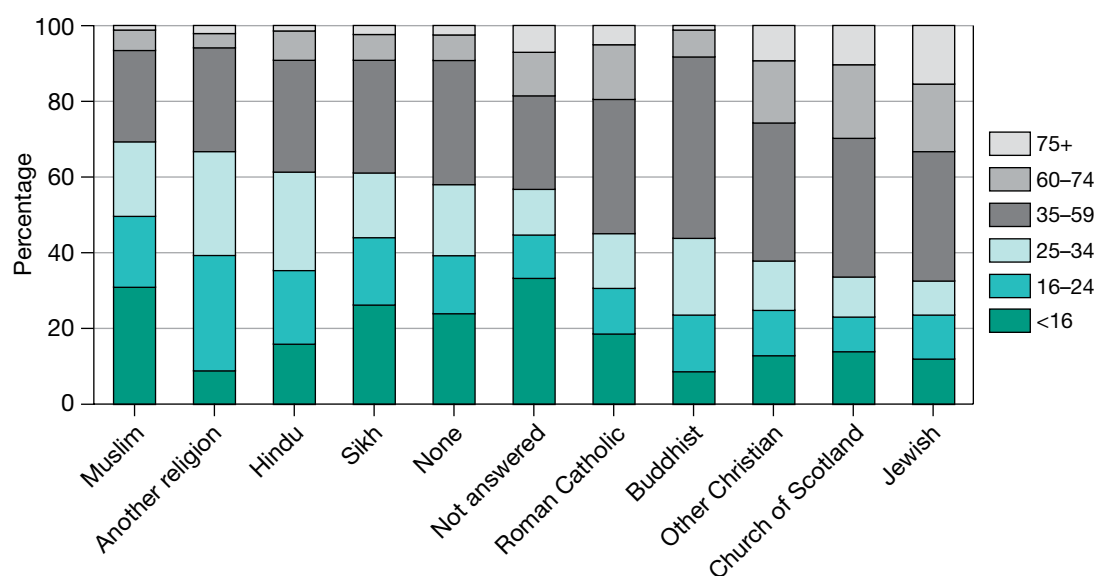
	<i>N</i>	%
Church of Scotland	2,146,251	42.4
Roman Catholic	803,732	15.9
Other Christian	344,562	6.8
Muslim	42,557	0.8
Buddhist	6,830	0.1
Sikh	6,572	0.1
Jewish	6,448	0.1
Hindu	5,564	0.1
Another religion	26,974	0.5
None	1,394,460	27.6
Not answered	278,061	5.5
Total	5,062,011	100

Source: General Register Office for Scotland.

Age and sex

At the time of the 2001 census, people who identified themselves as Christian or Jewish had an older age distribution than other religious groups (Figure 3.11.1). For example, 38% of other Christians, 34% of Church of Scotland Christians and 33% of Jews were under the age of 35, compared with 69% of Muslims, 67% of those mentioning another religion and 61% of both Hindus and Sikhs. Those declaring they had no religious affiliation also had a youthful age distribution.

Figure 3.11.1 Population by religion and age group, Scotland, 2001

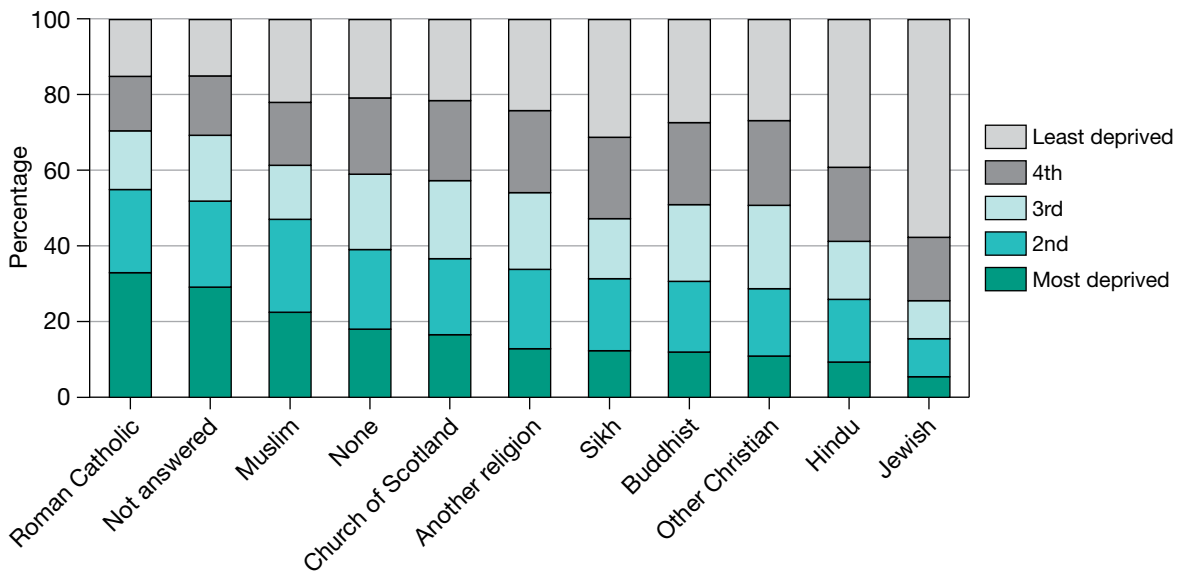


Source: General Register Office for Scotland.

Deprivation

People identifying as Roman Catholic and Muslim are more likely to live in more deprived areas, with 55% of Roman Catholics and 47% of Muslims living in the two most deprived quintiles (Figure 3.11.2). Jews and Hindus are particularly likely to live in less deprived areas: 57% and 39%, respectively, live in the least deprived quintile. Other Christian faiths, Buddhists and Sikhs are also disproportionately represented in the least deprived quintiles.

Figure 3.11.2 Population by religion and deprivation quintile, Scotland, 2001



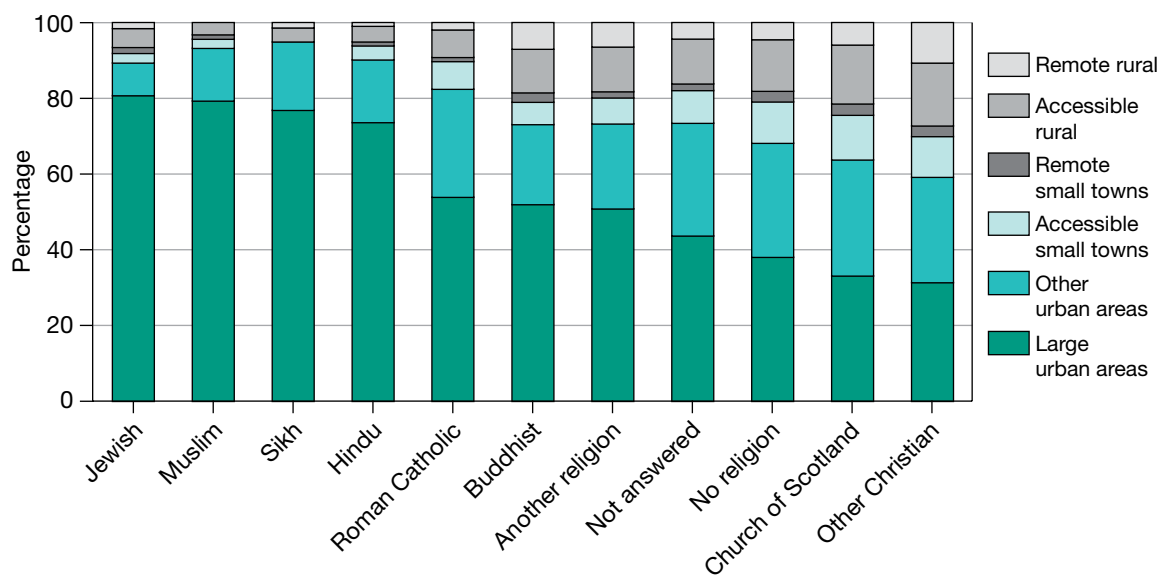
Source: General Register Office for Scotland.

Geography

Hindus, Jews, Muslims and Sikhs are more concentrated in large urban areas than followers of other faiths (Figure 3.11.3). Within the Christian faith, Roman Catholics are more likely to live in large urban areas than Church of Scotland followers (54% versus 33%).

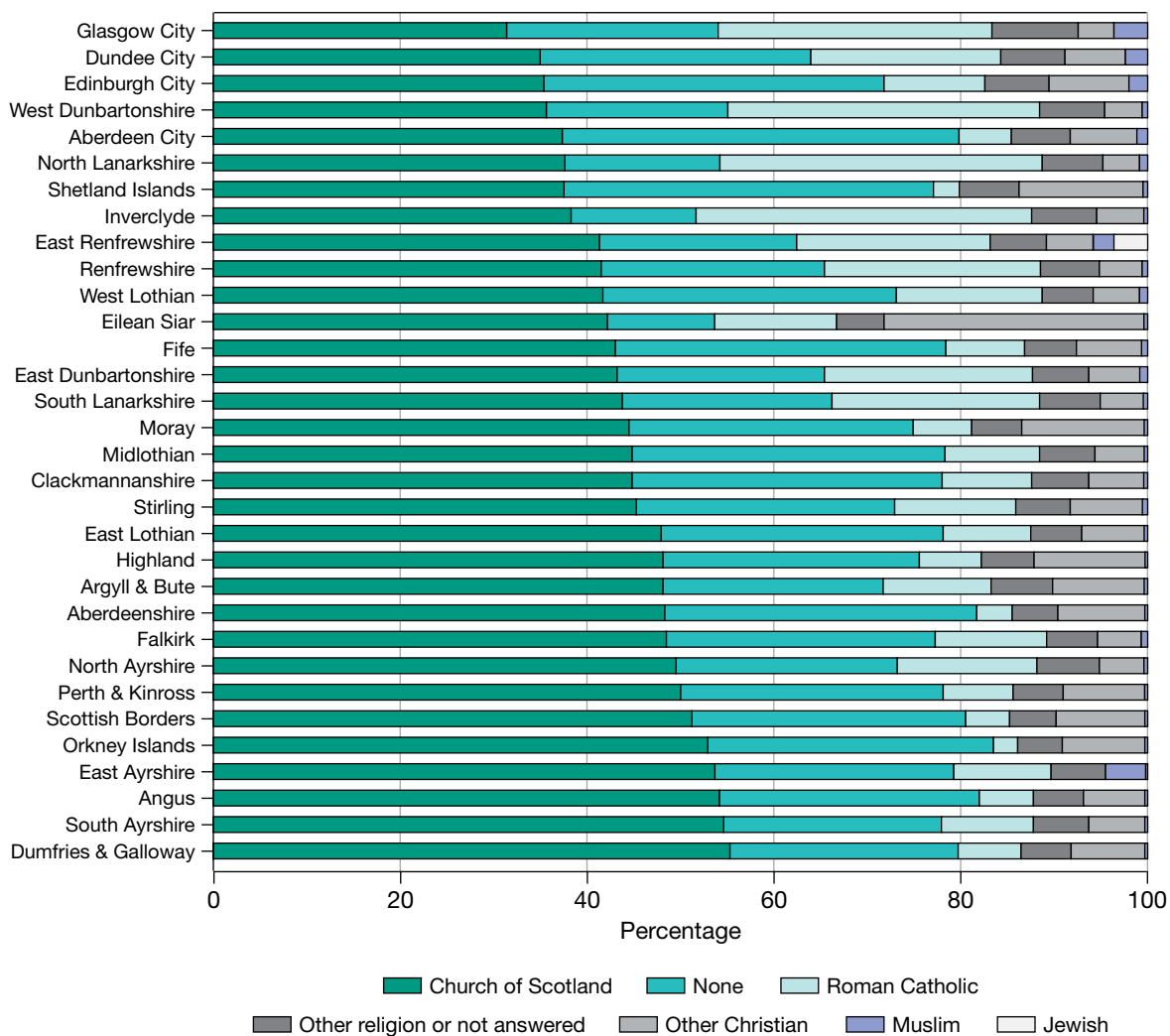
Across local authorities, there are both broad patterns of religious affiliation and very specific local detail (Figure 3.11.4). There is a broad pattern for Roman Catholics, with higher proportions in west central Scotland, especially in areas of former heavy industry, which reflects the pattern of nineteenth- and early twentieth-century migration from Ireland and the Highlands. Other Christian followers, mainly smaller Presbyterian denominations, are more common in rural areas. Local detail is seen in the concentration of Jews in East Renfrewshire, making up 3.5% of the population compared with just 0.1% in Scotland as a whole. There is a concentration of Muslims in the large cities, but also in East Renfrewshire.

Figure 3.11.3 Population by religion and urban–rural classification, Scotland, 2001



Source: General Register Office for Scotland.

Figure 3.11.4 Population by current religion and local authority, Scotland, 2001



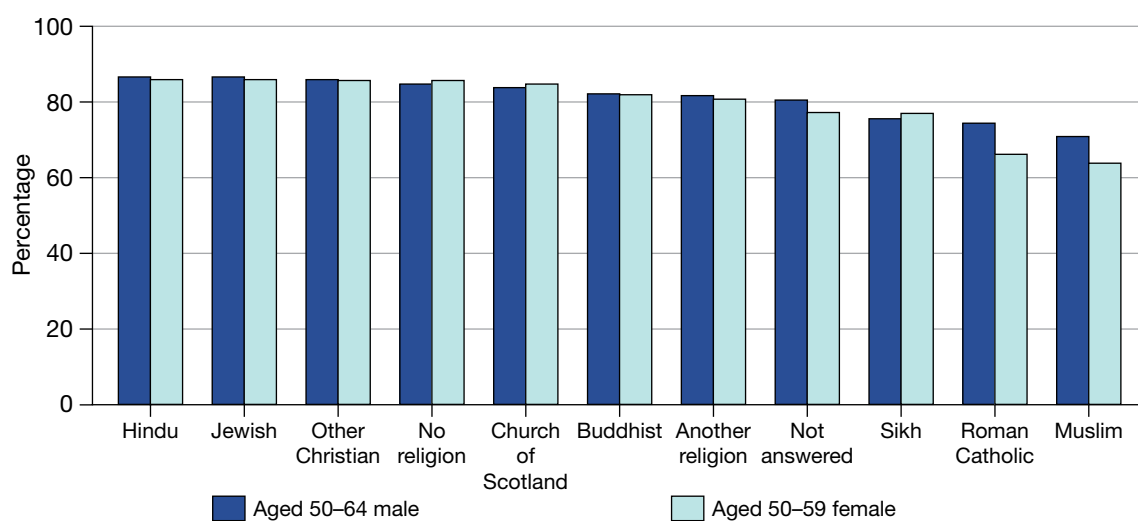
Source: General Register Office for Scotland.

Some health challenges

A comprehensive review of the evidence on the inter-relationship between religion and health found substantial evidence that religious involvement was associated with increased wellbeing, self-esteem, adaptation to bereavement, social support and marital stability and satisfaction and with less loneliness, depression, anxiety, schizophrenia and other psychoses, alcohol and drug abuse, and delinquency and crime, and with fewer suicides.¹²

Later working life is a period when inequalities in chronic health conditions become evident. Muslims, Sikhs and Roman Catholics in Scotland are less likely to assess their health as 'good or fairly good' at age 50–59 (women)/50–64 (men) (Figure 3.11.5). A similar pattern is seen for limiting long-term illness (LLTI), with Sikhs and Roman Catholics consistently reporting higher rates and Jewish people lower rates than the Scottish average.³ Between the ages of 50 and 74, Muslims of both sexes have the highest rates of reported LLTI, whereas between the ages of 30 and 49 Muslim women report high levels of LLTI but Muslim men are similar to the Scottish average. The small number of older Hindus have very high rates of reporting LLTI (and poor self-assessed health) even though Hindus below state pension age are among the least likely to report a LLTI. This may reflect a particular migration cohort passing through old age.

Figure 3.11.5 Percentage of people (aged 50 to state pension age) who assessed their health to be good or fairly good by current religion and sex, Scotland, 2001



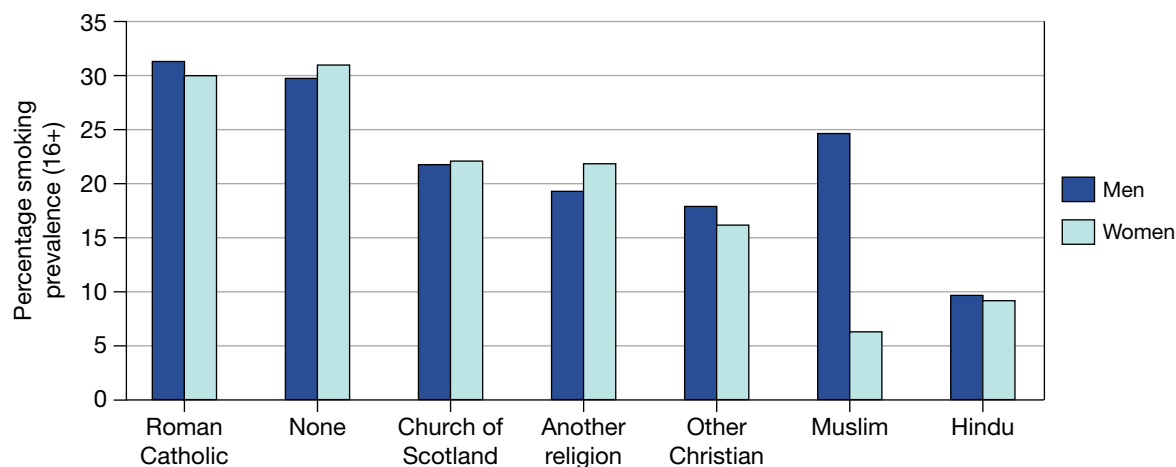
Source: General Register Office for Scotland.

In 2005/06, Scottish adults reporting their religion as Roman Catholic or none were more likely to smoke than other groups (Figure 3.11.6). Muslim male smoking was similar to the Scottish average but females had a very low reported smoking rate. There is some evidence that use of tobacco, illicit drugs and alcohol by young Scottish adults is higher among those with a weaker religious commitment.¹³

Differences in fruit and vegetable consumption (as an available indicator of diet) are moderate.^{viii} Just over one in five followers of no faith or of the Church of Scotland or

^{viii} Respondents of Christian faith or no faith in the 2003 Scottish Health Survey were compared with respondents of all other faiths in the 2004 Health Survey for England.

Figure 3.11.6 **Percentage of adults (aged 16+) who smoke cigarettes by current religion and sex, Scotland, 2005–06**



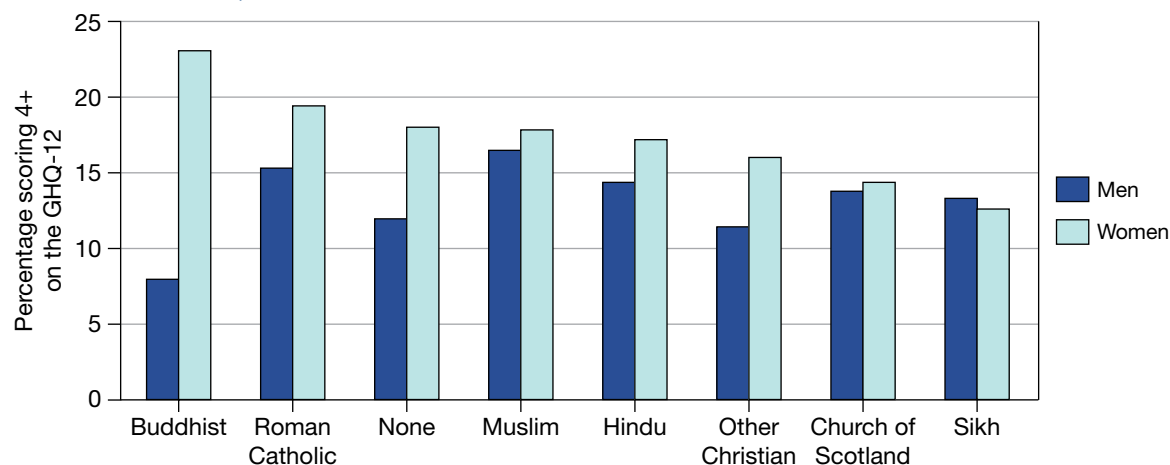
Excludes Jewish, Sikh, and Buddhist faiths because of small samples (<30 cases per gender).

Source: Scottish Household Survey 2005–06.

Roman Catholicism in Scotland eat five or more helpings per day. Between 30% and 40% of other Christians, Muslims, Hindus and Sikhs and nearly half of Buddhists eat five or more helpings. There is some evidence that the diet of Muslims in the west of Scotland may be rather poorer than these figures from England would suggest.¹⁴

Women with Buddhist, Roman Catholic or no religious affiliation are more likely to score positively on a screening tool (GHQ-12) for mental distress than other groups (Figure 3.11.7). There is less variation for men, though Buddhist men have a particularly low level of distress (8%), in contrast to Buddhist women (23%). The position for Muslims (and Muslim women in particular) is less certain, as the screening tool is less robust in this population.¹⁵

Figure 3.11.7 **Percentage of adults (aged 16+) scoring 4+ on the GHQ-12 by current religion and sex, Scotland, 2003–04**



Source: Scottish Health Survey 2003 (Christian faiths and none); Health Survey for England 2004 (all other faiths)

At a personal level, membership of a faith group can be a form of social capital.¹⁶ However, this can be a complex association, with conformity to (wider) peer group expectations (to attend or not attend church, for example) having a stronger effect on mental wellbeing than the action of attendance or non-attendance.¹⁷

Discrimination can contribute to poorer health. For example, long-running discrimination may have contributed to poorer health of working-age Catholics in west central Scotland through raised levels of stress, limited opportunities for occupational mobility and (in some cases) forced premature exit from the labour market.¹⁸ There is also evidence from an old study that Muslim women in the west of Scotland were particularly vulnerable to poor health owing to a combination of social and material disadvantages (low income, overcrowding), higher levels of stress and some poorer health behaviours (low consumption of fruit and vegetables and low levels of exercise).¹⁹ But this study is nearly 20 years old and a new generation of (often Scottish-born) Muslims may not share these characteristics.

Health improvement opportunities

Disaggregating data by religion provides fresh insights into health differences in Scotland, especially for the larger faiths, for which the statistics are more robust. Future analyses of accumulating Scottish data will be important for identifying the specific health benefits of religion and belief, independent of other characteristics which, it is suggested, are more common both in religious people and in people with a high level of wellbeing and life satisfaction.¹² Such multicollinearity raises problems of causal direction. How such knowledge will help the development of health improvement actions must, for the moment, remain an open question. For example, religion cannot be 'prescribed', but mindfulness is a secular approach that might have some similar effects.²⁰

Interventions unconnected with religion are likely to be important in addressing some inequalities associated with religion. For example, it has been estimated that around half the morbidity excess among middle-aged west of Scotland residents of Irish Catholic descent can be attributed to this population's disproportionate level of deprivation.²¹

Some faiths impact upon health behaviour through their culture and rules, particularly in relation to the use of substances such as tobacco and alcohol, sexual behaviour and diet. This impact is positive – no religion mandates smoking, drinking to excess or overeating. Such rules may not always be fully observed, but their existence can, for example through the influence of faith leaders or religious settings, provide opportunities for health promotion.^{22,23} Aligning health communications and promotion with religious tenets that support healthy and health-seeking behaviours may also provide meaningful entry points into people's lives, though such activities must also address barriers that faith tenets might raise.²⁴ (There are also many religious rules and practices relevant to health care but not to population health improvement.²⁵)

Discrimination towards those of different faiths and of none impacts upon health indirectly through its effect on community cohesion and safety.¹⁰ Some religious interpretations may lead to particular expectations or attitudes (e.g. towards gender equality or of acceptable forms of sexual expression) that could create tensions in the pursuit of equality across all strands. Issues of doctrine can be difficult, within as well as between faiths, with no simple resolution. The NHS can address this directly by practising a non-discriminatory approach to all individuals and groups, treating each person with dignity and respect. This includes meeting spiritual needs in appropriate ways for those who wish it.^{26,27}

Conclusion

The available information on health and religion in Scotland is very limited. Agreement on a standard question to be used across all major Scottish Government population surveys²⁸ will gradually improve the availability of information and enable better understanding of the impact of religion in the context of other influences on health such as socio-economic status and migration history. Data on strength of adherence would improve understanding further still. Recording religion on NHS records would illuminate healthcare experience.

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3.12 Sex and gender

Key points

- There are more women than men in the Scottish population: 52% compared with 48%.
- The number of transgender people in Scotland is unknown. In the UK, the number is estimated to be between 1 in 100 and 1 in 20 – between 50,000 and 250,000 people in Scotland.
- There are slightly more women than men in each age group from 35–44 upwards, with a marked difference after age 64, reflecting the difference in life expectancy and premature mortality between the sexes.
- There is an above average proportion of women in most deprived areas and an above average proportion of men in rural areas. Women are an absolute majority of the population in all areas except Moray and Shetland.
- Women live longer but with more ill-health than men. In particular, they experience high levels of mental distress perhaps associated with role overload, especially if compounded by low autonomy and poor access to resources.
- Men have adapted poorly to changing social and economic circumstances, with harmful coping strategies, such as alcohol and aggression, for dealing with emotional challenges.
- Transgender people experience high levels of discrimination, with direct impacts on mental health.
- Gender differences in health in large measure reflect socially determined roles and pressures. Ingrained perceptions of appropriate masculine behaviour need to be challenged in the early years and throughout childhood and youth. Better engagement with positive coping strategies would allow more men to respond to emotional challenges in ways less harmful to themselves, to those around them, and to society at large. A trend towards equalisation through young women adopting harmful health behaviours needs gender-sensitive approaches to behaviour change. Action to undermine the discriminatory and excluding reaction of society and individuals to transgender people is needed to address the fundamental cause of mental distress.
- There is an abundance of information on male/female sex and greater use could be made of it to explore and monitor the impact of sex/gender on health. There are almost no reliable data at all on transgender in Scotland.

Definitions

Sex and gender are often used as if they mean the same thing: they do not. Sex is a method of classification based on biological differences between males and females. Gender is a person's internal, deeply felt sense of being male or female, or something other, or in between.¹ Gender roles and expectations are *assumed* from biological characteristics

but gender identity and biological characteristics do not align in everyone. A biological male may, in terms of his gender self-identity, *feel* female. Gender roles are also social and cultural constructions to which are attached expectations about what are appropriate expressions of femaleness and maleness.²

In Scotland, the term transgender, or trans, is an umbrella term used to describe people whose gender identity differs from that assigned to them at birth. Gender identity can be expressed in a variety of ways (or, in a discriminatory society, may be suppressed). Various terms have developed as transgender expression has become more widely understood and recognised in an attempt to highlight similarities and differences. Transgender people include transsexual men and women (who have had legal gender reassignment), cross-dressing and transvestite people, intersex people (people born with chromosomal abnormalities or ambiguous genitalia, some of whom, but not all, have a gender identity different to the one they were assigned at birth) and polygender/androgynous people (people with a gender identity not defined as male or female, or which encompasses aspects of masculine and feminine). These descriptive terms are not exhaustive or definitive.³ The terms used in other parts of the world can be very different. Also, language is still evolving and may change in the future.

Introduction

Individual people will always view themselves, and experience their lives, in unique ways. However, the ability to express identity as a woman, trans or man depends on the freedoms and boundaries set by society. The health issues associated with gender are not simply a matter of biological sex, such as reproductive health, but are bound up with the way in which society expects – ‘allows’ – different genders to act in their economic, social and family lives, and the ways in which these different aspects of life are changing asynchronously.

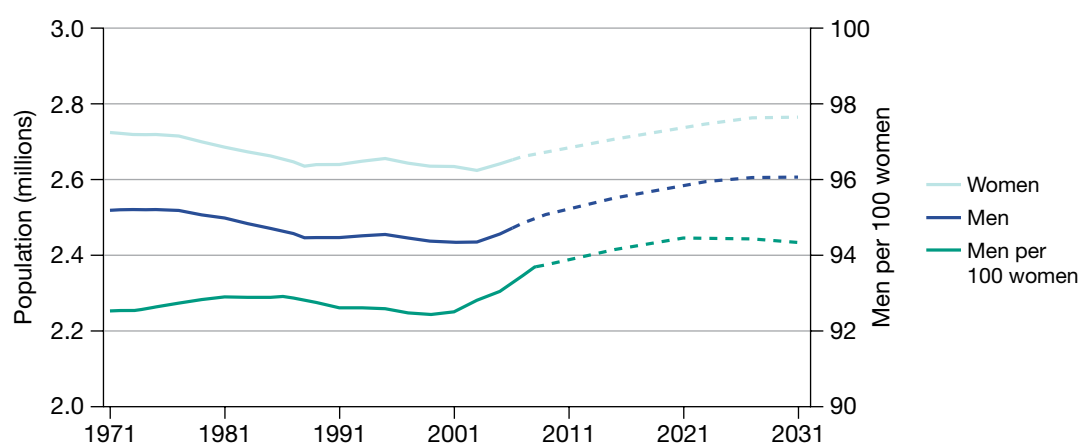
This section mainly reports on biological sex because it is the only information available in routinely collected datasets. It is rare for gender to be recorded – the term may be used but only with the response options of Male or Female, excluding trans. Self-reported ‘sex’ recorded in surveys could reflect gender identity but need not.

Population

In 2007, there were 2,485,599 (48%) men and 2,658,601 (52%) women living in Scotland. The population has increased in recent years, with a rather greater increase in men, possibly reflecting migration (see section 3.8) (Figure 3.12.1). This followed a decade of stability after more than a decade of declining population.

There is no reliable information on the number of transgender people living in Scotland. Within the UK population, estimates range from about 1 in 100 to as many as 1 in 20 in the male population.⁴ It has been estimated that there are 5,000 transsexual people in the UK, one in 12,000 of the adult population.² The Transgender EuroStudy offers some evidence that the trans population is growing.⁵ ‘More than 100 patients’ from Scotland have undergone gender reassignment surgery in ‘the past five years’.⁶ These procedures all took place in England because there are no specialist facilities in Scotland.

Figure 3.12.1 Population and projected population by sex, Scotland, 1971–2031



Source: General Register Office for Scotland.

Age

There are slightly more women than men in each age group from age 35–44 upwards, but only from age 65 do women begin to outnumber men substantially (Table 3.12.1).

Table 3.12.1 Estimated population by sex and age group, Scotland, 2007

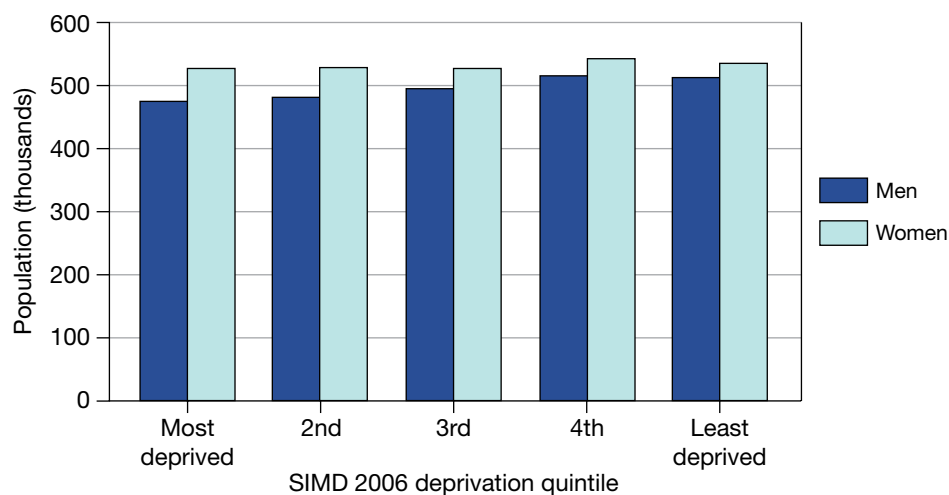
Age group	Men		Women		Total
	<i>N</i>	%	<i>N</i>	%	<i>N</i>
0–4	141,148	51	134,052	49	275,200
5–14	294,693	51	281,441	49	576,134
15–24	344,668	51	331,715	49	676,383
25–34	313,031	50	316,257	50	629,288
35–44	374,502	48	406,254	52	780,756
45–54	354,986	49	373,805	51	728,791
55–64	308,397	49	323,638	51	632,035
65–74	209,949	46	247,427	54	457,376
75–84	115,615	40	174,352	60	289,967
85 and over	28,610	29	69,660	71	98,270
All ages	2,485,599		2,658,601		5,144,200

Source: General Register Office for Scotland.

Deprivation

The female population is fairly evenly spread among the five deprivation quintiles, but there are fewer men in the most deprived areas (Figure 3.12.2). More lone pensioners and lone parents live in deprived areas,⁷ and both are more likely to be female⁸ and poor.⁹

Figure 3.12.2 **Estimated population by sex and deprivation quintile, Scotland, 2007**



Source: Scottish Neighbourhood Statistics.

Geography

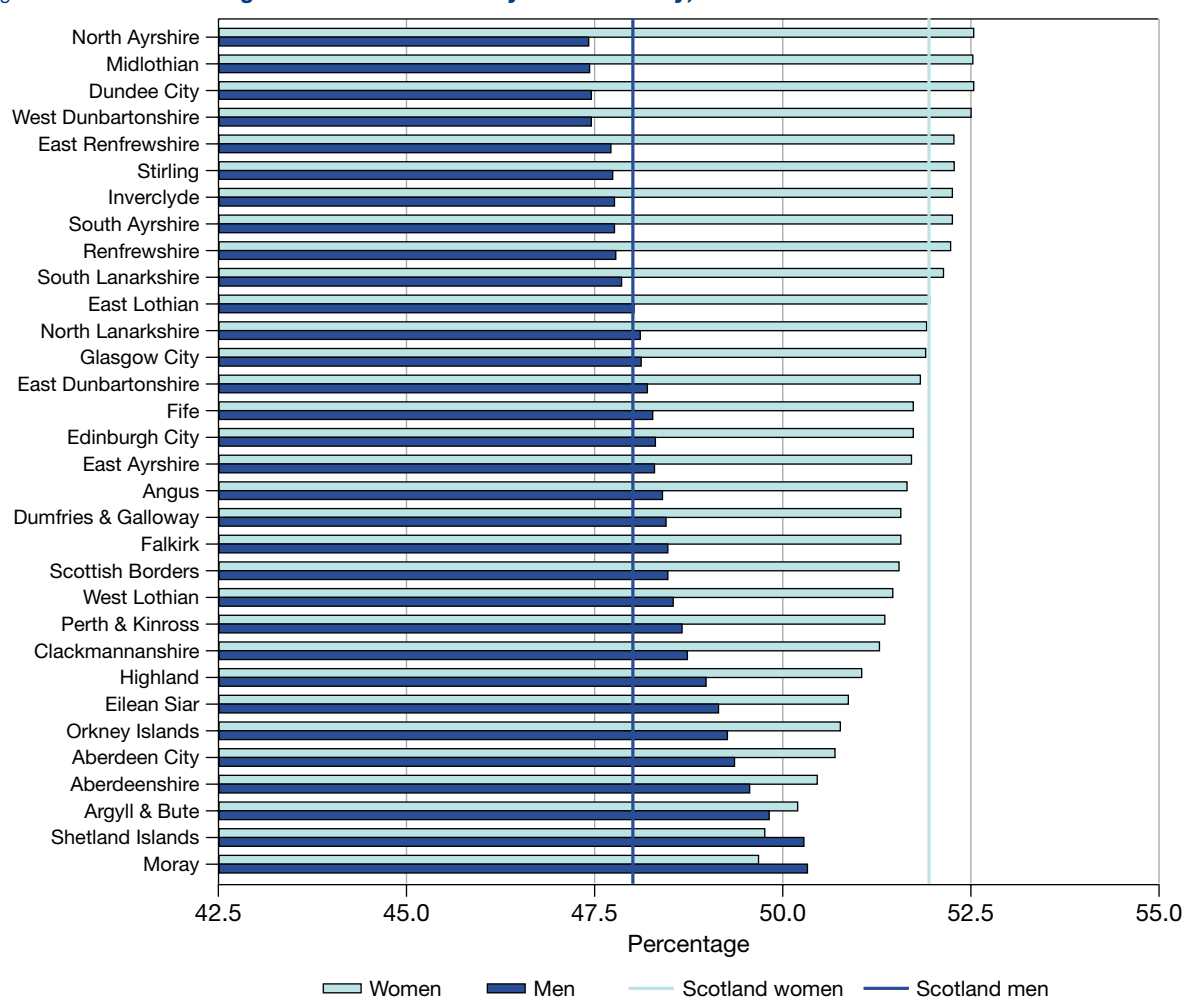
The imbalance between women and men is repeated in all local authorities except for Shetland and Moray (Figure 3.12.3). There is no obvious pattern to the geography at local authority level, but there is a clear pattern at the more detailed urban/rural level. Both accessible and remote rural areas have a greater proportion of men than urban areas and towns, though women are still in the majority (Table 3.12.2).

Table 3.12.2 **Sex distribution by urban–rural classification, Scotland, 2007**

	Men	Women	Total	Men per 100 women
Large urban	960,523	1,038,358	1,998,881	93
Other urban	746,245	808,818	1,555,063	92
Accessible small town	222,560	238,758	461,318	93
Remote small town	89,593	96,989	186,582	92
Accessible rural	301,518	306,652	608,170	98
Remote rural	165,160	169,026	334,186	98
Scotland	2,485,599	2,658,601	5,144,200	93

Source: Scottish Neighbourhood Statistics.

Figure 3.12.3 Percentage of men and women by local authority, 2007



Source: General Register Office for Scotland.

Some health challenges

Men die younger than women. Life expectancy at birth in Scotland is 79.7 years for women, almost five years longer than the 74.8 years for men.¹⁰ This gap has been narrowing in recent years. Causes of death vary between men and women. Very few are sex specific – breast and prostate cancer, for example. Most affect both men and women but to different degrees. For example, men are more likely to die from cancer and coronary heart disease (CHD) whereas women are more likely to die from stroke.¹¹ Such statistical generalisation, however, should not obscure the fact that many women do die from CHD and cancer and many men from strokes.

Women have more ill-health. Women are expected to live around 70 years in good health and 10 in poor health, whereas for men the figures are 68 and 7, respectively.¹² In the 2001 census, 21% of women reported living with a long-term illness compared with 19% of men.¹³ In 2004/05, the prevalence rate for arthritis and rheumatism among women aged between 65 and 74 was almost twice that for men (194 per 1,000 women compared with 110 per 1,000 men).¹⁴

Expected 'masculine' ways of dealing with emotions in Scottish cultures may not be good for men's health. In 2007, 74% of suicide deaths were men.¹⁵ Men are also more likely to be admitted to hospital because of unintentional injury, violence and assault, particularly in the 15–64 age group.¹⁶ But Scotland's emotional culture is not good for women's health either. Almost 90% of domestic violence incidents are perpetrated by men.¹⁷ Women are more likely than men to be admitted to hospital for self-harm.¹⁸ Women have higher levels of mental distress than men on standard scales.¹⁹ Women account for 70% of GP consultations in which a diagnosis of 'anxiety and other related conditions' is recorded.²⁰ In general, women make greater use of health services, even after allowing for reproductive health – around 52,000 women give birth each year^{ix} – and age-related differences.²¹

Women, taken as a whole, have better health-related behaviours than men in respect of diet, alcohol consumption and smoking, but subgroups within the population vary markedly.¹⁹ Women are more likely to be obese, though men are more likely to be overweight, and to have lower levels of physical activity¹⁹. Drug misuse is higher among men.²² There is some movement towards greater similarity of health behaviours, to the detriment of women. Early sexual activity that results in birth can be detrimental to longer-term life chances for young women, disrupting potential educational and employment opportunities.²³

Transgender people experience discrimination at work (50% reported this in one survey) and public harassment (over 60% reported this).²⁴ The UK's largest survey of transgender people ($n=872$) reported that 34% of adult trans people have attempted suicide.²⁵ Health services may not be supportive when needed. Research carried out in Scotland in 2001 found 'that professional isolation and ignorance of gender identity problems were widespread and that professionals held polarised views of transsexualism and gender dysphoria, ranging from strong moral disapproval to considerable apathy'.²⁶

Health improvement opportunities

Much media, political and professional attention is directed towards the life expectancy gap between different parts of Scotland. The gap in gender inequality is of a broadly similar magnitude. The gap between women and men is 4.9 years whereas that between the local authorities with the highest and lowest life expectancies is 5.5 years for women and 7.2 years for men.²⁷ Gender differences may be seen as biologically inevitable and disregarded when in large measure they reflect socially determined roles and pressures. The long-term widening of the gender mortality gap in rich countries matches changes in economic activity, status and social position experienced detrimentally by men.²⁸ In so far as these changes are associated with female emancipation, the problem is with male adaptation to changed circumstances rather than the circumstances as such.

Ingrained perceptions of appropriate masculine behaviour – not seeking help for problems, self-medicating with alcohol and drugs, aggression²⁹ – need to be challenged in the early years and throughout childhood and youth. This goes much wider than health. Male role models are in short supply in primary school classrooms, for example, with female teachers outnumbered male teachers by five to one.³⁰ The balance in nursing is even worse: in NHS Scotland, female nurses outnumbered male nurses by more than eight to one in 2008.³¹

^{ix} Estimated from ISD births data: SMR02=51,187 singletons, 1,004 multiple (i.e. 2–4); SMR02 excludes about 2% (c. 1,000).

Better engagement with positive coping strategies would allow more men to respond to emotional challenges in ways less harmful to themselves, to those around them, and to society at large.³²

Despite greater longevity, women experience more ill-health than men. Some of this is a direct consequence of their reproductive role and other biological differences, but much of it reflects social roles and relative economic status. Women are more likely to be responsible for managing a household on a limited income, to have multiple roles to juggle and to have less autonomy and less ability to claim resources for their own use – it is hardly surprising that they express greater mental distress.³³

Although women generally have better health-related behaviours, the trend for some behaviours, such as smoking and alcohol, is towards harmful equality. Nuanced approaches to behaviour change, and to the circumstances that promote or hinder such change, are needed to take account of gender influences on patterns and trends. (Other characteristics also need to be considered, such as age and socio-economic status.)

Both health improvement and health care need to consider gender both as an overarching social issue but also as very specific to each individual. Diagnosis and treatment should reflect the individual's condition, not be shaped by women's lower statistical likelihood of developing CHD.³⁴ The possibility of domestic violence should not be excluded because the patient is male, even if the index of suspicion should be much higher when the patient is female.

Transgender people's experiences of discrimination have a direct impact upon their health (though some reviews blur the view of specifically trans discrimination by including it with discrimination based on sexual orientation).³³ Specific health improvement actions around suicide, eating disorder, tobacco, depression, etc. may have some beneficial effect but can only alleviate symptoms rather than eliminate causes. Wider action is needed to undermine the discriminatory and excluding reaction of society and individuals to trans people that is the more fundamental cause of mental distress.³³

Health services need to be individualised so that transgender people receive appropriate screening and health care, reflecting the risks from their original biological sex as well as their trans status.³⁴

Conclusion

There are extensive data coded and analysed by male/female sex. Most person-based statistical datasets include sex. However, much less use is made of this than could be. Analysis by sex is commonplace, but too often the sexes are then considered separately – as biologically different populations – rather than their experiences and outcomes being compared. There is much scope for systematic analysis of gender variations using existing data, while acknowledging that it does not adequately define those whose gender identity differs from their biological or birth sex as there are no reliable and consistently collected data on transgender.

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3.13 Sexual orientation

Key points

- The best available data suggest that between 5% and 7% of the Scottish population aged 16 and over is lesbian, gay or bisexual (LGB) (211,000–296,000 people), with 78,000 reporting a same-sex partner within the last five years.
- Men and women report similar levels of same-sex genital contact (ever) and of recent same-sex partner. Prevalence of same-sex attraction and experience are lower for those aged 16–24 than ages 25–34 and 35–44, which are similar to each other. Partnership in the last five years is similar in all three age groups.
- Adults co-habiting with someone of the same sex as a couple are more common in the cities of Glasgow and Edinburgh.
- For Britain, there is some evidence that people not exclusively attracted to the opposite sex are more likely to live in deprived neighbourhoods, despite above average levels of education and occupational class.
- LGB people in Scotland face a range of health issues arising from homophobic prejudice and discrimination – including verbal abuse, physical assault and fear of crime – with poor levels of mental health. Smoking and substance use are higher among the LGB population of Scotland, as is risky sexual behaviour.
- A general reduction in prejudice and discrimination offers the best chance of improving LGB health. Given the importance of adolescence, schools are an important setting for such work. Eliminating discrimination in NHS services will have a direct benefit but also send an important message of inclusion. The drivers of increased exposure to risk behaviours are, however, little understood.
- The availability of descriptive data will increase over the next few years, with a standard question in Scottish Government surveys and an increased Scottish sample for the next Great Britain sexual health survey in 2010.

Definitions

Sexual orientation refers to the gender or genders to which a person is attracted. (Note that elsewhere in this chapter we refer to sex rather than gender for consistency with most data sources.) The Equality Network identifies different types of sexual orientation as follows.¹

- Straight/heterosexual: someone who is emotionally and physically attracted to the opposite gender.
- Lesbian: woman who is emotionally and physically attracted to other women.

- Gay: someone who is emotionally and physically attracted to the same gender. Most often it refers solely to men, but some women may prefer the term.
- Bisexual: someone who is emotionally and physically attracted to both men and women.

The last three are abbreviated here to LGB. LGBT, adding transgender, is a commonly used abbreviation but transgender is covered here in section 3.12, Gender. There are international differences in terminology, and even in the ordering of the acronym – in the USA, the most common style is GLBT.¹

Introduction

Sexual orientation is a central feature of each individual's personal identity. Yet we know little about how this aspect of identity affects health in Scotland today. A skewed picture is drawn by focusing disproportionately on the sexual health of the LGB population,² by research on subgroups that are easier to reach but may not be typical of the wider LGB population,³ and through media images of sexual orientation that may not reflect Scottish society (e.g. the so-called 'pink pound'). Extreme examples of homophobia and discrimination attract condemnation, but casual everyday reminders of exclusion, such as inappropriate language⁴ arising from culturally embedded heterosexism,³ are not recognised.

A key source of statistical information is the *British National Survey of Sexual Attitudes and Lifestyles* (NATSAL), the first of which was in 1990 and the second in 2000. This asks a range of questions on sexual attraction and behaviour, four of which are used here:

- Ever felt attraction to adult of the same sex?
- Ever had sexual experience/contact with adults of the same sex, with or without genital contact?
- Ever had sexual experience/contact with adults of the same sex, with genital contact?
- Had a same-sex partner in the last five years?

This section considers what is known, or can reasonably be inferred from wider UK studies, about sexual orientation and health in Scotland today.

Population

Robust estimates of the number of LGB people in Scotland do not exist. No survey has yet been undertaken with a sufficiently large and representative sample. However, UK studies are available. NATSAL 2000 (based on respondents aged 16–44) reported that 6.2% of men [95% confidence interval (CI) 3.7–8.7%, $n=366$] and 7.2% of women (95% CI 4.9–9.5%, $n=488$) in Scotland had ever felt attracted to an adult of the same sex (Table 3.13.1). These estimates are similar to those for Wales and the English regions outside of London and (for women) the south-east of England. London has particularly high rates, perhaps reflecting selective migration, with 12.9% of men and 16.5% of women aged 16–44 reporting having ever felt attracted to the same sex.

Table 3.13.1 **Percentage of adults aged 16–44 reporting same-sex sexual attraction and behaviour, Scotland (Great Britain), 1990 and 2000**

	Men				Women			
	1990		2000		1990		2000	
	Scotland	GB	Scotland	GB	Scotland	GB	Scotland	GB
Attraction	5.4	5.8	6.2	7.7	4.4	5.2	7.2	11.2
Sexual experience	4.7	6.2	4.8	8.4	4.1	3.7	6.0	9.7
Sexual experience with genital contact	2.8	3.7	3.2	5.4	2.2	1.8	2.6	4.9
Same sex partner, last five years	0.8	1.6	2.0	2.6	1.6	0.8	1.8	2.6

Base: all respondents aged 16–44, Scotland (Great Britain).

Source: British National Survey of Sexual Attitudes and Lifestyles, 1990 and 2000.

The UK Government estimated in 2004 that around 5–7% of the population was LGB.⁵ Stonewall Scotland believes that this is a reasonable assumption.⁶ Applying this estimate to the 2007 adult (aged 16 and over) population of Scotland would suggest that there are between 211,000 and 296,000 lesbian, gay or bisexual adults in Scotland.^x

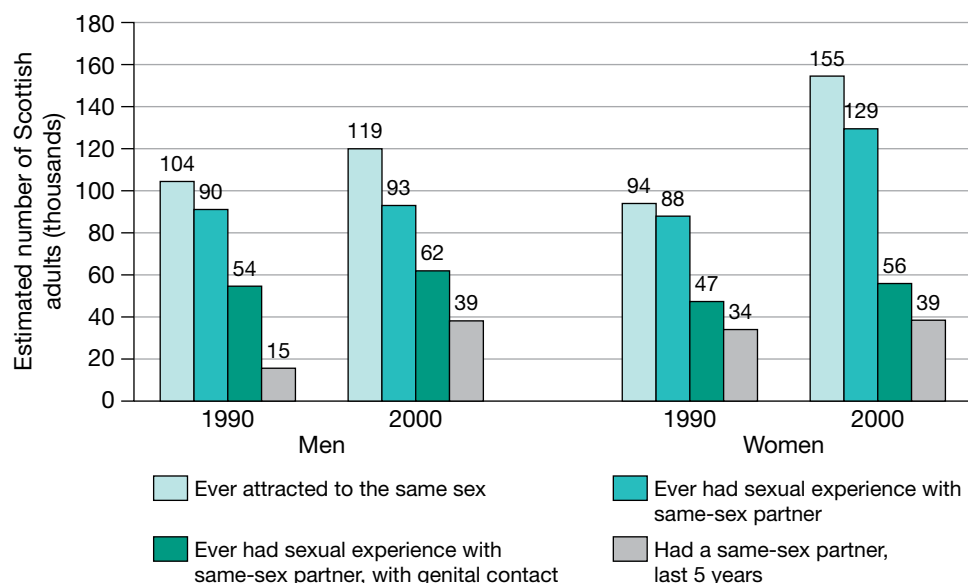
What constitutes a LGB adult in a statistical sense can vary substantially depending on how the counting is done. Figure 3.13.1 shows how it varies depending on the question. It applies the Scottish rates for those aged 16–44 to the whole adult (age 16+) Scottish population to give total population estimates of those not exclusively heterosexual.

This suggests that around 274,000 adults in Scotland have ever felt attracted towards the same sex, 222,000 have ever had a same-sex experience, 118,000 have ever had same-sex genital contact and 78,000 have had a same-sex partner in the past five years.

The wider cultural context in which self-reported sexual behaviour information is obtained also has an impact on the estimated size of the LGB population. The increase in adults reporting sexual behaviour with a same-sex partner between 1990 and 2000, for example, is likely to reflect greater openness because of changing social attitudes. The proportion of British adults who thought that same-sex relationships were always or mostly wrong declined from more than two-thirds to less than one-half between 1990 and 2000 (and further to one-third by 2006).⁷ The proportion who thought that such relationships were rarely or never wrong increased from one-fifth to two-fifths (and further to one-half by 2006). Given this trend, it is likely that same-sex orientation was still under-reported in NATSAL 2000 but that there will be a much lower level of under-reporting in NATSAL 2010.

^x 2004 Department of Trade and Industry percentages applied to 2007 mid-year population estimates of people aged 16+ in Scotland (General Register Office for Scotland).

Figure 3.13.1 **Estimated number of adults (aged 16+) with same-sex attraction or experience by sex, Scotland, 1990 and 2000**



Numbers shown are in thousands.

Source: British National Survey of Sexual Attitudes and Lifestyles, 1990 and 2000. Applies Scottish age 16–44 rates to General Register Office for Scotland mid-year population estimates of all aged 16+ in 1990 and 2000.

Age and sex

More women than men report any same-sex sexual experience ever, but women and men report very similar levels of same-sex genital contact and of a recent same-sex partner (Table 3.13.1).

The likelihood of reporting same-sex attraction and sexual experience is lower among young adults (aged 16–24), although there is little difference by age in reporting a same-sex partner in the last five years (Figure 3.13.2). The mean age at first reported heterosexual intercourse was 16.9 years in 2000, compared with 18.3 years for first same-sex sexual experience with genital contact.

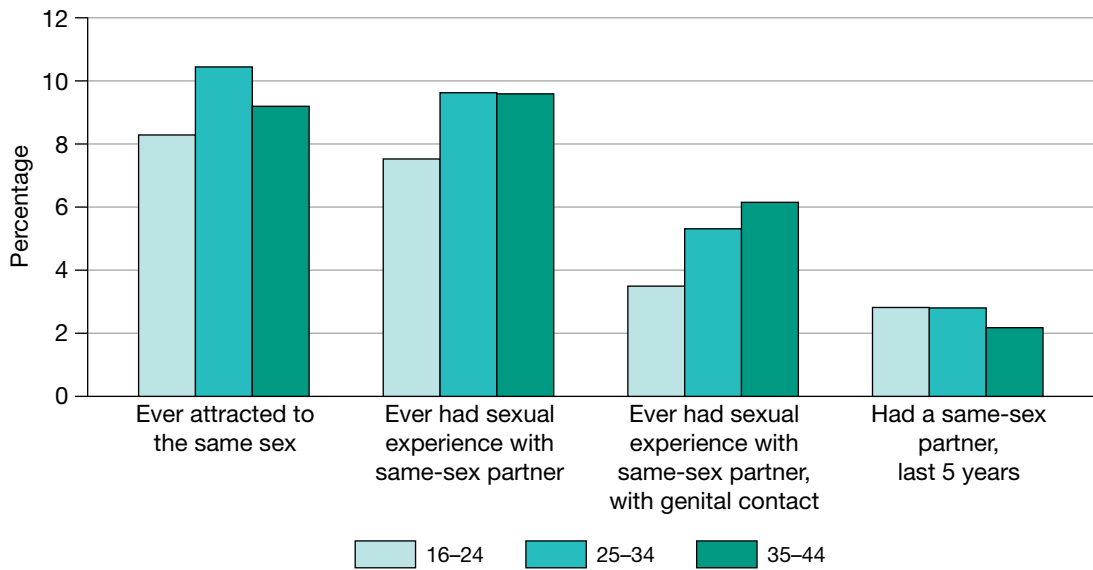
Unfortunately, information is not collected beyond age 44.

Deprivation

In Great Britain as a whole, those who are not exclusively heterosexual are more likely to live in more deprived communities (Figure 3.13.3).^{xi} Recent US research has found that poverty is at least as common among the LGB population as in the general population.⁸

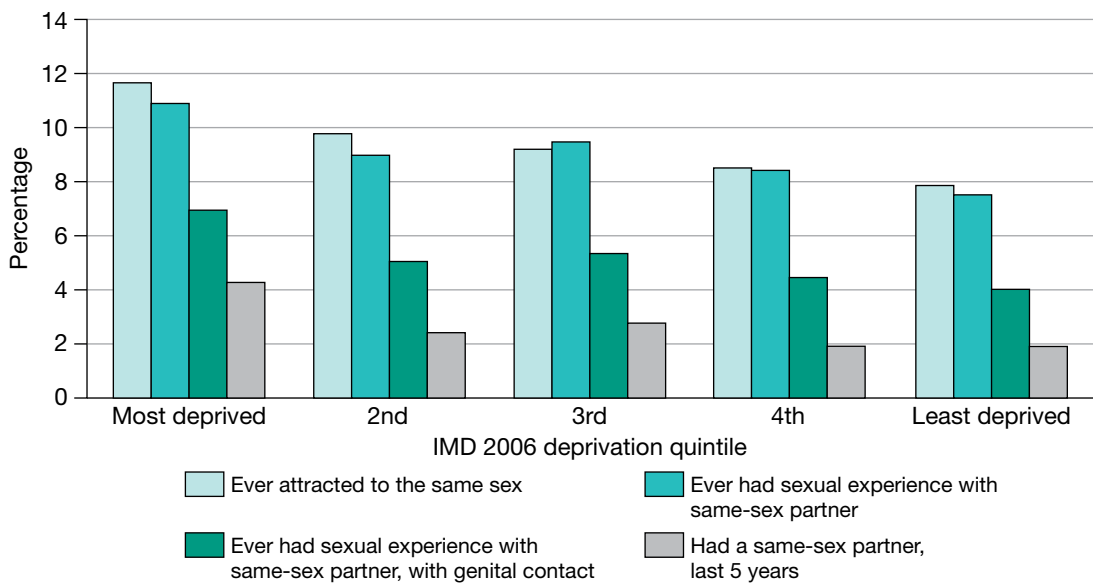
^{xi} As measured by the Index of Multiple Deprivation (IMD) 2000, a ward level measure developed by the Department of Environment, Transport and the Regions, dependent on six factors: income, employment, health and disability, education, housing, and geographical area. The index consists of five levels: the higher the score, the more deprived.

Figure 3.13.2 **Percentage of adults aged 16–44 with same-sex attraction or experience by age, Great Britain, 2000**



Source: British National Survey of Sexual Attitudes and Lifestyles, 2000.

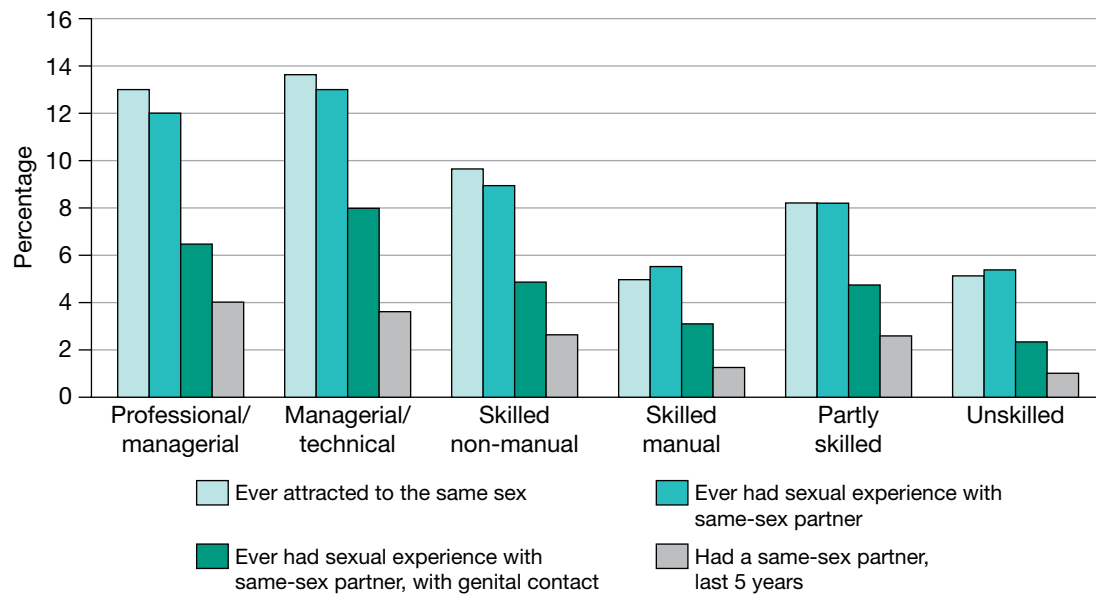
Figure 3.13.3 **Percentage of adults aged 16–44 with same-sex attraction or experience by deprivation quintile, Great Britain, 2000**



Source: British National Survey of Sexual Attitudes and Lifestyles, 2000.

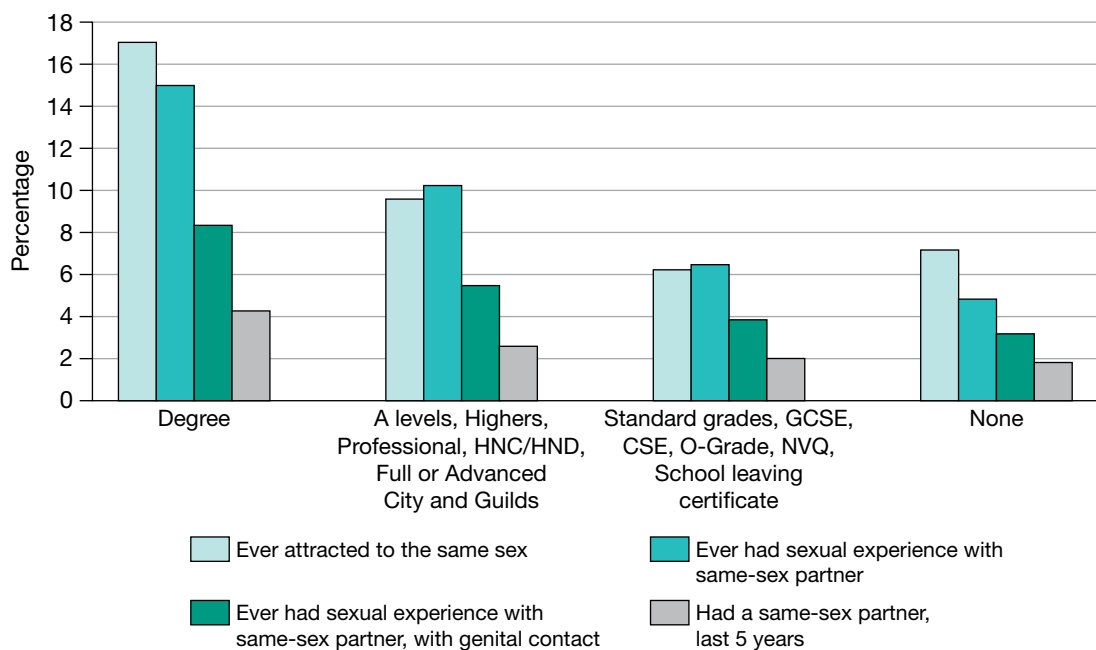
However, the picture is different when individual markers of socio-economic position are considered. In 2000, adults with non-manual occupations were more likely to report same-sex attraction and experience than adults from manual classes (Figure 3.13.4). A similar picture emerges for educational level, with those educated to A-level or above being more likely to report same-sex attraction and experience (Figure 3.13.5). The reason for these inconsistent findings is not understood.

Figure 3.13.4 **Percentage of adults aged 16–44 with same-sex attraction or experience by social class, Great Britain, 2000**



Source: British National Survey of Sexual Attitudes and Lifestyles, 2000.

Figure 3.13.5 **Percentage of adults aged 16–44 with same-sex attraction or experience by highest qualification, Great Britain, 2000**



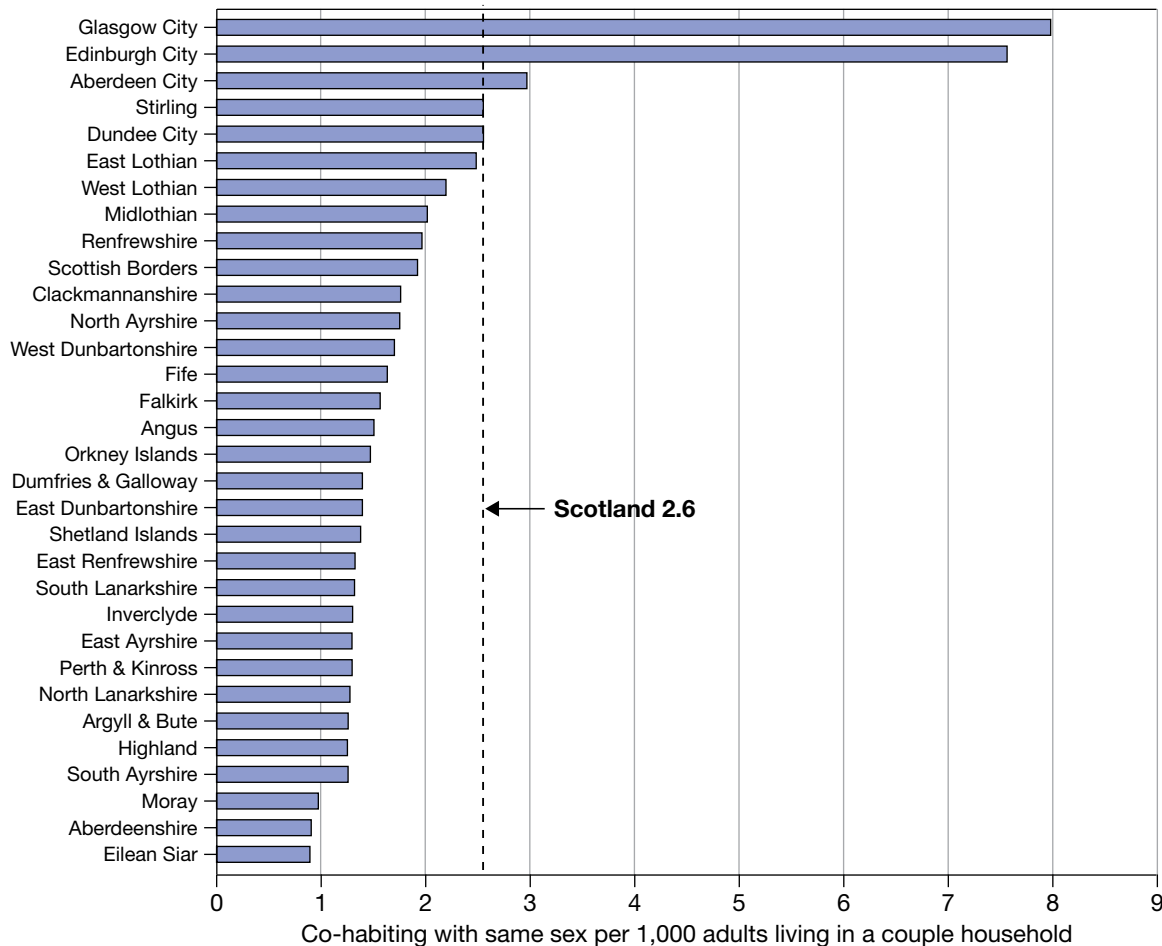
Source: British National Survey of Sexual Attitudes and Lifestyles, 2000.

Geography

There are no survey data that allow a geographical view of sexual orientation. The 2001 census includes data on the number of adults co-habiting as part of a same-sex couple. Only 6,110 such adults were recorded in Scotland – 0.26% of all adults living in couple households. Clearly this is a highly selected subgroup and its geography may not be typical. In the absence of any other data, however, we present the census data here.

Figure 3.13.6 shows the number of Scottish adults co-habiting in a same-sex couple in 2001, per 1,000 adults living in a couple by local authority. The Scottish average was 2.6 per 1,000. Same-sex co-habiting couples are particularly concentrated in Glasgow (8.0 per 1,000) and Edinburgh (7.6 per 1,000). This may reflect migration from elsewhere in Scotland. The experience of LGB people outside the Central Belt is thought to be both different and significantly more difficult because of perceived greater homophobia.^{9,10}

Figure 3.13.6 **Number of adults co-habiting with a member of same sex per 1,000 adults living in couples by local authority, Scotland, 2001**



Sources: General Register Office for Scotland.

Some health challenges

Knowledge about the health issues facing LGB people in Scotland is far from comprehensive.¹¹

Respondents to NATSAL 2000 who were not exclusively attracted to members of the opposite sex rated their health more poorly than those who were exclusively heterosexual (Table 3.13.2). The difference is small but statistically significant. (Scottish data show the same pattern but are not statistically significant because of the small sample size.)

Table 3.13.2 **Self-rated health by sexual orientation, population aged 16–44, Great Britain, 2000**

	Exclusively heterosexual	Not exclusively heterosexual
Good/very good	86.5%	83.5%
Fair	11.3%	13.8%
Bad/very bad	2.2%	2.7%
<i>N</i>	10,711	1,274

Source: British National Survey of Sexual Attitudes and Lifestyles, 2000.

In 2005, gay men in Scotland had a higher smoking rate (32.5%)¹² than the general male population (26%).¹³ In 2005/06, use of certain drugs in the last month was higher among gay men¹³ than in the general male population (poppers 18.4% versus 1.1%, ecstasy 4.3% versus 2.2%, cocaine 3.2% versus 2.2%).¹⁴ In Scotland, the proportion of gay men reporting that they would like to cut down the amount of alcohol they drink (28%)¹² was slightly higher than that seen for the general male population (24%).¹⁵

Smoking rates for lesbian women in Scotland are similar to those of the general female population (25% and 24% respectively in 2007),^{16,17} but drug and alcohol use is higher. In 2007, 38% of lesbian and bisexual women in Scotland reported using any drugs in the last year,¹⁶ compared with 9% of the general female population.¹⁴ Lesbian and bisexual women in Scotland also reported a somewhat higher frequency of drinking alcohol: 13.1% reported drinking on five or more days a week, compared with 7.0% of the general female population.¹⁶

Physical activity rates were found to be low among young LGB people in Glasgow in 2002 compared with other young people.¹⁸ Disordered eating is as prevalent in gay men as in heterosexual women, contrasting with lower prevalence in heterosexual men and lesbians.¹⁹

Men who have sex with men (MSM) are at higher risk of sexually transmitted infections, especially gonorrhoea, syphilis and HIV.²⁰ Nearly half (45%) of all men presenting with gonorrhoea to genitourinary medicine clinics in Scotland in 2007 were MSM.²¹ In 2007, 46% of the 453 new HIV diagnoses recorded in Scotland were among the MSM group. Between 2003 and 2007, there was a fivefold increase in the number of MSM diagnosed with syphilis.

Information on the specific health issues of bisexual people is particularly limited, but one study suggests that women who have sex with both men and women have a high level of adverse risk behaviours: smoking, alcohol, intravenous drug use and unsafe sex.²²

LGB people – especially younger people and bisexual individuals – have poorer mental health and wellbeing than the general population. Depression and anxiety, suicidal thoughts

and self-harm, eating disorders and substance misuse show higher prevalence rates among LGB people.²³ Young gay and bisexual men are four times more likely to attempt suicide than the general population.²⁴ One in five lesbian or bisexual women have self-harmed in the past year,¹⁶ compared with around 1 in 20 in the general female population.²⁵ A study of young LGB people in Glasgow (aged 25 and under) found rates of self-harm of 29% among men and 65% among women.²⁵ This compares with 10% in the young (aged under 16) general population, though these are not directly comparable statistics.¹¹ Some of this anguish might arise because, distinctively among 'minority groups', for young LGB people 'coming out' can mean alienation from family support.²³

Nearly two-thirds (68%) of LGB people report having been verbally abused, and 23% report having been physically assaulted because someone assumed they were LGB.²⁶ Three in ten (30%) LGB people in Scotland feel unsafe at home or in their neighbourhood,²⁶ compared with 22% of the general population who feel unsafe in their local neighbourhood after dark.²⁷

Underlying these illustrations of victimisation and poor self-worth are intolerant and discriminatory attitudes held by a sizeable minority of the Scottish population. People in Scotland are less accepting of those with a different sexual orientation than they are of other minorities. For example, in 2006, 33% of Scottish adults reported they would be unhappy/very unhappy if a relative formed a relationship with someone of the same sex. This compares with 10–11% who would be unhappy if a relative formed a relationship with someone who was black, Asian, Chinese or Jewish and 24% who would be unhappy about a relative forming a relationship with a Muslim.²⁸ There is some evidence of a reduction in discriminatory attitudes, with a decline in the proportion of adults in Scotland thinking that trends in equal opportunities for LGB have gone too far from 38% to 21% between 1992 and 2006.²⁸

The NHS reflects broader society in its attitudes and actions. In 2003, one in five (22%) of LGBT people in Scotland reported difficulties in accessing information on health issues.²⁶ One in seven (15%) had experienced problems in accessing mainstream health care services.²⁶ One-quarter had experienced inappropriate advice or treatment as a result of their sexual orientation, and a similar number had experienced homophobia from NHS staff.²⁶ In 2007, half of lesbian or bisexual women reported that they had had a negative experience in the health care sector in the past year; 1 in 50 had been refused a screening test for cancer.¹⁶ Lesbians may be at increased risk of ovarian cancer because of factors such as lower use of oral contraception and lower incidence of giving birth.²³ One in three (31%) of Scottish lesbians and 13% of Scottish gay men have children.²⁶

Health improvement opportunities

LGB people are a cross-section of Scottish society. None of us is defined solely by our sexual orientation. But we may be negatively defined by others because of it, and suffer prejudice and detriment to health as a consequence. Working to reduce levels of homophobic prejudice generally⁹ is thus both an important underpinning to general health improvement for the LGB population and a specific requirement for improved mental health. An example is the legal recognition of same-sex partnerships,²⁹ which is an

important symbolic statement even though only 1% of all legal unions in 2007 and 2008 (averaged) were civil partnerships.

High levels of substance use and risky sexual behaviour might be more prevalent among LGB people (to varying degrees in varying subgroups) for a range of reasons. The higher level of substance use starts in youth, with increasing divergence from the heterosexual population in the transition into young adulthood.³⁰ Mental health problems, discrimination, access to services and substance misuse may all be inter-related: closer collaboration between lifestyle health improvement initiatives and mental health services might enable multiple problems to be better tackled.³¹ Community-based health promotion has been recommended to help improve problematic alcohol and drug use among gay men.³² However, the applicability to Scotland of findings from areas such as Brighton and London, from which these recommendations come, is unclear. A better understanding of the reasons for Scottish LGB risk behaviours is essential to know how best to intervene.

Simply providing health services is not sufficient: awareness is also important. In a Scottish survey in 2007 that recruited gay men – which would not include all MSM – 70% did not think they were at risk of HIV and 46% had never been tested for the virus, despite the disproportionate risk that such men face.³³ Ensuring that services are not part of the problem, by eliminating discrimination, is essential both for its direct impacts and for the message of inclusion it sends out. The NHS is clearly important in this respect, but the school is probably the setting with the greatest influence, for good or ill (with much evidence of the latter), on the future health trajectory of LGB people.⁹

Conclusion

There is limited information on the LGB population of Scotland. A standard question has been developed and will be used in major Scottish Government surveys, which will lead to improved data.³⁴ An important source of information will be the 2010 NATSAL, for which an increased Scottish sample is planned. These new and improved sources will enable better descriptions of the LGB population, and of its diversity. This will expose even more the key gap in knowledge – how to intervene to improve LGB health.

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All web links were verified as working on 17 September 2009.

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4 Conclusion

Just as the variety of Scotland's weather makes for an interesting climate, so too does variety in the population bring its own richness and interest. But the response to 'difference' can be fear, discrimination and prejudice – closing down opportunities to develop and thrive not only for those experiencing prejudice but also for those expressing it and for the wider population. An inevitable result is a society in which inequality is a common feature.

Some sections of the population experience poorer health than others. Rarely this is because of a biological susceptibility not shared by other sections of the population. Sometimes differences reflect different ways of living and patterns of behaviour that expose some sections of the population to greater risk than others. Sometimes differences reflect the accumulated effect of life chances, or lack of them, and of adverse experiences, either personal (e.g. torture in country of origin) or collective (e.g. discrimination because of skin colour). Sometimes differences reflect discriminatory and unthinking service design and delivery (e.g. reduced access to health screening for people with some disabilities).

These differences require appropriate responses. But knowledge of the diversity of Scotland's population, of the health experience of the many different population groups which make up Scotland, and thus of the potential for health improvement specific to particular groups is both limited and scattered across many different reports, publications and websites. We have written this report to begin to draw together such information in a more accessible form. It will be used to inform the development of equalities resource web pages on the ScotPHO website in 2010.

Criticism of the incomplete and fragmented nature of information on the experience of population groups – particularly what are labelled as equality groups or strands – is commonplace in official reports.¹ Although some tools to improve data collection in the NHS in Scotland have been put in place, their use is patchy.² As this report has shown, however, even when information is available, it is not necessarily put to effective use.

Indeed, quantitative data alone – statistics – will not be sufficient to bring about change. Much of the quality of our lives derives from the quality of our day-to-day interactions with people and with commercial and public services. To capture such experience statistically would overwhelm our ability to collect, process and interpret information. We simply cannot capture everything that matters in statistics, not least because of the many and subtle forms that unfairness can take: '... there are differences in the images and stereotypes that people hold of different groups, differences that mean different types of groups may be subject to different kinds of prejudice.'³

There is also an issue of analytical capacity. If, in Scotland, we were to cross-analyse all potential combinations of characteristics within the six Fair for All strands, this could involve between 80,000 and 2.7 million combinations of characteristics (see Box). This might seem fanciful, yet the Equality and Human Rights Commission's proposed Equality Measurement Framework has a potential 88 indicators for eight equality dimensions. This gives millions of possible combinations. The researchers note this vast scope and advocate 'spotlight' indicators.⁴

This is not to suggest that statistics are unimportant or that more and better statistics are not needed. They *are* important and substantial improvements *are* necessary. Absolutely basic information is still largely lacking on some population groups, whereas the ability to analyse across characteristics, other than age and (administratively defined) sex, is quite inadequate. But the approach needs to be thoughtful and selective – focusing on what matters most and on key sentinel indicators.

Characteristic	Number of categories	
Age	6	For the six Fair for All strands plus socio-economic status, we took the response categories to the Scottish Government agreed (harmonised) survey question or, where there was not one, the question used in the draft 2011 census form. There is no standard age division so we used 6 as indicative of a typical range from young to old. Multiplying the categories for each characteristic together gives the number of potential combinations.
Gender	3 or 8	
Disability	3 or 9	
Ethnicity	5 or 21	
Sexual orientation	3	
Religion	11	
Socio-economic status	9	
Total potential combinations = 80,190–2,694,384		

The health problems of the population groups included in the report are immensely varied and almost impossible to summarise. The very clear exception is mental health. Across most groups, there is a repeated finding of diminished mental health because of the pervasive and insidious effects upon wellbeing of experiencing personal prejudice, collective discrimination and structural exclusion from full and fair participation in Scotland's material prosperity, social life and power structures. These effects may also contribute to poorer health-related behaviours.

Three specific health improvement opportunities can be recognised that cut across strands.

- Scotland is still home to deeply rooted prejudice based on fear, perhaps even dislike, of difference. The more opportunities there are for people to mix, the more chance there is that prejudice will be worn down through the recognition of shared interests and the shared search for solutions, whether that be adequate housing, responsive health care or healthy choices in the local shop. Community health improvement initiatives using bottom-up community development approaches can contribute to this.
- Health services aspire to inclusion but can fall short in different ways for different population groups. It is difficult to design health improvement and health care services to be fully inclusive. Nonetheless, existing initiatives to ensure that NHS services and health improvement actions meet the needs of all parts of the population show the direction in which all services must travel.
- Only a few lucky individuals will not encounter mental and physical challenges in their lives. A systematic approach to building personal coping skills and resilience would not only equip the population to face the personal challenges that are part of life but also strengthen Scotland's ability to weather the global uncertainties of the 21st century.

If asked to predict at the start of this project what our main impression would be at the end, we would have said something about inadequate statistics. But that is not our main impression now that it is concluded. It is the impact that diminished wellbeing – from prejudice, discrimination and exclusion – must have upon individuals and upon the country as a whole: the skills and energy that go to waste. This not only weakens Scotland's potential but it diminishes each of us individually whenever we acquiesce to the structures and attitudes that maintain unfairness in Scotland today.

References

All web links were verified as working on 17 September 2009.

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