

5. Health

Domain: The capability to be healthy

Sub-domains:

- A. Attain the highest possible standard of physical and mental health, including sexual and reproductive health.
- B. Access to timely and impartial information about health and healthcare options, including contraception.
- C. Access to healthcare without discrimination and in a culturally sensitive way.
- D. Be treated medically, or subject to experiment, only with informed consent.
- E. Be assured of patient confidentiality and be free from the stigmatisation associated with some health conditions.
- F. Maintain a healthy lifestyle including exercise, sleep and nutrition.
- G. Live in a healthy and safe environment including clean air, clean water, and the freedom from pollution and other hazards.

Final short list

Indicator 1: Limiting illness, disability and mental health

Measure 1.1 (E,W): Percentage who report a long-standing health problem or disability that substantially limits their ability to carry out normal day-to-day activities

Measure 1.1 (S): Percentage who report a long-standing illness that substantially limits their ability to carry out normal day-to-day activities

Measure 1.2 (E,S,W): Percentage who report poor mental health and well-being

Indicator 2: Subjective evaluation of current health status

Measure 2.1 (E,S,W): Percentage who report poor current health status

Indicator 3: Dignity and respect in health treatment

Measure 3.1 (E,W): Percentage with low perceptions of treatment with dignity and respect in healthcare

Measure 3.1 (S): Percentage with low perceptions of treatment with dignity and respect in healthcare (under development)

Measure 3.2 (E): Percentage reporting lack of support for individual nutritional needs during hospital stays

Indicator 4: Healthy living

Measure 4.1 (E,S,W): Percentage who are living a healthy lifestyle, covering (a) smoking (b) alcohol (c) physical activity (d) consumption of fruit and vegetables) (e) body mass

Measure 4.2 (E,W): Percentage who are living in an area with less favourable environmental conditions

Indicator 5: Vulnerability to accidents

Measure 5.1 (E,S,W): A&E accidents and injuries rate by location (under development)

General feedback on the health domain from the first round of specialist consultation

Participants raised a number of issues in the first round of specialist consultation that are of relevance at the health domain level (rather than at the level of individual indicators). A number of participants emphasised the importance of achieving an explicit balance between objective and subjective measures of health. The possibility of embedding the seven equality characteristics and social class within the *Connecting for Health* NHS system was also explored. Supplementary sources for the Health domain that were proposed included the Psychiatric Morbidity Survey, NHS complaints data and Equality Duty monitoring indicators. One participant highlighted the potential of EQ5D (a multi-domain measure of health and wellbeing) as a possible health domain indicator. It was suggested that EQ5D is a well-validated survey instrument and is easy to administer. It has been particularly important in establishing differentials in the health status of Gypsies and Travellers.

A number of issues were raised at the human rights specialist consultation event that are of direct relevance for the health domain. In particular, participants emphasised the importance of adequate coverage of the non-household population, and of administrative data sources – including data collected by the Inspectorates – where population sub-groups are not effectively covered by general household population surveys. Feedback from the human rights specialist consultation event also highlighted continued concerns about care of vulnerable people in health and social care institutions (and proliferation of shocking reports of abuse). It was suggested that it will be important for the EHRC to have a clear indicator to track and deal with this pressing problem.

General feedback from the second round of specialist consultation

Participants in the second round of specialist consultation also raised a number of issues that are of relevance at the health domain level (rather than at the level of individual indicators). One participant in the Scottish consultation event suggested that the extent to which people were given the information and support to manage their own conditions (for example asthma), without needing access to healthcare, would be an interesting indicator.

The importance of the survey of transgender people's experiences of health services at the European level (Whittle *et al*, 2008) was also emphasised. This found evidence that trans people avoid accessing routine healthcare because they anticipate prejudicial treatment from healthcare professionals. This survey could be a model for future surveys in the UK on transgender health.

One participant emphasized that there is considerable overlap with the Physical Security domain, and there is no one right way to make the distinction between the two. The World Health Organisation (WHO) include freedom from violence in indicators of health for example.

The Department of Health requested that we make more explicit the links between the recommended Indicators, PSAs and associated Department Strategic Objectives, patient experience statistics, and vital signs.

Indicator 1: Limiting illness, disability and mental health

Measure 1.1 (E,W): Percentage who report a long-standing health problem or disability that substantially limits their ability to carry out normal day-to-day activities

Measure 1.1 (S): Percentage who report a long-standing illness that substantially limits their ability to carry out normal day-to-day activities

Sources: Health Survey for England; Scottish Health Survey; Welsh Health Survey

Sub-domain: A

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics, with partial exception of disability
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	Not available
	- within England	Gender, ethnicity, disability, age, same-sex cohabitation, social class
	- within Scotland	Gender, ethnicity, disability ¹ , age, religion/belief, social class, sexual orientation (under development, in next survey)
	- within Wales	Gender, ethnicity, disability, age, social class collected But sample size too small to disaggregate by ethnicity, even if 3 years of data are combined
5	Aspect of inequality	Outcome
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

The measure tabled at the first and second rounds of specialist consultation was based on the General Household Survey (GHS), the Scottish Household Survey (SHS) and the Living in Wales Survey (LiW. This has been replaced following

¹ The survey question asks about long-standing illness that limits activities.

consultation responses with a measure from the Health Surveys for England, Scotland and Wales.

Feedback from the first round of specialist consultation

Participants were broadly supportive of a self-reported health indicator. There was a query as to whether the General Household Survey (GHS) is the best source for this indicator. It was suggested that the Family Resources Survey (FRS) might provide a definition of disability that is closer to the Disability Discrimination Act. Some participants suggested that non-long-standing illness might be important as well as long-standing illness (for instance heart attacks). Other felt that the prevalence of specific diseases should also be reflected in the portfolio of indicators for the health domain. It was pointed out that the prevalence of specific diseases is well-reported but not necessarily revealing.

Feedback from the second round of specialist consultation

One participant argued that self-reported current health is a better measure than limiting long-standing illness or disability because the latter is too close (in some cases identical) to the definition of disability used in surveys, and because the former shows strong inequalities by age and ethnicity. The importance of age-standardised results in providing more meaningful comparisons across other equality characteristics was highlighted. In terms of the best source for this indicator:

- DWP and the Office for Disability Issues prefer FRS to GHS.
- If limiting long-standing illness will be included in the core module of the Integrated Household Survey (IHS), this will be a good source, because of its huge sample size.
- UK Household Longitudinal Study may be a good source in future as it will contain an ethnic minority boost.
- The Better Together survey, due in 2009/10, could be a useful source in Scotland.
- The Living in Wales Survey is not a good source for this indicator as it produces low estimates. The Welsh Health Survey, or a GB-wide survey, would be better.

Decisions following consultation feedback

Following the specialist consultation, we have re-specified this measure. The new measure is derived from the Health Surveys for England, Scotland and Wales.

The Disability Discrimination Act (DDA) defines a disabled person as a person with 'a physical or mental impairment which has a substantial and long-term adverse effect

on his ability to carry out normal day-to-day activities.’ We have tried to focus this measure as closely as we can on this definition. The HSE variable is similar to, but not exactly in line with, this proposal. We recommend the adoption of the ODI definition in future rounds of this survey.

Table 5.1 Measure 1.1 (E) Percentage reporting limiting long-standing illness or disability

Authors’ calculations using Health Survey for England, 2006, England²

	Sample size	%
Age 18-24	1044	9.2
Age 25-44	4687	15.0**
Age 45-64	4724	27.3**
Age 65-74	1785	39.78*
Age 75+	1502	51.5**
Male	10007	19.1
Female	11392	21.5**
White	18870	21.5
Mixed	423	12.7**
Asian/Asian British	1284	13.5**
Black or Black British	588	9.7**
Chinese or other	184	9.2**
No limiting long-standing illness or disability	-	
Limiting long-standing illness or disability	-	
Higher managerial and professional occupations	3456	14.5
Lower managerial and professional occupations	5174	17.8**
Intermediate occupations	1823	21.0**
Small employers and own account workers	2401	18.8**
Lower supervisory and technical occupations	2207	21.9**
Semi-routine occupations	2994	24.3**
Routine occupations	2646	26.9**
Never worked and long- term unemployed	553	28.2**
Other	96	10.7

²Preliminary results. Statistical significance based on ANOVA test.

Measure 1.2 (E,S,W): Percentage who report poor mental health and well-being

Sources: Health Survey for England; Scottish Health Survey; Welsh Health Survey

Sub-domain: A

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics, with partial exception of disability
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	Not available
	- within England	Gender, ethnicity, disability, age, same-sex cohabitation, social class
	- within Scotland	Gender, ethnicity, disability, age, religion/belief, social class
	- within Wales	Gender, ethnicity, disability, age, social class collected
		But sample size too small to disaggregate by ethnicity, even if 3 years of data are combined
5	Aspect of inequality	Outcome
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

The surveys listed above have been selected because they are similar in the questions they ask which measure mental health. The English and Scottish surveys use the GHQ12 psychological measure of well-being, while the Welsh survey uses SF36.

Feedback from first round of specialist consultation

Participants questioned whether another survey might provide a closer match with a social model definition of mental health. The Psychiatric Morbidity Survey could be a potentially useful source of data, and could help on the issue of definition. The Count Me In Census (Healthcare Commission 2007b) was also highlighted as a useful source; and participants clarified that statistics on mental health within the criminal justice system are held by the Ministry of Justice. The impact of stigma and of cultural differences was also highlighted. Some religions do not recognise mental health conditions (for instance viewed as 'possession'). Participants suggested the use of alternative wording, for instance 'trouble with my nerves', anxiety, depression.

The Sheffield Study of the health status of Gypsies and Travellers was highlighted in this context (Department of Health 2004; Parry et al 2007; Van Cleemput et al 2007). Participants mentioned that the Department of Health GP Survey asks about suicide and mental health.

Feedback from second round of specialist consultation

Participants pointed out that referring to mental health problems is unhelpful as it can reinforce negative stereotypes. It was pointed out to us that the Welsh Health Survey does not use GHQ12 but another questionnaire instrument known as SF36.

Decisions following consultation feedback

The measure has been renamed 'Mental health and well-being' and is now included under Indicator 1, Physical and mental health and well-being. The threshold for GHQ12 we are adopting is *above 2* (that is, 3+) indicating likelihood of mental health problems, in line with the recommendation in McDowell and Newell (1987).

Table 5.2 Measure 1.2 (E) Percentage reporting poor mental health (GHQ12 score>2)Authors' calculations using Health Survey for England, 2006, England³

	Sample size	%
Age 18-24	1044	16.2
Age 25-44	4687	15.3
Age 45-64	4724	17.6
Age 65-74	1785	13.3
Age 75+	1502	17.1
Male	10007	11.4
Female	11392	15.7**
White	18870	13.9
Mixed	423	13.1
Asian/Asian British	1284	11.4**
Black or black British	588	10.9
Chinese or other	184	10.7
No limiting long-standing illness or disability	17227	9.4
Limiting long-standing illness or disability		30.2**
Higher managerial and professional occupations	3456	12.0
Lower managerial and professional occupations	5174	12.5
Intermediate occupations	1823	14.0
Small employers and own account workers	2401	12.1
Lower supervisory and technical occupations	2207	13.2
Semi-routine occupations	2994	15.8**
Routine occupations	2646	15.7**
Never worked and long-term unemployed	553	17.8
Other	96	19.2

³Preliminary results. Statistical significance based on ANOVA test.

Indicator 2: Subjective evaluation of current health status**Measure 2: 1 (E,S,W): Percentage who report poor current health status**

Sources: Health Survey for England; Scottish Health Survey; Welsh Health Survey

Sub-domain: A

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics, with partial exception of disability
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	Not available
	- within England	Gender, ethnicity, disability, age, same-sex cohabitation, social class
	- within Scotland	Gender, ethnicity, disability ⁴ , age, religion/belief, social class, sexual orientation (under development, in next survey)
	- within Wales	Gender, ethnicity, disability, age, social class collected But sample size too small to disaggregate by ethnicity, even if 3 years of data are combined
5	Aspect of inequality	Outcome
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

Consultation feedback

A key feedback issue on selection criteria has been the importance of including a balance of objective and subjective indicators within each domain. Participants at the life and health specialist consultation event on life and health emphasized the importance of subjective health and well-being both for the capability to be healthy, and for other capabilities, including individual, family and social life. Many participants supported the inclusion of an indicator focusing on subjective health status in addition to the more objective measures included under Indicator 1.

⁴ The survey question asks about long-standing illness that limits activities.

Table 5.3 Measure 2.1 (E) Percentage reporting poor self-reported health (self-reported health bad or very bad)Authors' calculations using Health Survey for England, 2006, England⁵

	Sample size	%
18-24	1044	2.0
25-44	4687	3.3
45-64	4724	8.3**
65-74	1785	12.3**
75+	1502	14.7**
Male	10007	5.4
Female	11392	5.5**
White	18870	5.4
Mixed	423	4.2
Asian/Asian British	1284	5.7
Black or black British	588	3.8
Chinese or other	184	4.2
No limiting long-standing illness or disability	17227	0.8
Limiting long-standing illness or disability	4166	23.5 **
Higher managerial and professional occupations	3456	2.0
Lower managerial and professional occupations	5174	3.0
Intermediate occupations	1823	6.2**
Small employers and own account workers	2401	5.7**
Lower supervisory and technical occupations	2207	6.4**
Semi-routine occupations	2994	7.4**
Routine occupations	2646	9.9**
Never worked and long-term unemployed	553	11.4**
Other	96	0.9
Key intersectional groups		
Bangladeshi / Pakistani women	Can isolate significant effects for Bangladeshi and Pakistani women aged 22-44 and 45-64 (white women comparable age = reference group)	

⁵Preliminary results. Statistical significance based on ANOVA test.

Indicator 3: Dignity and respect in health treatment

Measure 3.1 (E,W): Percentage with low perceptions of treatment with dignity and respect in healthcare

Measure 3.1 (S): Percentage with low perceptions of treatment with dignity and respect in healthcare (under development)

Sources: England: National Patient Survey Programme (Inpatient Survey); Wales: Living in Wales Survey; Scotland: Better Together Survey

Sub-domains: A, B, C, D, E

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3/4	Disaggregation	
	- at GB level	Not available
	- within England	Gender, disability, age*
	- within Scotland	Under development
	- within Wales	Gender, ethnicity, disability, age, religion/belief, social class collected But sample size too small to disaggregate by ethnicity or religion/belief even if 3 years of data are combined
5	Aspect of inequality	Process
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

*based on Inpatient Survey 2006, ethnicity collected but not available through public release

Feedback from the first round of specialist consultation

_Generally speaking, participants felt that the terminology of dignity and respect is useful and covers the salient aspects of unequal treatment. However, some participants emphasized that the dignity and respect concept is sometimes understood minimally (in terms of politeness of counter staff, for example). It is important to conceptualize dignity and respect as a ceiling, not a floor. It is also not

clear whether the dignity and respect indicator will provide effective coverage of sub-domain E – “being free from stigma”.

Some groups may be discouraged from accessing health services because of previous discrimination and lack of treatment with dignity and respect. Groups of this type would not be covered by user-surveys such as patient surveys. It is therefore important to include the dignity and respect in public services questions in general population survey such as the Health Survey for England and its equivalents, and not to limit the inclusion of this question to patient population surveys.

Gypsies and Travellers being refused access to GPs at registration would also not be picked up as part of a patient user survey. There is a need for separate monitoring of discrimination against Gypsies and Travellers in health care. The Sheffield Study provides a model (Department of Health 2004; Parry *et al* 2007; Van Cleemput *et al* 2007).

The Primary Care Trust survey includes questions on whether patients felt they were given enough information, and whether they have had a care review. Participants emphasized that this is also a potential source of data. The Longitudinal Survey of Disability being developed by ONS will also be useful source for disabled people’s experiences.

Another concern was the problem of adaptive expectations for elderly people, who often self-report high levels of dignity and respect, even though qualitative studies suggest the reverse.

Patient experience indicators are included both in the National Indicator Set and the NHS Vital Signs framework. Other process indicators could arise from the National Census of Inpatients in Mental Health and Learning Disability Services in England and Wales (HC 2007b) that can quantify how many patients feel as though they consented to their treatment (this would map to sub-domain D). Mental health may also be a suitable area for exploring issues of discrimination and stigmatisation in more depth.

Feedback from second round of specialist consultation

Age Concern told us that being patronised was one way in which older people were often treated with disrespect in healthcare and other settings. They would like to see this element included in a measure of dignity and respect.

As in the first round of specialist consultation, participants highlighted that people who do not receive healthcare, even if they need it, will be excluded from patient surveys. This produces a bias in the measure because non-access may in some

cases be due to previous bad experience or the anticipation of being treated with disrespect.

A key aspect of being treated with dignity for transgender people is that staff and fellow patients respect the person's acquired gender, and their privacy. This requires particular sensitivity where the health issue relates to their previous gender (for instance prostate problems for a trans woman, or gynaecological matters for a trans man). Issues of this kind are likely only to be picked up in specialist surveys. Coverage of the non-household population was another key concern.

An alternative to our proposal suggested by one participant was a question (possibly from GHS) on whether people would know where to get help if they needed it.

Participants at the Welsh consultation event were concerned about the extent to which respondents would give honest answers to survey questions about being treated with respect in healthcare. The Living in Wales Survey in the years 2006-2008 includes questions on being treated with dignity and respect by GP surgeries, hospitals, patient transport services, dental practices, A&E departments and ambulance services.

Participants in the Scottish consultation event suggested that in Scotland the Better Together Survey should be included when it becomes available. See the *Better Together* website (www.bettertogetherscotland.com).

DoH web consultation response

DoH welcomed the inclusion of dignity and respect indicators and asked us to develop the links between these measures and Departmental objectives (PSA, Strategic Objectives and Vital Signs) more explicitly. The strong links between the proposed approach and the DoH Operating Framework (Vital Signs, DoH 2007) and Departmental PSA and Strategic Objective Indicators. The Vital Signs Framework (DoH Operating Framework) were listed as including:

- Self-reported experience of patients and users
- Patient and user reported measure of respect and dignity in their treatment⁶.

The web consultation response noted that dignity and respect are also included in the Departmental Strategic Objective Indicator Framework (36, 38) and self-reported

⁶ DoH Strategic Framework:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085928

experience of patients and users is the basis for the DoH PSA 19.1. The latter covers access and waiting; safe, high quality, co-ordinated care; better information, more choice; building closer relationships; a clean, comfortable, friendly place to be⁷. It was further noted that in July 2008, the final report of the Darzi Review outlined a new health agenda focusing on the reduction of health inequalities rather than extending capacity as a central goal. Patient experience was viewed as a core priority.

DoH suggested that we should include a measure that covers privacy as well as dignity, building on the approach set out in the DoH patient experience metrics spreadsheet (Area 3: dignity, privacy and compassion for patients and users). It was noted that analysis of the patient survey data by ethnicity is very difficult to do. Even in the large surveys, such as adult inpatients, the number of respondents from most minority ethnic groups is small. It is possible to calculate national scores by ethnicity but the confidence intervals are very large and it is not possible to say reliably whether the scores differ by ethnic group. It is for this reason that DoH used logistic regression for the BME analysis (see link above). For these reasons, analysis by ethnicity may not be possible. The Healthcare Commission do not publish results by sex, age or disability. If breakdowns on the patient survey data are required for these groups then requests for these must be made to the Healthcare Commission.

Follow-up discussions with the Welsh Assembly Government

WAG noted that it would be useful to see further details on this indicator as dignity is not easy to define and means different things to different people.

Decisions following consultation feedback

Like many of the participants in the health consultation, we welcome new and emerging survey questions that focus on the concept of dignity and respect. We also agree with participants in the human rights consultation, that indicators of dignity and respect can in many cases be regarded as “human rights” indicators (Chapter 3). At the same, we share the concern of participants regarding the possibility of survey respondents interpreting the dignity and respect concept in a minimalist way. We are particularly concerned at the finding that older people are systematically less likely to

⁷The list of questions used as a basis for constructing patient experience scores does not, however, appear to include either self-reported dignity and respect, or individual support for nutritional needs, which are included in the specification of measures 3.2 and 3.3. For further details, see

http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSPatients/DH_087516 and

http://www.healthcarecommission.org.uk/db/documents/Chapter_11_Improving_the_patient_experience-The_Better_Metrics_project_v8-Nov07.pdf

report lack of dignity and respect in their treatment, given the current equality and human rights agenda around treatment of older people in health and social care. There is a need for methodological development in this area (including detailed cognitive testing of the dignity and respect concept covering older people, young people, ethnic minority groups etc).

In its web consultation comments, DoH was particularly concerned that we build on DoH analysis by linking the dignity and respect concept to patient experience of privacy and the other elements of “Area 3”: Dignity, privacy and compassion in healthcare, reflected in the DoH metrics spreadsheet. For this reason, and because we also have some concerns about relying on reported perceptions of dignity and respect as a basis for equality and human rights monitoring, we are recommending a broad-based measure of dignity and respect, covering: reported perception of dignity and respect, privacy, sharing accommodation with the other sex, being talked to by doctors and nurses as if you are not there, and not receiving support for individual nutritional needs when required. This covers a number of the elements of the Area 3 concept, including global experience of dignity and respect, which covers, for example, sharing of accommodation between the sexes, and “being talked to by nurses and doctors as if you are not there”, as well as reported dignity and respect.

The patient experience metrics spreadsheet area 3: control and involvement, seems to map well with our understanding of autonomy. These indicators are noted for the purposes of our parallel project, which focuses on the development of autonomy indicators that will be used with the Equality Measurement Framework.

This said, a number of problems have arisen at the technical stage in relation to the Patient Survey data. First, a weighting variable that would facilitate the use of the National Patient Survey for individual patient level analysis (rather than Trust level analysis) is not currently available⁸.

Second, we are concerned that we cannot currently access the ethnicity variable for the National Patients Survey (since it is not included in the data release, although this information is held by the Healthcare Commission). The Healthcare Commission has said that the ethnicity variable cannot be released because of data protection issues and confidentiality (Healthcare Commission, 2008). DoH web consultation comments further suggest that monitoring patient experience data by ethnicity using the National Patient Survey data can be problematic because of small sample size and

⁸ In a study for the PSA delivery note, the weighting issue was viewed as being small, and the PSA Patient Experience indicator derived from the Patient Survey will also be unweighted.

confidentiality issues, and that DoH uses logistic regression only for BME analysis in this context.

We hope that in follow-up work these issues will be resolved. Since the primary purpose of the Equality Measurement Framework is to examine cross-sectional variations by ethnicity (rather than time series improvement year by year) we feel that an approach based on logistic regression is satisfactory and we note that time series analysis using this statistic might be problematic. Cross-sectional analysis using techniques such as logistic regression by ethnicity should be robust and will give an insight into variations in the equality and human rights position of individuals and groups.

We therefore recommend that the EHRC request access to the ethnicity variable from the Healthcare Commission and that data analysis proceeds in a secure way (satisfying the relevant standards vis-à-vis confidentiality and data protection). If the ethnicity variable cannot be released, tables should be requested from the Healthcare Commission or Department of Health.

If this strategy fails, the Citizenship Survey provides a global question on perceptions of respect in healthcare that could be used as an alternative source of data for this indicator. The Patient Survey data is preferable because it is closely related to the DoH's own monitoring framework, and because it provides further contextual probing, whereas the Citizenship Survey is limited to global questions. However, the data derived from the Citizenship Survey would be appropriate if data disaggregated by ethnicity cannot be derived from the Patient Survey data.

The quality of the Citizenship respect data has been questioned in relation to the monitoring of PSA 15 (see National Audit Office 2009) and a current GEO project aims to develop improved survey questions on perceptions of respect in treatment in public services. The outcomes of this project should also be given consideration in the development of this indicator.

Table 5.4 Measure 3.1 (E) Percentage not treated with dignity and respect in healthcare servicesAuthors' calculations using National Patient Survey for Inpatients, 2006, England⁹

	Not being treated with dignity and respect (in patients, weighted %)		Broad-based dignity and respect (either: reported not <i>not</i> being treated with dignity and respect, or lack of privacy, or sharing accommodation with opposite sex, or being spoken to as if not there, or capability for adequate nutrition not satisfied) (in patients, weighted %)¹⁰	
	Sample size	%	Sample size	%
Age 16-35	8055	36.5	8055	72.1
Age 36-50	12853	28.9**	12853	65.4**
Age 51-65	48519	17.0**	48519	60.1**
Age 81+	11242	19.1**	11242	67.8**
Male	35882	17.3	35882	62.2
Female	43135	24.4**	43135	64.2**
No limiting long-standing illness or disability	36244	16.9	36244	62.3
Limiting long-standing illness or disability	2553	24.1**	2553	64.2**

⁹ Preliminary results. Statistical significance based on ANOVA test.¹⁰ This broader category was introduced in response to comments from the DoH, which suggested that concepts such as privacy are closely related to dignity and respect and should be covered. See commentary above.

Key intersectional groups Over 81 and have limiting long-standing disability	23 per cent of those 81+ with a long-standing disability reported that they were not always treated with dignity and respect
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Table 5.5 Measure 3.1 (E) Perceptions of treatment with dignity and respect in healthcare services¹¹

Authors' alternative calculations from Citizenship Survey, 2007-8, England and Wales

	Measure 1: Always treated with dignity and respect				Measure 2: Treated with dignity respect sometimes, rarely or never				Measure 3: Rarely or never treated with dignity and respect				Measure 4: Mean Score			
	WP	Significance O	LR	LR (D)	WP	Significance O	LR	LR(D)	WP	Significance O	LR	LR (D)	WMS	Significance O	OL	OL (D)
Age 16-29	42.0	RG			12.1	RG			1.9	RG			1.72			
Age 30-39	34.8		** -ve	**	13.1				1.2				1.90			**
Age 40-49	38.3		** -ve	**	8.6	**	-ve	** -ve	1.0	**	-ve		1.72	**		+ve
Age 50-64	44.8		** +ve		6.9	**	-ve	** +ve	1.1	**	-ve		1.63	**	**	**
65+	61.8	** +ve	** +ve	**	4.0	**	-ve	** -ve	0.6	**	**		1.43	**	**	**
				+ve		-ve				-ve	-ve			-ve	-ve	-ve
Male	45.6	RG			8.6	RG			1.3	RG			1.65			
Female	43.6	** -ve	** -ve	No	8.9				1.0				1.66	**	**	
														+ve	+ve	

¹¹ Preliminary results. WP=weighted percentage, WMS=weighted mean score; O=oneway (unweighted sample only), LR= single logistic regression, LR(D)= single logistic regression adjusting for survey design effects. Significance is examined using a number alternative tests in line with our suggestions for taking the data work analysis forward at the next stage of the project.

	WP	O	LR	LR (D)	WP	O	LR	LR(D)	WP	O	LR	LR (D)	WMS	O	OL	OL (D)
White	44.6	RG		No, all	8.8	RG			1.1	RG			1.65			
Asian	43.	** -ve	** -ve		9.2				1.4		**		1.67	**	**	
Black	41.6	** -ve	** -ve		11.7	**	**		1.3				1.72	**	**	** +ve
Mixed	48.4				10.9	+ve	+ve		2.9		**	**	1.66			
Other	49.6				10.7		+ve		1.0		+ve	+ve	1.63			
No limiting long-standing illness or disability	43.5	RG			9.0	RG			1.0	RG			1.67			
Limiting long-standing illness or disability	49.0	** +ve	** +ve	** +ve	8.5				1.7	**	**	**	1.62	**	**	**
										+ve	+ve	+ve		-ve	-ve	-ve
Managerial	42.0	RG			8.6	RG			1.1	RG			1.68			
Intermediate	40.8				9.6				1.2				1.70			
Small employer	47.3	** +ve		** +ve	9.0				1.0				1.63	**	**	**
Lower supervisory & technical occupations	50.3	** +ve		** +ve	7.0			** +ve	0.8				1.58	**	**	**
														-ve	-ve	-ve

	WP	O	LR	LR (D)	WP	O	LR	LR(D)	WP	O	LR	LR (D)	WMS	O	OL	OL (D)
Semi-routine	47.2				12.3				3.5	+ve (si + b, not sch)	**	**	1.69			
Never worked	47.5				9.2				0.6				1.63			
Full-time student	44.9				6.2				0.3				1.62			
Heterosexual or straight	44.3	RG			8.8	RG			1.1	RG			1.66			
Gay, lesbian, bisexual or other	38.7				11.7				2.5				1.76			
Prefer not to say	55.7			**	12.0		**		0.8				1.58			
				+ve			+ve									
Christian	45.4	RG			8.5	RG			1.1	RG			1.64			
Buddhist	42.0				12.5				1.3				1.72			
Hindu	46.6				8.2				1.1				1.63			
Jewish	47.5				8.7				1.4				1.63			
Muslim	45.9		**	-ve	9.2				1.1				1.65			
Sikh	40.0		**	-ve	8.9				1.5				1.70			
Any other religion	42.1				8.1				2.6				1.69			
No religion	40.6	**	**	**	10.8	**	**	**	1.4		**		1.71	**	**	**+ve
		-ve	-ve	-ve		+ve	+ve	+ve			+ve			+ve	+ve	

	WP	O	LR	LR (D)	WP	O	LR	LR(D)	WP	O	LR	LR (D)	WMS	O	OL	OL (D)
Key intersectional groups																
Age 16-39 and no limiting long-standing illness or disability		RG				RG					RG					
Age 16-39 and limiting long-standing illness or disability		** -ve				** +ve					** +ve			**		** +ve

Table 5.6 Measure 3.1 (W) Perceptions of treatment with dignity and respect in healthcare services

Authors' calculations from Living in Wales Survey, 2006, Wales

	Dignity and respect: Inpatient, outpatient or day case at hospital (%)	Dignity and respect in GP surgery (%)
16-24	1.66	1.77
25-44	1.56	1.59
45-64	1.41**	1.48**
65-74	1.36**	1.31**
75+	1.28**	1.27**
Male	1.39	1.42
Female	1.48**	1.51**
Non-White	1.50	1.39
White	1.44	1.48
No limiting long-standing illness or disability	1.45	1.49
Limiting long-standing illness or disability	1.42	1.41**
Higher managerial and professional occupation	1.48	1.43
Lower managerial and professional occupation	1.45	1.47
Intermediate occupations	1.52	1.53
Small employers and own account workers	1.45	1.43
Lower supervisory and technical occupations	1.40	1.44
Semi-routine occupations	1.44	1.49
Routine occupations	1.35	1.49
Not classified	1.54	1.52
None	1.60	1.63
Christian	1.39**	1.43**
Minority religion	1.54	1.32**
Key intersectional groups		
Age 16-44, no limiting long- standing illness or disability	1.52 (unweighted)	1.58 (unweighted)
Age 16-44, limiting long- standing illness or disability	1.77 (unweighted) **	1.66 (unweighted)

Male non-white	1.83 (unweighted)	1.57 (unweighted)
Male white	1.36 (unweighted) **	1.39 (unweighted)

Measure 3.2 (E,W): Percentage reporting inadequate support for individual nutritional needs during hospital stays

Source: National Patient Survey Programme (inpatient survey)

Sub-domains: A, B, C, D, E

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	Not available
	- within England	Gender, sex, disability age*
	- within Scotland	Not available
	- within Wales	Not available
5	Aspect of inequality	Process
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

*based on Inpatient Survey 2006, ethnicity collected but not available through public release

We are also recommending the inclusion of a supplementary process measure under Indicator 3, Measure 3.2, support for nutritional needs (inpatients). The data is derived from Patient Surveys and is used as an indicator by Age Concern.

We are including this Measure because of our concern that perceptions of unfair treatment in public services by older people (including perceptions of dignity and respect) can be an unreliable guide to the equality and human rights position of older people in some contexts. The issue of lack of dignity and respect of older people in areas such as health and social care is currently a key issue on the equality and human rights agenda, with a series of recent qualitative studies raising the profile and establishing importance of embedded “cultures” of discrimination against older

people (for instance JCHR (2007), HC (2007a), HC *et al* (2006a)). However, these qualitative findings are difficult to reconcile with quantitative variations analysis of perceptions of treatment with dignity and respect undertaken by the Healthcare Commission on the basis of Patient Surveys, which suggest that older people are significantly *less* likely to report that they have *not* been treated with dignity and respect in a variety of health care settings (mental health services, emergency departments, local health services, outpatient departments) (HC 2006b: 32-45).

Our preliminary analysis of both the Citizenship data and the 2006 Inpatient Survey data supports this finding, with older people being found to be significantly *more* likely to report experiencing dignity and respect. We recommend that further research is required to explain the apparent conflict between these qualitative and quantitative findings and, given the factors uncovered, to assess the implications for developing social survey questions on perceptions of unfair treatment in public services in a range of contexts. This further research should include systematic examination of the possibility of adaptive expectations, and detailed cognitive testing of the understanding and interpretation of the dignity and respect concept by older people.

The preliminary technical analysis (based on the 2006 Inpatient Survey) is presented below. The trend in general perceptions of dignity and respect data (indicating a lower tendency for lack of dignity and respect with age) is reversed. Over-81s are significantly less likely to have the capability for adequate nutrition satisfied during hospital stays. This trend is also present in the 2007 data, although in 2007 the finding for over-81s is not statistically significant.

We recommend that the EHRC work with the Healthcare Commission and other stakeholders on the extent to which the treatment of older people is captured and reflected in (1) general perceptions of dignity and respect data (2) the extent to which the question on nutritional support captures and reflects older peoples treatment (and on question development as necessary).

Although we cannot recommend the inclusion of additional measures under this indicator at the current stage, we recognize that general subjective / perceptions-based measures of dignity and respect may require probing with additional statistics. For example, the *Count Me In Census* undertaken by the Healthcare Commission (HC 2007b) provides another possible source of an additional measure under this indicator, capturing and reflecting the treatment of people with mental health problems and learning difficulties. A possible supplementary measure, for example, would be the disparities of pathways to referral to mental health services, including via health services and criminal justice routes, with disaggregation including by ethnicity. This year's *Count Me in Census* will also provide statistical information on

disparities in issues of consent and the use of restraint by ethnicity, and will be an invaluable supplementary source for use with the Equality Measurement Framework. We are considering the possibility of developing a supplementary indicator of autonomy that could potentially incorporate this data source.

In follow-up discussions, WAG suggested that Measure 3.2 is important and that nutrition is one of the key cross-cutting themes in the review of the NSF for Older People being undertaken by CSSIW / HIW. In taking the development of this indicator forward, it will therefore be useful to link it with the review.

Table 5.7 Measure 3.2 (E) Percentage for whom needs for nutritional support are not satisfied during hospital stay

Authors' calculations from 2006 National Patient Survey for Inpatients, England)¹²

	Sample size	Percentage reporting not always receive adequate nutritional support (receiving such support sometimes / never) (weighted)
16-35	8055	14.3
36-50	12853	10.2**
51-65	48519	7.9**
81+	11242	16.0**
Male	35882	9.2
Female	43135	10.5**
No limiting long-standing illness or disability	36244	5.6
Limiting long-standing illness or disability	2553	13.0**
Key intersectional groups		
Over 81 and have limiting long-standing disability or illness		20 per cent of those 81+ with a long-standing disability report lack of support for individual nutritional needs during hospital stay (no of cases in sample = 1222)

¹² Preliminary results. Statistical significance based on ANOVA test.

Technical follow-up work

- Figures based on responses to the following question: did you get enough help from staff to eat your meals?
- Figures based on coding of a binary variable ('don't need support for nutritional needs' or 'received support for nutritional needs' to zero, 'sometimes received nutritional support' and 'no coded to one).
- 59614 respondents answer affirmative to 'don't need support for nutritional needs'. Coding these to missing generates different results, with age no longer significant. Nevertheless, the upward trend in age remains, including for the over 81s, reversing the dignity and respect result for this age group. Results by disability remain significant, and it is also possible to isolate a significant result for the over 81s with a long-standing disability or illness.
- This difference should be further analysed in follow-up work.
- Figures for "never received nutritional support" are significant for over 81s, and could be reported separately.

Indicator 4: Healthy living

Measure 4.1 (E,S,W): Percentage who are living a healthy lifestyle, covering (a) smoking (b) alcohol (c) physical activity (d) consumption of fruit and vegetables) (d) body mass

Source: Health Survey for England, Scotland and Wales

Sub-domain: A, F

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	
	- within England	Ethnicity, age, gender, disability
	- within Scotland	Gender, ethnicity, disability ¹³ , age, religion/belief, social class, sexual orientation (under development, in next survey)
	- within Wales	Gender, ethnicity, disability, age, social class collected But sample size too small to disaggregate by ethnicity, even if 3 years of data are combined
5	Aspect of inequality	Outcome
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

The measure tabled at the first and second rounds of specialist consultation was based on the Taking Part Survey, and focused on participation in sport. This was revised following consultation responses.

Feedback from the first round of specialist consultation

- The Taking Part survey is being discontinued to be replaced by a Sport England survey under another name (Audit Commission).

¹³ The survey question asks about long-standing illness that limits activities.

- A key feed-back issue is that a measure based on participation in sport may not work well for disabled people.

Feedback from the second round of specialist consultation

- The indicator should focus on exercise or physical activity rather than sport. The recommendation now is that people should be doing at least 5 x 30 minutes exercise per week, so this is the level we should be monitoring.
- Participants at the Scottish and Welsh consultation events, and some of the responses to the web consultation, thought that there were other aspects of a healthy lifestyle that should be reflected in this indicator, including: diet (fruit and veg consumption), smoking (or chewing khat), obesity, and alcohol consumption. The last three would tie up with Scottish national indicators.
- The DoH web consultation response emphasized the inclusion of smoking prevalence.
- In addition, a web consultation response suggested that substance misuse should be included in a healthy lifestyle indicator.
- This indicator should be age-standardised.

In terms of alternative sources:

- The UK Household Longitudinal Study will have a module on health which could be a useful source, given the ethnic minority boost.
- The Sport Council for Wales biennial survey and the Welsh Health Survey are possible sources.
- Smoking and alcohol consumption are available from the GHS and obesity is available from the Health Survey for England.

Recommendations on 'health' thresholds

Working definition: Percentage who are: (a) not smoking; (b) not drinking more than recommended amount of alcohol (c) meeting physical activity recommendations; (d) consuming at least 5 portions of fruit or vegetables per day; (e) who are not overweight or obese.

Percentage of adults not meeting recommended consumption levels of fruit and vegetables

Recommendation: Five or more portions of fruit and vegetables per day.

Percentage of adults not meeting recommended alcohol consumption levels

Recommendation: No more than four units for men and three units for women in a day.

(Note: derived variable table in CVD report - Percentage of adults drinking more than the recommended amounts on at least one day in the past week.)

Percentage of adults meeting recommended physical activity levels

Recommended physical activity levels: being active at moderate or greater intensity for at least 30 minutes a day either in one session or through a number of shorter bouts of activity of 10 minutes or longer (translated into physical activity levels).

Percentage of adults who are overweight or obese

BMI categories according to NICE guidelines: Underweight: Less than 18.5 kg/m², Normal: 18.5 to less than 25 kg/m², Overweight: 25 to less than 30 kg/m², Obesity I: 30 to less than 35 kg/m², Obesity II: 35 to less than 40 kg/m², Obesity III: 40kg/m² or more.

All recommendations and thresholds are taken from the Health Survey For England 2006 Report (Information Centre2008) and are monitored over a period of a week.

Measure 4.2 (E,W): Percentage who are living in an area with less favourable environmental conditions

Source: DEFRA Sustainable Development Indicator 60 matched to household survey data, for instance IHS

Sub-domains: G, A

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	Not available
	- within England	Ethnicity, age, gender, disability, religion/belief, social class
	- within Scotland	Under development
	- within Wales	Under development
5	Aspect of inequality	Outcome
6	Frequency	<i>Ad hoc</i>
7	Individual level	Yes
8	Robustness	Good

This indicator was not tabled at the first round of specialist consultation, but a number of participants highlighted the importance of developing a supplementary indicator focussing on the impact of poor environmental conditions on health. At the second round, measure 5.1 was tabled, and we asked for suggestions for the development of a measure of living in a safe environment. As a result of feedback, measure 5.1 was confirmed and a new measure 5.2 was introduced.

Measure 4.2 is based on data used by the Department for the Environment, Food and Rural Affairs (DEFRA 2008) in Sustainable Development Indicator number 60. Information on a range of local conditions are mapped by the Environment Agency to Census Super-Output Areas (each covering a population of about 1,500 people):

- Ambient air pollution
- Biodiversity
- Derelict land
- Flood risk
- Green space
- Poor housing quality
- Industrial airborne releases
- River quality

The worst (or 'least favourable') 10 per cent of areas has been identified for each condition. The number of conditions for which an area is in the worst 10 per cent is then counted (0, 1, 2 or 3+ conditions). DEFRA then compares this count to the Index of Multiple Deprivation – a measure of social and economic disadvantage – to assess the degree of overlap between environmental deprivation and other forms of disadvantage. For the purposes of the Equality Measurement Framework, however, it is proposed to match the index of 'least favourable environmental conditions' by Census Super Output Area to household survey data, so as to examine the individual characteristics of people living in better and worse environmental conditions. The IHS would be a strong candidate for matching, given its large sample size. (The matching might need to be carried out by ONS to protect confidentiality and prevent inadvertent disclosure). Disaggregation based on where people live by gender, age, disability, ethnicity, religion/belief and social class within England would then be possible, and sexual orientation questions may be added to the IHS in future.

Although the data on environmental conditions are currently only available for England, DEFRA is exploring with the devolved administrations the possibility of extending the analysis to Wales and Scotland.

Feedback from the first round of specialist consultation

Participants suggested that an environmental indicator (for instance a clean environment indicator) would be appropriate to cover sub-domain G. DEFRA statistics were suggested as a source. It was suggested that asthma admissions could also be used as a proxy indicator for clean air and that accident rates (ROSPA data and Fire Service) could be used as a proxy for an unsafe environment.

A number of participants highlighted that it will be important to highlight the differential accident rates experienced by Gypsies and Travellers and the health impact of these (as established in the Sheffield Study, Department of Health 2007 and Parry *et al* 2007). These are often associated with poor environmental conditions, for instance poor living conditions and living near busy roads.

Hospital accident rates were viewed as a useful complementary source for monitoring domestic violence. Environmental data on living conditions, for instance rat-infested environments, were viewed as relevant for environmental health.

Feedback from the second round of specialist consultation

Air quality was highlighted as an important indicator. For children, rates of asthma would be a good alternative. Not all accidents are to do with a poor environment, for example it might be taking the wrong medication or falling down the stairs. The name of the overall indicator should reflect that.

The quality of the immediate environment – damp in the home, for example – can be assessed using housing surveys, such as the Scottish House Condition Survey. Problems in the local area as perceived by the respondent are measured in the SHS, including dog-fouling.

Another concern was that there is a risk of overlap between the quality of local environment indicators and indicators included in the Standard of Living domain.

Feedback from follow-up meetings and discussions

The Scottish Government suggested that as there is no data source for this measure in Scotland, the measure could be changed from a subjective measure to a physical measure using administrative data from the Scottish Environmental Protection Agency (SEPA). The mapping postcodes from the SHS onto the administrative data set was also discussed.

Indicator 5: Vulnerability to accidents

Measure 5.1 (E,S,W): A&E accidents and injuries rate, by location (under development

Definition: A&E accidents by location (a. home; b. work; c. public place; d. work/educational establishment; e. other)

Source:

http://www.ic.nhs.uk/webfiles/publications/AandE/AandE0708/AandE_Attendances_in_England_%28Experimental_Statistics%29_2007-08.pdf

Sub-domains: G, A

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	
	- within England	Ethnicity, age, gender, disability
	- within Scotland	Under development
	- within Wales	Gender, age, ethnicity (under development)
5	Aspect of inequality	Outcome
6	Frequency	Tbc
7	Individual level	Yes
8	Robustness	Good

We are recommending the inclusion of this supplementary measure, capturing vulnerability to accidents, drawing on a new data release on A&E admissions in England (January 2009) on an experimental basis. The measure has been introduced in response to the views of participants at both the health and physical security specialist consultation events. At the former, the ability of the EMF to capture and reflect differentials in vulnerability to accidents due to poor local environmental conditions such as dangerous roads and living environments was highlighted as a particular concern. Established differentials in the accident rates of Gypsies and Travellers, as highlighted in DoH 2004 and Parry *et al* (2007) were also emphasized. At the physical security event, the need to monitor A&E accident rates was emphasized from the perspective of domestic violence and intimate partner violence.

Many victims present themselves at A&E and are not picked up by the criminal justice system. The OPHI guidelines also emphasise the importance of monitoring domestic violence as a health as well a criminal justice system issue, and highlight the recommendations made by WHO in this area (Diprose, 2007). In addition, police-recorded crime figures on transport accidents have recently come under the spotlight, and monitoring A&E accident rates may have particular value added as an information base in this area.

The A&E admissions statistics are a new release and issues around data cleaning and data quality are highlighted. The data is not yet considered statistically reliable and robust by the DoH (DOH 2009, Personal Communication).

Nevertheless, we feel that there is a very close match between this data and the concerns of participants, and unlike previously released A&E data, a range of variables covering equality characteristics are available. However, since the data is a new release, and data quality is an issue, we recommend that the EHRC / GEO commission a separate small research project focusing on the analysis of this data from the equality and human rights perspective.

There is a new database for Wales being planned for A&E, called the Emergency Department Data Set (EDDS), expected to be piloted in 09/10 with full compliance by April 2010. The data collected is broadly in line with England's Commissioning Data Set. It is proposed that it will include date of birth, sex and ethnicity but not religion. Information on location of accident will be included. We recommend that the feasibility of deriving an equivalent indicator for Wales from this database is examined as part of the proposed research project.

The Scottish Government has also indicated that there is on-going data development work in this area that could provide a basis for this measure in Scotland.

Recommendations

Looking at the portfolio of indicators being proposed for the Health domain as a whole, the set of indicators reflect the sub-domains.

In line with the selection criteria outlined in Chapter 2, both objective and subjective measures are included.

Indicator 3 Measures 3.1, 3.2 and 3.3 (being treated with respect in healthcare; dignity, privacy and compassion in healthcare (patients and users); and individual support for nutritional needs (inpatients) ensures that a particular human rights concern is captured and reflected in this domain.

We recommend that:

- The Health Survey of England adopts the ODI definition of a disabled person as a person with ‘a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities’ in future rounds of the survey.
- EHRC, GEO and the devolved administrations work with the Care Quality Commission to secure the release of the ethnicity variable or to make alternative arrangements for the development of Measures 3.1 and 3.2 (for instance provision of tables).
- EHRC, GEO and the devolved administrations support further research to address the issue of adaptive expectations and older people in the light of the data analysis under Measure 3.1 (perceptions of dignity and respect) and 3.2 (inadequate nutritional support during hospital stays).
- EHRC, GEO and the devolved administrations support a research project examining the new experimental A&E statistics on accident and injury by location, and their potential for possible integration into the EMF.