A Health Profile of Fife

2001-2002

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1. INTRODUCTION


Approaches to profiling health

Reviewing information on population, births, deaths, disease and life circumstances and lifestyles can help us to describe and monitor the health of the people of Fife. It can also be used to facilitate effective planning, to help design effective interventions and to explore factors that influence health. We can also examine how Fife is progressing towards targets set for a healthier Scotland and a healthier Fife including some of those listed in the following documents: ‘Towards a Healthier Scotland’, ‘Fife Partnership Community Plan’ and ‘Director of Public Health Annual Report 2000’.

There are a number of ways in which we can examine the health of the people of Fife and the health of people living in different areas and in different circumstances within Fife. Firstly we can examine health and health behaviours by gender and age as many health topics have particular relevance for older or younger ‘Fifers’ or males or females.

Secondly we can examine the health, and determinants of health, of people living in different areas by looking at Fife in terms of different geographies. One way to do this is to present comparisons by postcode sectors (Figure 8, page 18), of which there are 54 in Fife. Alternatively comparisons can be made across the 92 Fife council wards (Figure 4, page 14). A more common method used is to examine the differences between Local Health Care Co-operative (LHCC) areas. There are five LHCC areas within Fife: Dunfermline, West Fife, Glenrothes, Kirkcaldy/Levenmouth and North East Fife (Figure 1, page 2). LHCCs were established in 1999 and each represents a voluntary grouping of GP practices with responsibilities for delivering and improving the quality of care to their local communities in accordance with health needs and local clinical priorities.

Finally many of the health topics presented within this section are presented in terms of the differences between people living in areas of differing levels of deprivation. The Carstairs Deprivation Index has seven deprivation categories: Depcat 1 representing the least deprived area to Depcat 7, the most deprived. There are no Depcat 7 areas within Fife however the method of calculation using postcode sectors, average population 5000, may hide small areas of the worst deprivation. Figure 2 (page 2) shows Fife by deprivation category. Area deprivation patterns in Fife also do not reflect the fact that many individual people who live in deprived circumstances do not live in the most deprived areas (Chart 6, page 9).
Figure 1: Fife NHS Board Area by LHCC Boundaries.

Figure 2: Fife NHS Board Area by Deprivation Category.

Source: Community Health Index/Carstairs Index.

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Source: Community Health Index/Carstairs Index.
2. DEMOGRAPHY

2.1 Population

Chart 1 shows the current and expected population structure for Fife. At present males and females aged 30 to 44 constitute the largest proportion of the population. The overall size of the population is expected to decrease slightly by 2016 from 350400 to 348415 Fife residents. However greater life expectancy, falling birth rates and advances in health care will all contribute to an increasing proportion of older people and a corresponding decrease in the number and proportion of younger people. The number of Fife residents aged over 65 is expected to increase by 26% and the number over 85 by 32% between 2000 and 2016 whilst the number of residents aged 0 to 14 years is expected to decrease by 16%.

Chart 1: Fife Population (both sexes) 2000 and 2016 by 5 year age groups.

Source: General Register Office (Scotland)

2.2 Life Expectancy

Life expectancy is calculated from population and mortality data for a specific time period. At the turn of the century life expectancy at birth for Scottish males and females was 44.7 and 47.4 years respectively. By 1960 this had risen to 66.2 and 72 years. The latest figures released show that life expectancy at birth for Scottish males is now 72.9 years and 78.2 years for Scottish females.\(^5\)

Chart 2 shows that life expectancy for babies born in Fife in 1998 to 2000 is greater than that expected for Scotland as a whole, 74.1 and 79.1 years. However Scotland has the lowest life expectancy of the United Kingdom countries. Fife females only ranked 90\(^{th}\) and Fife males 84\(^{th}\) out of 119 health authorities/areas in the United Kingdom in terms of longest life expectancy.\(^6\)

Source: Office for National Statistics

2.3 Births

In 2000 there were 3520 births to Fife residents aged 15-44, of which 22 were stillborn. This represents a birth rate of 48.8 per 1000 women, a figure very similar to the rate of 48.6 reported nationally. Chart 3 illustrates a decline in the overall birth rate within Fife in the last few years.


Source: General Register Office (Scotland)
However there has been a 17% increase in the number of births to Fife mothers aged 35 and over between 1997 and 2000. In 2000 357 babies were born to mothers aged 35 and over compared to 306 in 1997. There has also been an increase in the number of babies born to women under 20 years of age, but at 5% this increase is not as marked as for older mothers.  

A key local target to reduce the percentage of babies who are born weighing less than 2500g was set in the Director of Public Health’s Annual Report 2000. 5.3% of all babies born in Fife in 2000/2001 weighed less than 2500g, a lower proportion than the 5.7% reported nationally and an improvement on the 5.6% recorded in Fife in 1995/1996. 

2.4 Deaths

Perinatal mortality

Perinatal mortality is defined as “deaths resulting from stillbirths or death in the first week of life”. The rate in Fife and Scotland as a whole is very low, in 2000 there were 8.8 per 1000 total births in Fife and 8.4 in Scotland.

All cause mortality

Over the last 5 years Scotland has had a consistently higher mortality rate than Fife for all causes of death. This five year pattern can be seen in Chart 4. In 2000 the standardised mortality rate for Fife was 747 per 100,000 population compared to a rate of 822 reported for Scotland.

Main causes of mortality

Chart 5 shows a five year trend in the number of deaths by four main causes. The main cause of death in Fife remains heart disease despite reducing the number of deaths from this cause since 1996.\(^\text{5}\) However the number of deaths from cancer in 2000 was almost as great as the number of deaths from heart disease. There were 996 deaths from heart disease and 982 from cancer in 2000. If the number of deaths from heart disease continues to fall at the same rate cancer may become the major cause of death in Fife.

Chart 5: Number of deaths by main cause; Fife 1996-2000.

Source: General Register Office (Scotland)

3. LIFE CIRCUMSTANCES

It is widely recognised that health and wellbeing are influenced by life circumstances, such as employment, income, housing, and education. This section highlights some of the variations that exist in life circumstance across Fife. Two projects in Fife (Fife Index and Fife Public Health Dataset Pilot Project) which aim to develop information systems to acquire and deliver evidence for decision making and evaluation by community planning partners in order to develop healthy public policy, are also described.
3.1 Fife Index

The Fife Index has been designed to illustrate multiple deprivation across Fife. The Index is calculated from a set of indicators of need at local authority ward level for seven different domains (children, income, employment, health and disability, housing community safety and service access). Relative deprivation or inequality across Fife can also be shown from the Index by ranking each of the wards in Fife. Figure 4 (page 14) illustrates how the inequality expressed in the Index can contrast at a very local level. Some of the most and least disadvantaged neighbourhoods, at opposite ends of the scale, adjoin each other in Fife’s towns: Smeaton/Overton and Dunnikier in Kirkcaldy and Dunfermline Woodmill and Pitbauchlie in Dunfermline.

Building the Index has highlighted the willingness of different organisations to work together and is a good example of how collaboration between Community Planning partners in Fife is working. Further information can be found on www.fifedirect.org then search for ‘State of Fife Core Indicators’.

3.2 Public Health Dataset

The Fife Public Health Dataset will build on the work of the Fife Index, expanding domains and indicators to include a wider set of information for community planning. The Fife Public Health Dataset Project is a two year pilot project, funded through the Public Health Institute of Scotland. The project is designed to enable effective provision of integrated public health information. Analysis of data from the Fife Public Health Dataset Project will be included in future Director of Public Health Annual Reports. Further information can be found on www.fifedirect.org then search for ‘Public Health Dataset’.

3.3 Unemployment

Fife’s unemployment rate averaged 5.9% in 2001. This compares with the Scottish and UK averages of 4.3% and 3.3% respectively. Over time there has been some convergence between the Fife and Scottish rate. Between 1998 and 2001 the gap in unemployment rates had fallen from 1.8 percentage points to 1.6 percentage points. The intensity of unemployment is variable across Fife. During 2001 unemployment was highest (7.2%) in the Kirkcaldy travel to work area (TTWA) and lowest (3.2%) in the St Andrews TTWA.\(^8\)

The employment domain of the Fife Index includes both registered unemployed and probably the largest group of ‘hidden’ unemployed people unable to work through sickness. Figure 5 (page 14) illustrates the Employment Domain of the Fife Index, using 1998 employment data for the 1996 Fife Council wards. The former coalfields of Central and West Fife and Levenmouth dominate the top two deciles of the Index. Unemployment rates amongst the economically active ranged from 26.3% in Ballingry and Lochore to 1% in St Andrews West. All of the wards in the top decile of the Employment domain index had unemployment rates over 20%. As well as 10,492 people registered unemployed in 1998/999 there were a further 15,410 people of working age on Incapacity Benefit and Severe Disability Allowance. The proportion of these ‘hidden’ unemployed to the official unemployed (those who are registered unemployed) is particularly
high in the former coalfield wards. A significant minority of Incapacity Benefit recipients are in their thirties and forties.

### 3.4 Health and Disability

Figure 6 (page 15) shows the Health and Disability domain of the Fife Index. This domain contains indicators for deaths below the age of 65, low birth weight babies (less than 2500 grams), census reported limiting long term illness, attendance allowance and disability living allowance recipients, and incapacity benefit and severe disablement allowance recipients. There is an evident correlation between unemployment and chronic ill health, specifically in the coalfield communities across Fife and the into the rural west Fife villages. This extends across the range of indicators of premature mortality, morbidity, as well as the sickness/disability related benefits. There are implications for a cycle of sickness and unemployment with knock on effects for household income and children.

### 3.5 Income

The variations seen in employment across Fife are also evident in terms of income support. Figure 7 (page 15) illustrates the Income domain of Fife Index. The indicators within the Income domain of Fife Index come from three means tested benefits: income support, job seekers allowance and family credit. Population groups for the indicators include: people of working age and children living in households in receipt of these three benefits, as well as those aged over 60 in receipt of income support. Just 1% of people living in St Andrews West receive these benefits, as compared to 44% of those living in Smeaton/Overton. The ten most deprived neighbourhoods in this domain have just under one third of their population (15,000) relying on these benefits. Financial poverty affects a substantial proportion of those living in the most disadvantaged communities. However, the most deprived neighbourhoods still only contain a minority of Fife’s population who rely on these benefits, 50,000 people live in other parts of Fife.

A significant minority of those receiving income related benefits were in low paid employment (5,700 people, with 10,650 child dependents), representing 2.7% of the working age population in Fife. 25,000 children in Fife (37%) live in households who are in receipt of one of three income related benefits – income support (18%), job seekers allowance (3%) and family credit (16%), making them the largest group of the population relying on this benefit.
Investigation of the data provided by the Fife Health and Lifestyle 2001 survey highlighted that not all people living in deprived circumstances live in deprived areas (Chart 6). This is mainly a function of the way area based measures of deprivation are calculated. However this way of looking at people living on low incomes illustrates the issue from both a ‘people’ and ‘area’ perspective. 12% of respondents with an annual household income of £5,000 or less lived in areas of least deprivation (Depcat 1 and 2) as did 12% of respondents with an income of between £5,000 and £10,000. Conversely not all people living in the most deprived areas (Depcat 5 and 6) suffer from individual deprivation, defined by household income. 6% of respondents with an annual income of more that £30,000 lived in areas of most deprivation as did 11% of respondents with an income of £20-29,999.

3.6 Education

Educational attainment interacts strongly with health and with child poverty, as well as being an indicator for the preparedness of young people to enter further education, training or work. Chart 7 shows the percentage change in the destination of Fife school leavers between 1990/91 and 1999/2000. The percentage of young people entering higher and further education have increased by 11% and 10% respectively over the ten year period. Whilst those joining skillseeker or youth training schemes have fallen by 22%.
Chart 7: Destination of school leavers; Fife 1990/91 and 1999/00.

There is variation across Fife in school leaver destinations as shown in Chart 8. School leavers who live in the Cowdenbeath area (defined by school leavers postal address) have the lowest share of people entering in higher education (13%), but have the highest level of those joining skillseeker or youth training (31%). More than 40% of school leavers who live in North East Fife enter higher education. This is more than three times the corresponding share for Cowdenbeath school leavers.
3.7 Stronger Communities

The physical and social environment in which people live can have an impact on their health and lifestyles and as such it is important to gain an understanding of the perceptions individuals have of where they live. Chart 9 illustrates how people responding to the Fife Health and Lifestyle Survey 2001 rated their neighbourhood. 44% of respondents rated their neighbourhood as ‘very good’ and a further 46% rated their neighbourhood as ‘fairly good’. Less than 5% thought their neighbourhoods were ‘poor’ and only 2% thought their neighbourhood was ‘very poor’. Of those respondents who rated their neighbourhood as ‘very poor’ only 27% lived in the most deprived areas of Fife (Depcat 5 and 6) as defined by the Carstairs Index.4
The same survey also asked how good services and amenities were within neighbourhoods. Overall 70% of respondents considered their neighbours to be a particularly good aspect of their neighbourhood and 65% indicated that their neighbourhoods were quiet and peaceful. Almost half of all respondents considered their neighbourhoods to have good health services, but only 19% considered their neighbourhoods to have good community facilities and only 16% of respondents considered their neighbourhood to have good facilities for children.

The experience of different neighbourhoods by deprivation category was most striking around the areas of safety and/or low crime rate, and neighbourhood maintenance (Chart 10). More than three quarters of respondents who lived in the least deprived areas found their area to be safe and/or to have a low crime rate in comparison to less than a third in the most deprived areas. Only 31% of respondents who lived in the most deprived areas indicated their neighbourhood was well maintained compared to 68% of respondents living in the least deprived areas.
An indication of community involvement can be gathered from information on volunteering. Chart 11 details the percentage of respondents to the Fife Health and Lifestyle 2001 who are volunteers. 18% of respondents give up their time to help as an unpaid volunteer, 17% of men and 18% of women. Men aged 45-54 and women aged 35-44 were the most likely to have undertaken voluntary activity.

Chart 11: Percentages of males and females volunteering by age.

Source: Fife Health and Lifestyle Survey 2001
Volunteers in Fife were mostly in full-time employment (38%) or retired (23%), whereas nationally volunteers tend to be in further or higher education, still at school or self-employed. Respondents were most likely to report volunteering for a charity (35%) or religious group/organisation (27%). The percentage of men (37%) who were volunteers for sports clubs/organisations and community groups was twice that of women (17%).

Figure 4: Fife Index – Index of Multiple Deprivation.

Figure 5: Fife Index – Employment Domain
Figure 6: Fife Index – Health and Disability Domain

Health and Disability Domain

Figure 7: Fife Index – Income Domain
4. **LIFESTYLES**

Much of the information in the following section has been extracted from the results of the 2001 Fife Health and Lifestyle Survey. The 2001 survey follows on from an initial survey conducted in 1996. The design and implementation of the 2001 survey was aided by collaboration with and practical support from Fife Council as part of Fife NHS Board’s involvement in the Fife Health Alliance and Fife Partnership.

The aim of the survey was to collect information about the health and lifestyles of the adult Fife population. This would enable trends in health and lifestyle behaviours to be observed, progress to national and local targets monitored and to facilitate effective planning and promotion of health. The survey contained 70 questions covering social and personal information, general health, physical activity, smoking, alcohol, food, safety and injury, caring, women’s health, stronger communities, sexual health and wellbeing.

The survey was sent, by post, to a random sample of 1.5% of the population of Fife registered with a GP aged 16 and over, 4359 individuals. A total of 2155 completed surveys were returned representing a valid response rate of 51.4%. This was a slightly lower response rate than the 53% achieved in 1996 but compares favourably with response rates reported for other similar surveys. Although individuals who responded to the survey were slightly more likely to be female, older and less deprived than those who did not respond this is a broadly representative sample of the Fife population. Data were analysed primarily by sex, age group, deprivation category and income group which allows us to investigate inequalities in health behaviours by age, gender, deprivation and poverty.

4.1 **Diet**

The current recommended level of consumption of fruit and vegetables is five portions per day. In 1996 18% of respondents reported consuming at least five portions of fruit and vegetables daily. By 2001 this figure has more than doubled to 37%, 28% of male and 44% of female respondents. The target set for Fife in the Director of Public Health’s Annual Report 2000 was to increase the rate to 30% by 2010. The figures above indicate that Fife has surpassed this target in 2001. Similar figures to those reported here have been reported in other recent health and lifestyle surveys which indicates there may have been changes across the Scottish population.

Respondents living in the most deprived areas were more likely to report eating no fruit and vegetables (3.3%) and less likely to report consuming five portions (32%). In comparison only 1% of respondents living in the least deprived areas did not eat the recommended amount of fruit and vegetables daily and 45% did eat five portions of fruit or vegetables. Figure 8 illustrates the percentage of respondents within each postcode sector consuming the recommended five portions. If we compare this with the figure of Fife by deprivation category (Figure 2) we can see that percentages are higher in areas such as North East Fife which are less deprived and lower in areas of higher deprivation.
The likelihood of consuming the recommended daily amount of fruit and vegetables increases with increasing household income (Chart 12). Respondents in the lowest income bracket were most likely to report consuming no fruit and vegetables in a day (4.4%) and least likely to consume the recommended amount (29.5%). Conversely 44.3% of respondents with a household income of more than £30000 consumed the recommended daily amount.

Chart 12: Percentage of survey respondents consuming no portions or five portions of fruit and vegetables per day by income.

The 1996 report ‘Eating for Health’ set a number of significant targets to improve the diet of Scottish people by 2005. These targets were further endorsed in ‘Towards a Healthier Scotland’. The data collected in the 2001 Health and Lifestyle survey can be used as a baseline to monitor our progress towards these targets for the following food types.

The national target set for bread consumption is to increase by nearly half the intake of bread mainly through wholemeal or brown bread however the most common type of bread consumed amongst survey respondents was white, eaten by 52% of all respondents. Brown or granary bread was eaten by a quarter of all respondents and wholemeal by 16%.

A national target has been set to double the daily intake of breakfast cereals by the year 2005. Consumption of breakfast cereals was high amongst survey respondents, 71% of males and 76% of females reported eating breakfast cereals in the last 7 days and more than a third had eaten breakfast cereal on 6-7 days in the last week. Consumption of breakfast cereals reported in Fife is higher than figures reported nationally in the 1998 Scottish Health Survey.

Doubling the consumption of oily fish is the target endorsed in the 1999 White Paper ‘Towards a Healthier Scotland’. 42% of respondents had consumed oily fish in the previous seven days, the majority of whom reported eating oily fish
on one day in the last week. Both older men and women were more likely to report consuming oily fish than younger respondents.

One of the key dietary targets for Scotland is to increase the average non-sugar carbohydrate intake by 25% through increased consumption of fruit and vegetables, bread, breakfast cereals, rice, pasta and through an increase of 25% in potato consumption. Nearly all respondents had consumed potatoes during the past week, 93% of males and 93% of females. The percentage of respondents eating potatoes (excluding chips) nearly every day has fallen by 11% from 20% in 1996 to 9% in 2001. However the proportion of respondents eating pasta or rice on one or two days a week has increased from 37% in 1996 to 59% in 2001.

Figure 8: Percentage of respondents eating five or more portions of fruit and vegetables; by postcode sector.

Percentages

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Source: Fife Health and Lifestyle Survey 2001
4.2 Exercise

40% of male and 33% of female respondents achieved the recommended minimum level of 30 minutes of moderate physical activity on at least five or more days a week. These figures are significantly lower than the target of 50% of males and 40% of females set for 2005 by the White Paper ‘Towards a Healthier Scotland’ but are greater than the figures reported nationally of 38% and 27% respectively in the Scottish Health Survey (1998).

Increasing age was associated with decreasing frequency of moderate physical activity (Chart 13). Younger males and females were more likely to have achieved the recommended level than older men and women. More than half of all male respondents aged 16-24 (52%) achieved the recommended level compared with 34% of men aged 75 and over. Less than a fifth of women aged over 75 (16%) achieved the recommended level in comparison to 37% of women aged 16-24.

Chart 13: Percentage of survey respondents achieving recommended moderate levels of activity by age (males and females).

The differences between deprivation areas in terms of the proportion of respondents achieving the recommended levels was smaller, 35.4% in the least deprived areas through 36.3% in areas 3 and 4 to 33.1% in the most deprived areas. There was also no relationship between increasing income level and increasing likelihood of meeting the recommended levels. Respondents with the highest household income had the lowest percentage of respondents achieving the recommended level (32%). Respondents with an income of £10-19,999 had the highest proportion, 41%.

There were more stark differences by income in terms of physical activity as measured by the amount of walking respondents undertook each day for travel. Increasing income was associated with decreasing frequency of walking for
travel (Chart 14). 27% of respondents in the lowest income bracket (under £10000) reported walking for 15 minutes everyday compared with 17% of respondents in the highest income bracket.

In contrast to walking for travel, there was little difference between respondents in the different income groups for walking for pleasure. However those in lower income brackets were still slightly more likely to report walking for pleasure.

Chart 14: Percentage of survey respondents undertaking at least one 15 minute walk for travel on none or seven days by income.

There were no clear patterns emerging in terms of the amount of walking undertaken for travel when measured by deprivation. Respondents living in the least deprived areas (Depcat 1 and 2) had the greatest number of respondents who reported walking everyday for the purposes travel (Chart 15). 30% of respondents from areas with a deprivation category of 1 or 2 walked everyday for the purposes of travel compared to 22% of respondents from areas with most deprivation (Depcat 5 and 6).
4.3 Alcohol

Figures from the Fife Health and Lifestyle Survey 2001 revealed that average weekly alcohol consumption was 18 units for men and 8 units for women. 52% of respondents had consumed a sensible amount of alcohol in the last week. This is defined as less than 21 units for men and less than 14 units for women.¹

24% of male and 9% of female respondents who had drunk alcohol had exceeded sensible drinking levels. The percentages of male and female respondents who exceeded the recommended weekly intake have increased by 2% between 1996 and 2001. Chart 16 shows that men aged 16-34 were the most likely to report drinking beyond sensible levels and men of all ages were more likely to drink to excess than women.
Nationally 32% of males and 14% of females (aged 16-74) exceed sensible drinking levels. The target set in the White Paper ‘Towards a Healthier Scotland’ is to reduce the incidence of adults exceeding weekly limits by 2005 to 31% of men and 12% of women. Although the percentages in the survey of respondents exceeding sensible limits are already lower than those nationally and those set for national targets, the trend within Fife appears to be that of an increasing excessive consumption.

There is no clear relationship between levels of alcohol consumption and deprivation (Charts 17 and 18). Females living in the least deprived areas (Depcat 1 and 2) were more likely to report drinking to excess than females living in other areas. Males and females from the most deprived areas (Depcat 5 and 6) had the lowest percentage of respondents drinking more than sensible limits. A similar pattern is observed when looking at alcohol consumption by level of household income. Females who reported the highest level of household income also had the highest proportion of respondents drinking to excess (13%) as did males with an household income of £20-29,999 (30%).
Chart 17: Percentage of survey respondents reporting excessive alcohol consumption by deprivation (males and females).


Chart 18: Percentage of survey respondents reporting excessive alcohol consumption by income (males and females).

4.4 Drugs

In 2000 a study was conducted to estimate the true, as distinct from the reported, prevalence of problem drug use in Fife. Information was collected from a range of agencies working with drug users, GPs, Fife Constabulary, Fife Social Work Service and information supplied to the Scottish Drug Misuse Database. From all of these sources 1348 individuals aged 15-54 were identified as using opiates or benzodiazepines.

By applying statistical models to this data (details of which can be found in the full report) a prevalence figure of 1.5% (Confidence Intervals 1.2-1.9%) of the population aged 15-54 was obtained, 2867 problem drug users. This figure is far greater than the reported figure of 1348 and presents the possibility of there being 1519 hidden users. The estimated prevalence amongst 15-24 year olds is 2.6% (CI 2.2-3.2). Chart 19 shows the estimated prevalence and confidence intervals for each health board area and Scotland. Fife has a lower prevalence than Scotland.

Chart 19: Drug use prevalence estimates Scottish Health Board Areas; 2000.

This study also provides evidence of an association between problem drug use and social exclusion. Findings indicate there is an association between increasing income support claimant rates and the prevalence of problem drug use. Using the same techniques there is an estimated prevalence of 0.5% of drug injectors (866 individuals). It is estimated that 29% of these injectors are infected with the hepatitis C virus.

In 2000/01 there were 598 new clients in Fife registered on the Scottish Drugs Misuse Database, 31% of whom were heroin users and a further 31% injecting heroin users. Chart 20 shows the trend in the above figures since 1996/97.
73% of new clients were males and 83% were unemployed. Of the 598 new clients registered 21% were under the age of 20, a figure similar to the 22% reported in 1998. The rate of reported heroin use in new clients under 20 years of age has decreased from 22% in 1998 to 19% in 2001 which indicates that progress is being made towards the target of ‘reducing the rate of heroin use in known drug users aged under 20 years’.

### 4.5 Teenage Pregnancies

Scotland has one of the highest rates of teenage pregnancy in the UK. The Fife rate for pregnancies to 13-15 year olds has been lower than the Scottish rate for the previous two years, however the Fife rate for 16-19 year olds remains higher than the Scottish rate (Charts 21 and 22). Such is the concern that a national target was set in ‘Towards a Healthier Scotland’ to reduce pregnancy rates amongst 13-15 year olds by 20% from 1995 in 2010. Fife is making progress towards this target with the rate reported in 2000 of 7.3 per 1000 already 21% less than the baseline rate of 9.5 per 1000.

Source: Information and Statistics Division (SMR02).

Chart 22: Teenage Pregnancies 16-19 year olds rate per 1000 population Fife and Scotland; 1996-2000

Source: Information and Statistics Division (SMR02)
4.6 Smoking

In the 2001 Fife Health and Lifestyle Survey 28% of respondents reported smoking tobacco, 32% of male and 25% of female respondents. There has been no change in the prevalence of tobacco smoking reported by survey respondents between 1996 and 2001, the figure remaining constant at 28%. The prevalence of smoking reported in 2001 is lower than the 33% reported nationally in the 1998 Scottish Health Survey. However although the rate reported for Fife is lower than national figures and already lower than the national 2010 target of 31% the above figures indicate no decreasing trend in smoking prevalence in Fife.

Smoking prevalence was highest amongst men aged 25-34 (42%) and 45-54 (39%). Smoking prevalence in women peaks between the ages of 25-34 (32.9%) and 35-44 (30%). The age group of 16-24 is the only one where the percentage of female smokers is greater than the percentage of male smokers (Chart 23). In 2000 Of the 1000 mothers who reported being a smoker at their first ante-natal booking visit 46% were aged 24 and under. Reported prevalence is therefore higher in younger women, consistent with findings from other studies and illustrates that smoking amongst young women is a major health issue.

Chart 23: Percentage of male and female smokers by age.

Concern is so great about the level of smoking reported at ante-natal booking visits that a national target of 23% by 2010 has been set. In 2000/01 29% of Fife women attending ante-natal booking visits reported being a smoker compared with 30% in 1996/97. Fife has had a consistently higher rate than Scotland (Chart 24).
Chart 24: Percentage of mothers reporting smoking at ante-natal booking Fife and Scotland; 1996/97-2000/01 and 2010 target.

There is a strong relationship between individual and area based measures of deprivation and smoking prevalence. Survey findings showed that smoking is highest in areas with the highest levels of deprivation and amongst respondents with the lowest incomes. 17% of survey respondents with an income of £30,000 or more a year classed themselves as smokers compared with 32% of respondents with an income of less than £10,000 (Chart 25).

Chart 25: Percentage of smokers and non smokers by income group.
This finding is re-enforced by examining the percentage of expectant mothers who report being smokers at their ante-natal booking visit by area deprivation. Chart 26 shows that the percentage of expectant mother reporting smoking increases with increasing deprivation, 12% amongst mothers from areas of least deprivation and 50% amongst mothers from areas of most deprivation.

Chart 26: Smoking prevalence at first ante-natal booking visit, rate per 1000 population, Fife by deprivation category; 2000/01.

Source: Information and Statistics Division (SMR02).
4.7 Breastfeeding

The rate of breastfeeding at 6-8 weeks after birth has remained fairly constant at about 35% for the last 6 years in Fife. The national target for 2005 is to raise breastfeeding rates at 6-8 weeks to 50%.\textsuperscript{13} Chart 27 illustrates the progress made towards this target in Fife and Scotland. The financial year 2000/01 was the first year in which the Scottish rate (35.2%) began to exceed the Fife rate (34.6%).

Chart 27: Percentage of mothers breastfeeding at 6-8 weeks after birth; Fife and Scotland; 1995/96 – 2000/01 and 2005 target.

Deprivation has a large impact on breastfeeding rates. In 2000 the percentage was 54% in areas of least deprivation compared with 14% in areas of most deprivation. This stark contrast can be seen in Chart 28.
There is a considerable percentage decrease in the number of women breastfeeding at first visit (approximately 10 days after birth) to those at 6-8 weeks and again at 8-9 months. This is illustrated in Chart 29 which shows the percentage of babies born in 2000 who were being breastfed at first visit, 6-8 weeks and 8-9 months by LHCC area. For example in the Dunfermline LHCC area breastfeeding rates at first visit are 45% by 6-8 weeks the rates have dropped to 36% and by 8-9 months they are 14%.

Chart 29: Breastfeeding percentages at first visit, 6-8 weeks and 8-9 months; Fife LHCC areas; 2000.
5. KEY HEALTH TOPICS

5.1 Heart Disease

A key national target is to reduce deaths from coronary heart disease in the under 75s. The target is for deaths to be reduced by 50% between 1995 and 2010.\(^1\) In 2000 Fife had a standardised mortality rate of 85 per 100,000 population compared to a rate of 119 in 1995. Chart 30 below shows that at present Fife is likely to meet this target.

Chart 30: Coronary Heart Disease, Standardised mortality rate per 100,000 population <75 years; Fife; 1995-2000 and 2010 target.

![Chart 30: Coronary Heart Disease, Standardised mortality rate per 100,000 population <75 years; Fife; 1995-2000 and 2010 target.]

Source: General Register Office (Scotland)

There are differences within Fife in the rates of deaths from coronary heart disease. For the three years between 1998 and 2000 West Fife LHCC had the highest mortality rate of 108 deaths per 100,000 population from coronary heart disease and NE Fife LHCC the lowest with a rate of 66 (Chart 31).
Chart 31: Coronary Heart Disease, Standardised mortality rate per 100,000 population <75 years; Fife and LHCCs; 1998-2000.

There is a clear link between deprivation and deaths from coronary heart disease, areas of most deprivation (Depcat 6) had a standardised mortality ratio of 124 in 1998-2000 compared with a ratio of 66 in areas of least deprivation (Depcat 1 and 2) (Chart 32).

Chart 32: Coronary Heart Disease, Standardised mortality ratio by deprivation category; Fife residents aged under 75 years; 1998-2000.

Source: Community Health Index/General Register Office (Scotland)

Source: General Register Office (Scotland)
Chart 33 compares Scotland with a selection of other European countries for deaths from Ischaemic Heart Disease. Eastern European countries report the highest rates however Scotland has one of the highest rates in Europe and has a much higher rate than other western European countries. Wider comparisons across Europe documented in ‘Chasing the Scottish Effect’ show the same pattern.14

Chart 33: Ischaemic Heart Disease, Age standardised mortality rates per 100,000 population; Selected European Countries; 1996.

Source: World Health Organisation

Although numbers and rates of people dying from these conditions continue to fall (Charts 5 and 30) there are indications that more people are living with all forms of heart disease. There has been a consistent rise in the prevalence and number of consultations for heart disease (all forms) in general practice since 1996. Figures recorded through the Continuous Morbidity Recording scheme, a scheme which records all consultations with GPs in a sample of Scottish practices, show that there were less than 150 per 1000 population consultations in 1996 but more than 200 per 1000 population in 2000. Within the CMR scheme prevalence is defined as “the total number of patients with at least one first, persistent or recurrence diagnosis, of a specified condition, during the time period” and consultations are defined as “the total number of (face-to-face) doctor/patient consultations”.

34
The use of statins, a prescribed medicine shown to have benefits in reducing mortality from ischaemic heart disease, is recommended in the national SIGN guidelines for prevention of coronary heart disease. Chart 35 shows that there has been a dramatic increase in the prescribing rate for statins between 95/96 and 00/01 in both nationally and in Fife.

Chart 35: Statin prescribing rate per 1000 Arbuthnott\(^1\) population; Fife and Scotland; 1996/97 – 2000/01.

Source: Information and Statistics Division (PCIG).

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\(^1\) Weighted population taking into account different relative healthcare needs.
5.2 Stroke

A key national target is to reduce deaths from stroke in the under 75s by 50% between 1995 and 2010. In 2000 Fife had a standardised mortality rate of 27 per 100,000 population, the rate in 1995 was 35 (Chart 36).

Chart 36: Stroke; Standardised mortality rate per 100,000 population <75 years; Fife 1995-2000 and 2010 target.

For the three year period 1998-2000 Dunfermline LHCC, with a rate of 32 per 100,000 population, had the highest mortality rate for deaths from stroke (Chart 37). North East Fife LHCC had the lowest rate of 18 per 100,000.
Deaths from stroke are also associated with deprivation (Chart 38). People living in the most deprived areas had the highest standardised mortality ratio (139) more than twice that for least deprived areas (63).

Chart 38: Stroke; Standardised mortality ratio by deprivation category; Fife residents under 75 years; 1998-2000.
Scotland’s poor position internationally continues with regard to deaths from cerebrovascular disease (Chart 39). As with deaths from ischaemic heart disease and cancer Scotland has a higher rate than other western European countries.\textsuperscript{14}

Chart 39: Cerebrovascular Disease; 1996 Age standardised mortality rates per 100,000 population; Selected European Countries.

5.3 Cancer

A key national target is to reduce deaths from all cancers in the under 75s by 20% between 1995 and 2010.\textsuperscript{1} In 2000 Fife had a standardised mortality rate of 140 per 100,000 population compared to a rate of 155 in 1995. Chart 40 below shows progress towards this target.
There are differences within Fife in terms of the mortality rate from all cancers. West Fife LHCC had the highest mortality with a rate of 155 and NE Fife the lowest with a rate of 118 in the three years between 1998 and 2000. Chart 41 shows that four of the five LHCC areas had rates higher than the Fife rate.

In 1998 there were 810 new cancer registrations for men and 853 new cancer registrations for women (Table 1, page 41). New cancer registrations were
lower than the ten year average of 821 for men but slightly higher than the average of 853 registrations for women. Charts 42 and 43 show the 10 year average figures for registrations and deaths for the most common cancers for males and females.

Chart 42: Average number of registrations and deaths for the most common male cancers. Fife; 1989-1998.

Chart 43: Average number of registrations and deaths for the most common female cancers. Fife; 1989-1998.
Breast cancer accounted for nearly a quarter of all female new cancer registrations as did lung cancer in men. The top five most frequently occurring cancers accounted for nearly two thirds of all new male cancer registrations and more than half of female (Table 1). Since 1989 there have been changes to the relative rankings of the top five cancers for both men and women. In 1989 the second most commonly occurring cancer for men and women was large bowel cancer with 115 and 96 registrations respectively. By 1998 prostate cancer had become the second most commonly occurring cancer amongst men. Lung cancer has moved to 2nd place in the ranking of female cancers, this is likely to be linked to the increased prevalence of female smoking in recent years.

Table 1: Number of new cancer registrations by sex in Fife; 1998 and 1989

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<tr>
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</thead>
<tbody>
<tr>
<td>Lung</td>
<td>155</td>
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<td>193</td>
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<tr>
<td>Prostate</td>
<td>105</td>
<td>131</td>
<td>76</td>
<td>133</td>
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<td>Large Bowel</td>
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<td>120</td>
<td>96</td>
<td>103</td>
</tr>
<tr>
<td>Bladder</td>
<td>59</td>
<td>49</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>Stomach</td>
<td>60</td>
<td>39</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>All</td>
<td>749</td>
<td>810</td>
<td>743</td>
<td>853</td>
</tr>
</tbody>
</table>

There is a clear association between deprivation and the incidence of cancer, mortality from cancer and the percentage chance of survival at 5 years following a diagnosis of cancer. Chart 44 clearly demonstrates that for Scotland areas of most deprivation (quintile 5) have greater incidence and mortality than areas of least deprivation and lower relative survival. This picture is likely to be the same in Fife.

Chart 44: Incidence, mortality and cause specific survival at 5 years by deprivation. All malignant neoplasms, Scotland; 1991-1995.


‘Chasing the Scottish Effect’ compared Scotland with other selected European countries and showed that Scotland had one of the highest mortality rates for all
cancers and lung cancer in 1996.\textsuperscript{14} Chart 45 illustrates Scotland’s poor position for mortality from all cancers.

Chart 45: All Cancers; 1996 age standardised mortality rates per 100,000 population; Selected European Countries.

![Bar chart showing all cancers mortality rates per 100,000 population for selected European countries.

5.4 Mental Health

Suicide

Males aged 15-44 accounted for the greatest number of suicides in 2000 in Fife, 22 deaths nearly half of all suicides recorded. Men of all ages have a greater rate of suicide than women. This has been a persistent trend since the early 1990s (Chart 46).

Chart 46: Number of suicides by sex and age group; Fife; 1992-2000.

Suicide is one of the biggest causes of potential life lost. Chart 47 compares the years of life lost for ischaemic heart disease, one of Fife’s biggest causes of death, and suicide for those aged under 75. Years of life lost is calculated by subtracting age at time of death from 74.5 years. For anyone over 75 this is set to zero. Years of life lost is greater for ischaemic heart disease than suicide for all 5 years shown. However in 2000 the years of life lost to suicide (489) was almost half the years lost to ischaemic heart disease (1024) although suicide accounted for only 44 deaths compared to 324 deaths from heart disease. This illustrates the relatively young age of deaths from suicide.
Anxiety, Stress and Depression

The most commonly experienced forms of mental health problems are anxiety and depression. These problems are usually experienced and reported by women more than men which is illustrated in Chart 48 which shows that consultations for both anxiety and depression are greater amongst women and that for both sexes consultations are greater for depression than anxiety.
Stress is one of the major causes of a number of mental and physical health problems. Life circumstances and lifestyles both contribute to the amount of stress individuals experience. Amongst respondents to the Fife Health and Lifestyle Survey 2001 those who were unemployed were most likely to report high levels of stress as were respondents living in the most deprived areas. 18% of respondents living in the most deprived areas reported experiencing high levels of stress compared to 11% from areas of least deprivation. 21% of respondents who were unemployed reported high levels of stress compared to 17% of respondents who were employed and just 4% of respondents who were retired.

Respondents to the Fife Health and Lifestyle survey were asked to indicate their main sources of stress. The most commonly reported sources of stress were pressure on time at work, financial worries and health (Chart 49).
5.5 Accidents

All accidents

Accident data collected from emergency admissions covers a wide range of different types and locations of accidents. These figures relate only to accidents which have required inpatient admission.

In the 2000 Director of Public Health Annual Report a target was set to reduce the hospital admission rates for accidents in children under 15 years to 11 per 1000 by 2010. In 2001 there were 758 children admitted to hospital arising from an accident, a rate of 11.4 per 1000. This compares favourably with the figures from 1995/96 when the accident rate was 13.5 per 1000 (Chart 50).
Chart 50: Emergency Admissions – accidents; Fife residents aged under 15 rate per 1000 population; 1995/96-2000/01 and 2010 target.

![Chart 50](image)

Source: SMR01.

Chart 51 shows that emergency admission rates are consistently higher for Fife residents aged over 75 than any other age group. However rates for Fife children are higher than rates for residents aged between 15-64 and 65-74. The main type of accident for all age groups were 'falls' which accounted for 45% of all accidents to children and 85% of accidents to those aged over 75 in 2001.

Chart 51: Emergency Admissions – accidents; Fife residents (by age group) rate per 1000 population; 1998-2001.

![Chart 51](image)

Source: SMR01.
Not all accidents will result in an admission to hospital but may have required some form of medical treatment or caused disruption to an individuals daily life. 15% (326) of respondents in the 2001 Fife Health and Lifestyle Survey reported having had an accident in the previous 12 months which had caused them to see a health professional or to take time off work. The most common location for these accidents was in the home (35%). The most commonly reported type of accident was a fall, slip or trip (40%) which is consistent with findings from hospital admission rates.

Chart 52 shows that from 1996/7 there has been an initial increase in the death rates from accidents but there has been a substantial decrease in these figures between 1999 and 2000. These figures will need to be closely monitored to see if this is in fact a new trend or if figures will again rise as greater variability may occur year by year due to the small numbers of deaths. For example in 2000 there were 26 deaths in the under 75s from accidents.

Chart 52: Accident mortality; Standardised rate per 100,000 population; Fife; 1996-2000.

Source: General Register Office (Scotland).

Road Accidents

Road accidents can be defined as “accidents which result in personal injury and occur on roads or footways in which a vehicle is involved and which becomes known to the police”. There are two ways of looking at road accidents in terms of the number of accidents or the number of casualties. The main focus in this report will be the number of casualties.

There were 1076 casualties resulting from 784 road accidents in Fife in 2000. 12 (1%) of these casualties were fatal (defined as an injury which causes death less than 30 days after the accident). 237 were serious, defined as injuries requiring hospitalisation as an inpatient or other serious injuries such as fractures, internal injuries and severe cuts/lacerations whether the person is
detained in hospital or not. 38 (15%) of all fatal and serious casualties in Fife in 2000 were children under the age of 15. A further 827 casualties were classified as slight for example slight bruising, cuts or sprains that require roadside attention.

Chart 53 shows the number of all casualties for all ages in Fife since 1996. Figures for 2000 have shown a slight increase on the total number of casualties reported in the previous two years but there has been a substantial 35% reduction in the number of casualties compared with baseline figures collected between 1981 and 1985. In 2000 Fife had the lowest rate per 1000 population for fatal and all severity casualties in Scotland (Chart 54). Despite reductions in the number of road traffic accidents and casualties new national targets were set in 2000 to see a reduction by 40% in the number of serious or fatal casualties and a 50% reduction in the number of child fatalities and serious injuries by 2010.17

Chart 53: Road Accidents – number of casualties (all types) by year; Fife Police Force Area.

6. KEY POINTS

- There will be an increasing number and proportion of older people and a corresponding decrease in the number and proportion of young people within Fife populations in the coming 15 years.

- Life expectancy for babies born in Fife between 1998 and 2000 is, 74.1 years for males and 79.1 years for females compared with 72.9 years and 78.2 years for babies born in Scotland as a whole.

- There has been a decline in the overall birth rate within Fife in the last few years and an increasing number of births to older mothers.

- Heart disease and cancer continue to be the major causes of death in Fife but good progress is being made towards 2010 targets.

- Deaths from heart disease are falling, in 2000 the number of deaths from cancer was almost as great as the number of deaths from heart disease.

- Since 1989 there have been changes to the relative rankings of the top five cancers for both men and women. There has been an increase in the number of registrations for lung cancer for both males and females with it being the number one cause of cancer death amongst men in 1998 and the second most common cause amongst women.

- Scotland performs poorly when compared to other European countries for deaths from heart disease, cancer and stroke.
Since 1990 there has been a persistent trend in the greatest number of suicides being reported for males aged 15-44 and men of all ages having a greater rate of suicide than women.

The most commonly experienced forms of mental health problems people experience are anxiety and depression. In Scotland GP consultations for both anxiety and depression are greater amongst women than men.

Amongst respondents to the Fife Health and Lifestyle Survey 2001 those unemployed and respondents living in the most deprived areas were most likely to report high levels of stress. The most commonly reported sources of stress were pressure on time at work, financial worries and health.

The percentage of Fife mothers breastfeeding remains constant and lower than the Scottish percentage.

Pregnancy rates amongst 13-15 year olds in Fife and Scotland are falling.

It is estimated that the true prevalence of drug misuse is much higher than reported use. The estimate of true prevalence in Fife is 1.5% within the age range of 15-54 (2867 drug users).

Inequalities as measured by area deprivation and household income exist in Fife and Scotland in both mortality from disease and in lifestyles for example deaths from cancer and smoking prevalence.

There has been a significant improvement since 1996 in the diet of Fife residents as measured by fruit and vegetable consumption with the proportion of respondents consuming the recommended daily amount more that doubling from 18% to 37%.

Low levels of moderate exercise and rates of smoking and excessive alcohol consumption remain cause for concern:
- 40% of males and 33% of females achieved the recommended level of moderate activity.
- 28% of respondents classed themselves as a ‘smoker’.
- 24% of males and 9% of females consumed more that the sensible weekly amount of alcohol.

Fife’s unemployment rate averaged 5.9% in 2001. The intensity of unemployment is variable across Fife. During 2001 unemployment was highest (7.2%) in the Kirkcaldy travel to work area (TTWA) and lowest (3.2%) in the St Andrews TTWA.

The use of area based indices of deprivation has limitations. Not all people living in deprived circumstances in Fife live in deprived areas. For example 12% of lifestyle survey respondents with an annual income of less than £5,000 lived in the least deprived areas.

The percentage of Fife young people entering higher and further education have increased by 11% and 10% respectively since 1990/91.
7. **ACKNOWLEDGEMENTS**

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8. **REFERENCES**


