

Exploring Health Inequalities in Kent

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1 Report Information

This report on health inequalities in Kent forms part of a trio of reports focussed on the overlapping determinants of health outcome inequality.

The other reports in the series are:

- Introducing Health Inequalities in Kent
- Measuring and Tracking Health Inequalities in Kent

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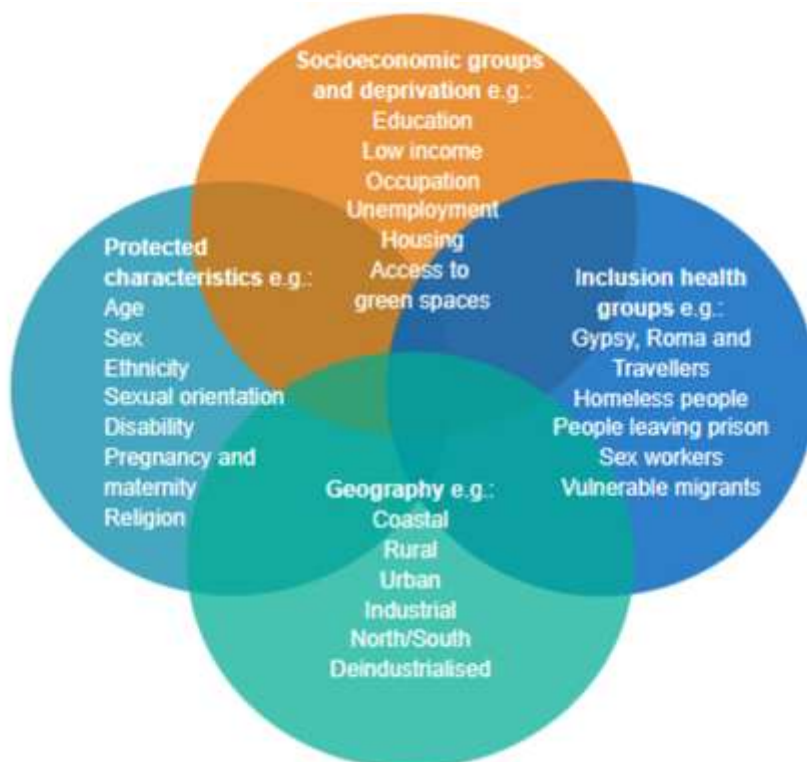
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2 Introduction

“Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society” [1]. Health inequalities encompass variations in health status, life expectancy, and the prevalence of diseases among different socioeconomic groups, ethnicities, and geographic locations.

Inequalities are often rooted in wider determinants of health such as education, employment/income, access to greenspace, and housing. The combination of socio-economic, environmental and demographic factors affect an individual’s behaviour and access to care, which ultimately affects health outcomes.

Individuals may experience multiple and intersecting dimensions of inequality, requiring a nuanced and tailored approach. Figure 1 shows the different dimensions of health inequality and how they might overlap.



Source: Local Inequalities Explorer Tool 2023 [2]

Figure 1. The overlapping dimensions of health inequalities

Inclusion health groups typically experience multiple overlapping risk factors for poor health. However, individuals from inclusion health groups are often not accounted for in electronic records; meaning specific, detailed analysis of health inequalities in these groups is not possible unless improvements are made to data capture protocols.

During the financial year 2023/24, 11,627 Kent households were assessed under the statutory homeless duty [3]. The rate of rough sleeping per 10,000 households stands at 2.0 in Kent compared to 2.0 in the South East and 1.9 in England [4].

The 2021 Census recorded that 0.3% of the Kent population identified themselves as being from Gypsy and Irish Traveller ethnic groups, compared with the England average of 0.1% [5].

The analysis herein focuses on seven dimensions of inequality: age, sex, ethnicity, deprivation, rurality, household overcrowding and access to greenspace.

It is important to note that not all dimensions of inequality are considered in this analysis because the information is not available. There are population groups outside of this analysis that face significant inequality; for example, adults with a learning disability die, on average, 21.5 years younger than people in the general population [6].

The first part of this analysis focuses on socio-economic and demographic dimensions of inequality and how they interact to affect health outcomes. For example, we explore how depression prevalence varies by deprivation, age, sex and ethnicity.

The interaction between deprivation, age and sex is presented in section 2.2.1 and ethnicity is included as a fourth dimension in 2.2.2.

The second part of the analysis focuses on socio-environmental dimensions of inequality to explore how deprivation, sex and ethnicity interact with household overcrowding and access to natural greenspace.

Error bars are presented for the majority of charts in this report; all error bars indicate 95% confidence intervals.

3 Key Findings

1. The age profile of the population differs by deprivation quintile (20% groupings) and ethnic group. More deprived areas tend to be younger than the least deprived. Non-White ethnic groups tend to be younger too, especially Black and Mixed groups.
2. Black and Other groups tend to be more deprived.
3. Deprivation has the strongest relationship with health outcomes than other dimensions of inequality; all health outcomes in this analysis are worse for the most deprived 20% of the population compared to the least deprived 20%. There is a clear gradient between most and least deprived quintiles.
4. Many outcomes differ by age, sex and deprivation, such as prevalence of GP-recorded depression or hospital admissions for alcohol.
5. Some outcomes show a weaker relationship with deprivation, such as prevalence of hypertension or coronary heart disease.
6. In some outcomes which are strongly associated with age, the rate among older people in the most deprived areas is far higher than the least deprived. Examples include prevalence of two or more long-term conditions and Diabetes.
7. In general, males have worse rates than females but there are exceptions. Hospital admissions for mental health conditions and obesity-related conditions are a lot higher among younger women aged 18 to 44.
8. The relationship between health outcomes and ethnicity is not as clear and consistent as it is with deprivation. There are clear differences in rates of some diseases between ethnic groups but there is no consistency in which ethnic group has better or worse rates.
9. Close proximity to areas of greenspace is highest in the most deprived areas of Kent.
10. Rates of household overcrowding follow a social gradient, increasing steadily with deprivation and peaking in the most deprived communities.

11. Health outcomes tend to be worse in urban areas.

12. All health outcomes examined, with the exception of emergency hospital admissions for any cause, are worse in coastal areas

4 Socio-economic and Demographic Inequality

4.1 Kent Population

Figure 2 shows relatively low levels of deprivation in the west of the county as measured by the Index of Multiple Deprivation, 2019 [7]. However there are pockets of high deprivation in the towns of Gravesend, Dartford and Maidstone. Coastal towns generally have more widespread higher levels of deprivation although inland towns have significant areas of high deprivation.

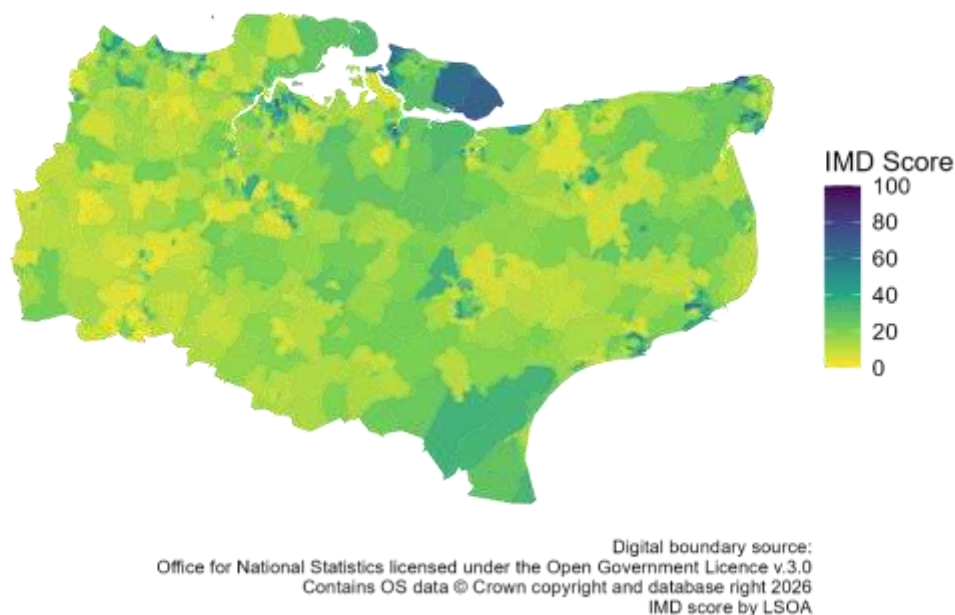


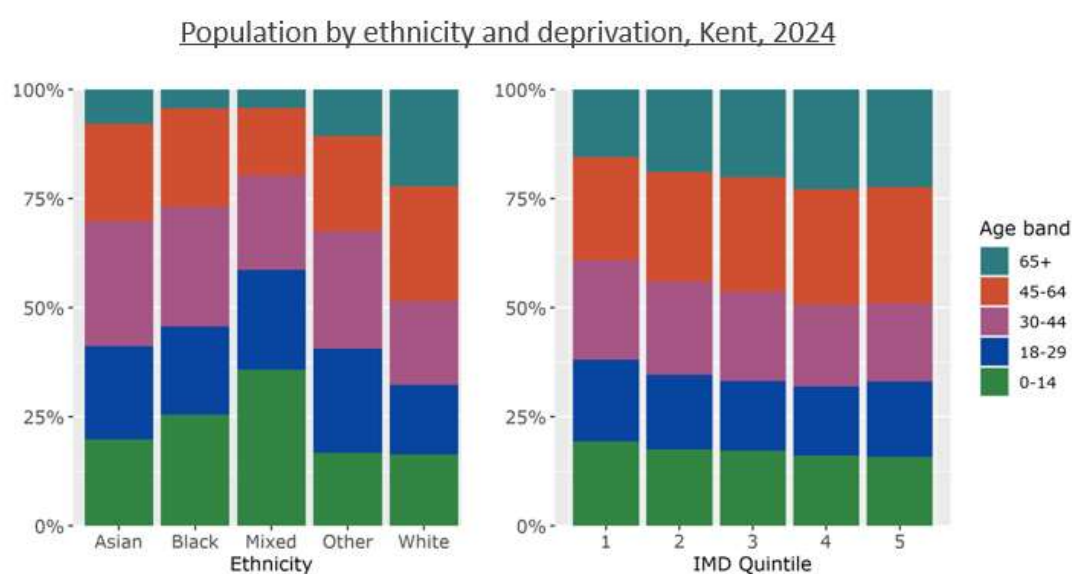
Figure 2. Index of Multiple Deprivation 2019 lower super output area scores in Kent

According to ONS mid-year population estimates for 2024, the population aged 0-18 makes up 22.8% of the Kent population compared to 22% of the England population.

The population aged over 65 makes up 20.4% of the Kent population, compared to 18.6% of the England population.

10.6% of the Kent population is of a non-White ethnic background. This is lower than the England average of 19%. Non-White is an amalgamation of ethnic groups and includes all who do not identify as White.

The proportion of people in each age group varies by ethnicity and deprivation quintile in the total Kent population. Figure 3 shows that the White ethnic group has a higher proportion of people in the 65+ age group. Over half of the Mixed ethnic group are aged below 30. People in the least deprived group (the top 20%) tend to be older, while those in the most deprived group (the bottom 20%) tend to be younger.

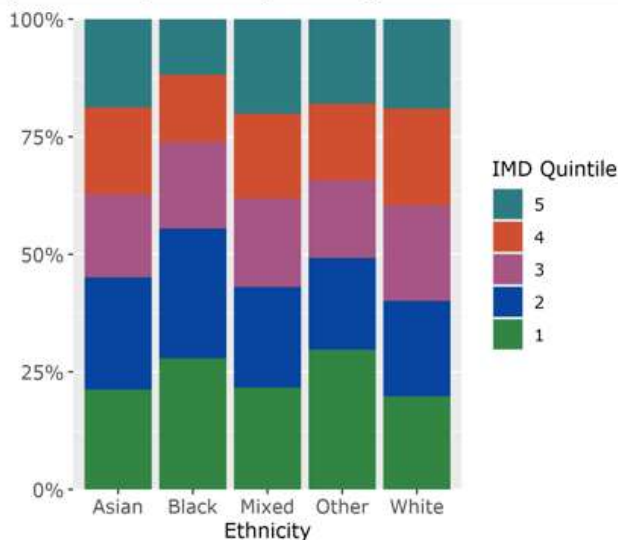


Source: KMCR, Indices of Deprivation 2019

Figure 3. Kent population proportions by age and ethnicity (left), and age and IMD quintile (right)

There is also an interaction between ethnicity and deprivation. Figure 4 shows that in the White ethnic group, the proportion of the population in each deprivation quintile is roughly equal. In other ethnic groups, a greater proportion of the population is in more deprived quintiles, most notably in the Black ethnic group where 60% of the population is in the two most deprived quintiles.

Population by ethnicity and deprivation, Kent, 2024



Source: KMCR, Indices of Deprivation 2019

Figure 4. Kent population proportions by ethnicity and IMD quintile

4.2 Health Outcome Measures

Table 2 lists the outcome indicators used to measure inequality in this report. They span different segments of the population, conditions and behaviours. Prevalence indicators are recorded in primary care, all other indicators (with the exception of excess weight in year 6 which is recorded in schools) are recorded in hospital settings.

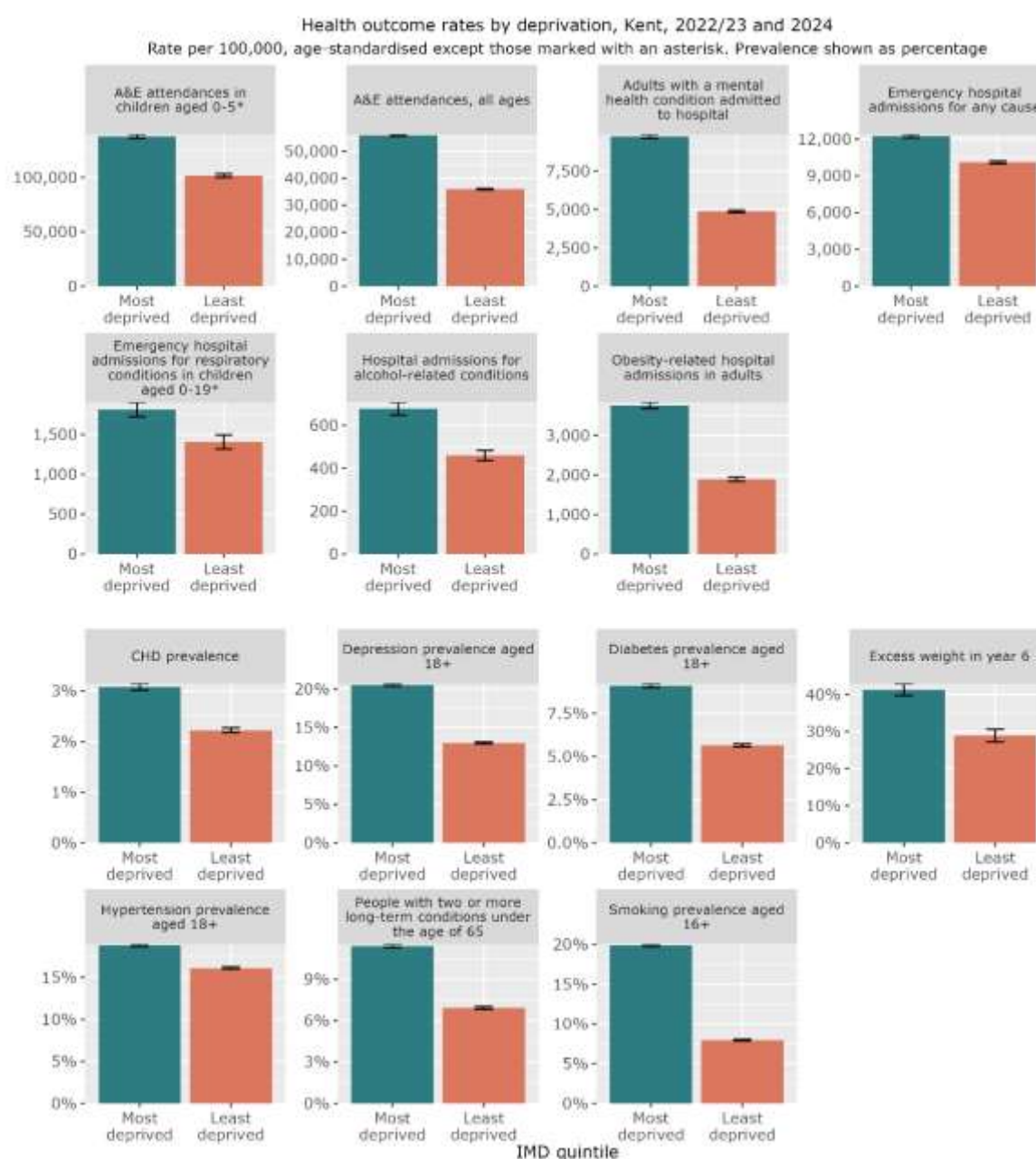
Under-recording of ethnicity in both primary care and hospital settings may artificially produce differences in health outcome measures between ethnic groups. Similarly, under-presentation at primary care may produce artificial differences in prevalence measures.

Table 2. Health outcomes analysed, sources and year of data

Health Outcome	Data Source	Year
People with two or more long-term conditions under the age of 65 years	Kent & Medway Care Record (KMCR)	2024
Emergency hospital admissions for chronic obstructive pulmonary disease (COPD)	Hospital Episode Statistics (HES)	2022/23
Hospital admissions for respiratory conditions in children aged 0-19 years	HES	2022/23
Excess weight in Year 6	HES	2022/23
Smoking prevalence aged 16 years plus	KMCR	2024
Hospital admission episodes for alcohol-related conditions	HES	2022/23
Depression prevalence aged 18 years plus	KMCR	2024
Diabetes prevalence	KMCR	2024
Coronary heart disease (CHD) prevalence	KMCR	2024
Hypertension prevalence	KMCR	2024
Emergency hospital admissions for myocardial infarction (MI)	HES	2022/23

4.2.1 Inequality by Deprivation

Deprivation has the strongest relationship with health outcomes than other dimensions of inequality; all health outcomes in this analysis are worse for the most deprived 20% of the population compared to the least deprived 20% (Figure 5).



Source: NHS England, KMCR

Figure 5. Health outcome rates in most and least deprived quintiles of Kent, 2022/23 and 2024

4.2.1.1 Hospital admissions for respiratory conditions in children aged 0-19

Figure 6 shows that the rate of emergency hospital admissions for respiratory conditions in people aged 0-19 is generally higher for males; and higher in the most deprived compared to the least deprived.

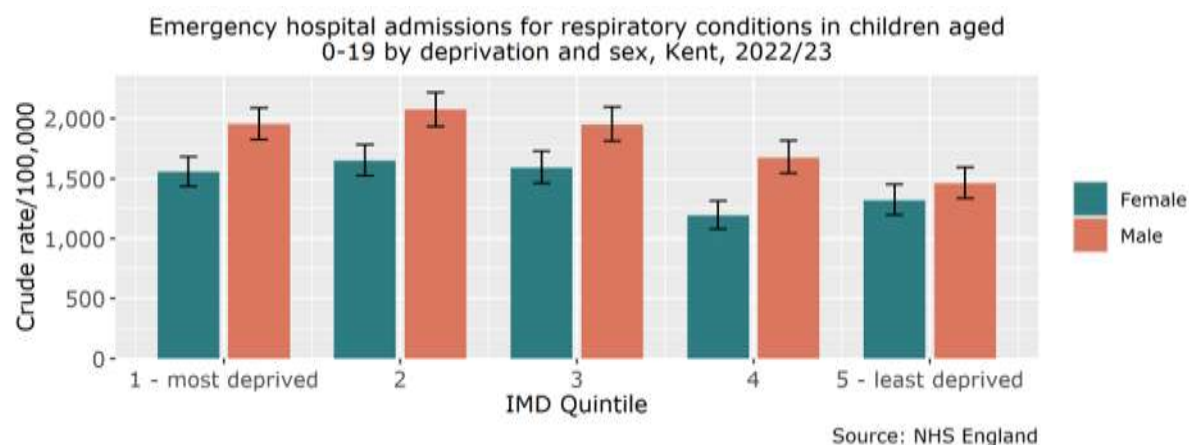


Figure 6. Crude rate of emergency hospital admissions for respiratory conditions for people aged 0-19 by deprivation and sex, Kent, 2022/23

4.2.1.2 Depression prevalence aged 18 years plus

Figures 7 and 8 show rates of depression by age, deprivation and sex. Rates for females are significantly higher across all age and deprivation groups. For every age group, rates are highest in the most deprived 20% of the population.

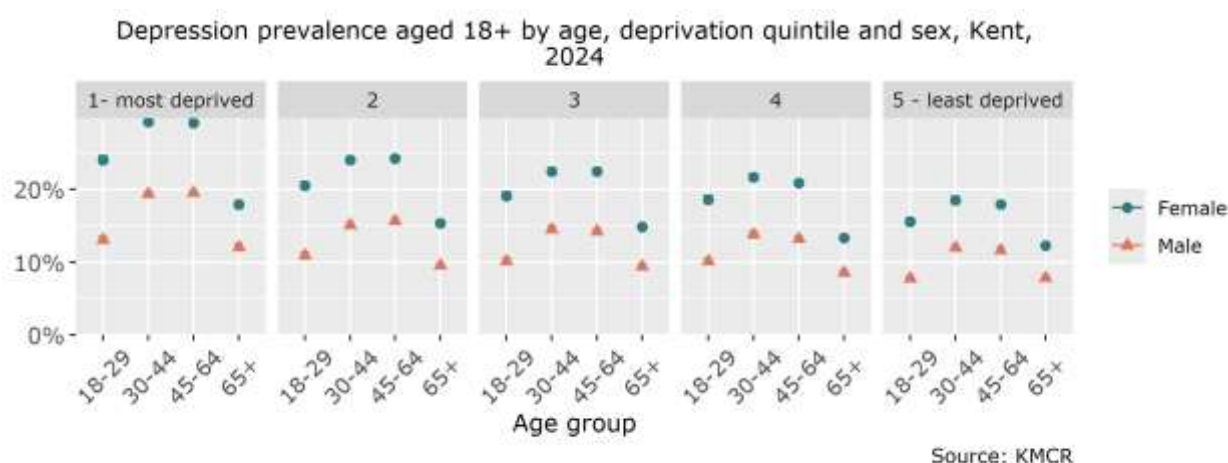


Figure 7. Depression prevalence in over 18 year olds by deprivation and sex, Kent, 2024

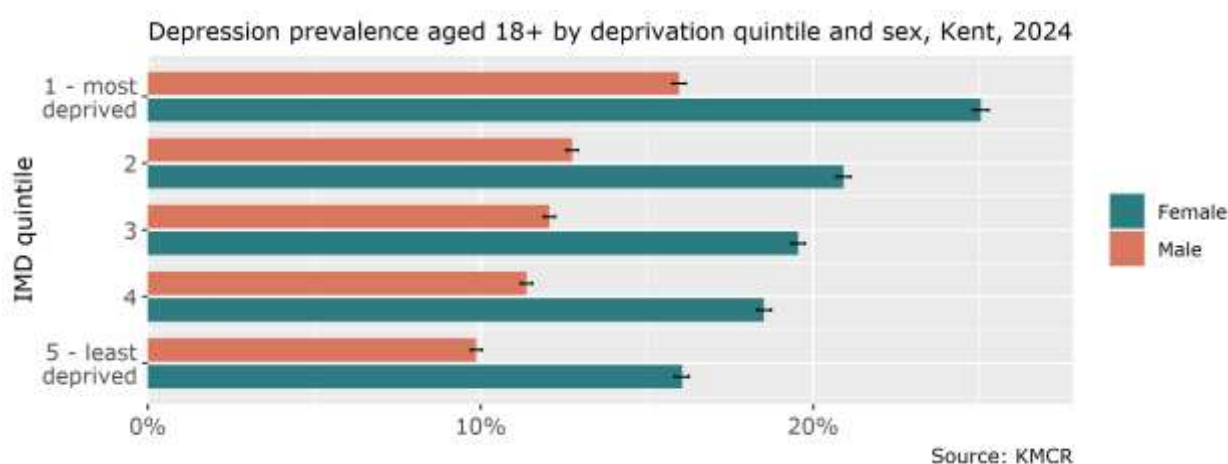


Figure 8. Age-standardised prevalence of depression in over 18 year olds by deprivation and sex, Kent, 2024

4.2.1.3 Hospital admission episodes for alcohol-related conditions

Figure 9 shows that admission rates for alcohol-related conditions in males tend to increase with age and at a faster rate for the most deprived 20% of the population compared to the least deprived 20% of the population. In females, rates increase with age up to the 45-64 age group but then do not increase further. There is not a clear deprivation gradient but rates are higher in the most deprived compared to the least deprived.

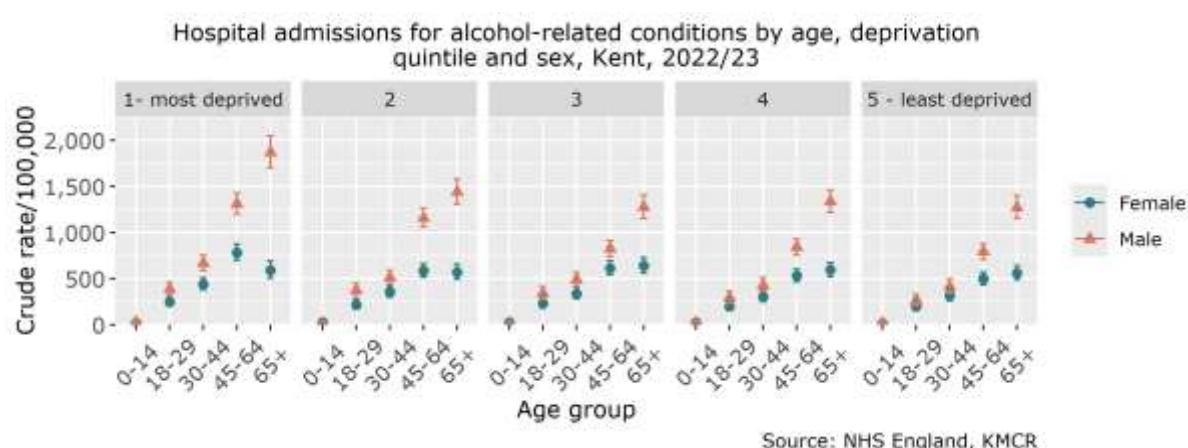


Figure 9. Crude rate of hospital admissions for alcohol-related conditions by age, deprivation and sex, Kent, 2022/23

When age is standardised, males have significantly higher rates of admission. Figure 10 shows that males and females in the most deprived 20% of the population have significantly higher rates of admission compared to the least deprived 20% of the population.

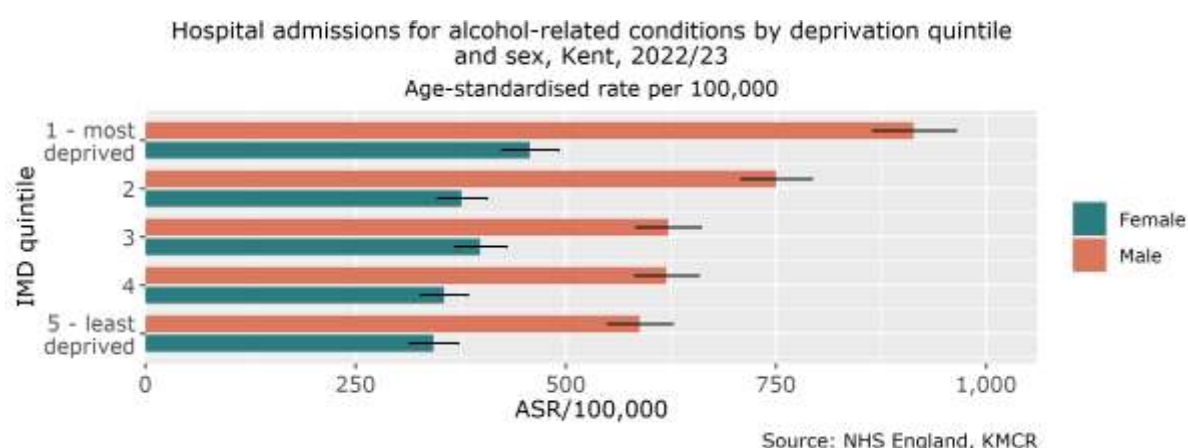


Figure 10. Age-standardised rate of emergency hospital admissions for alcohol-related conditions by deprivation and sex, Kent, 2022/23

4.2.1.4 Coronary heart disease (CHD) prevalence

When age is standardised, prevalence of CHD in males is approximately three times higher than females and higher in the most deprived 20% of the population compared to the least deprived 20% as shown in figure 11.

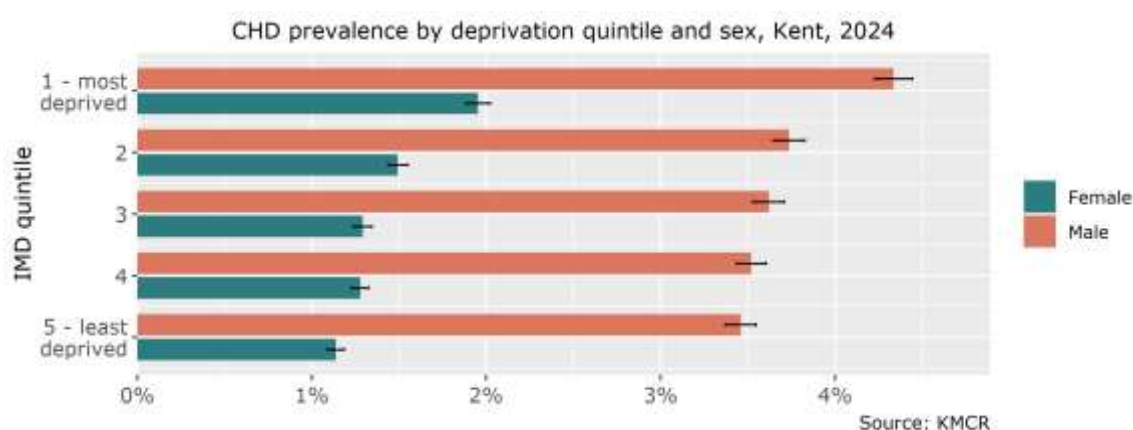


Figure 11. Age-standardised prevalence of coronary heart disease by deprivation and sex, Kent, 2024

4.2.1.5 Diabetes prevalence

Figures 12 and 13 show rates of diabetes by age, sex and deprivation. Prevalence is significantly higher in the most deprived 20% of the population compared to the least deprived, with a clear deprivation gradient seen in figure 14. The gap between male and female prevalence is similar across all deprivation quintiles, with rates consistently higher in males.

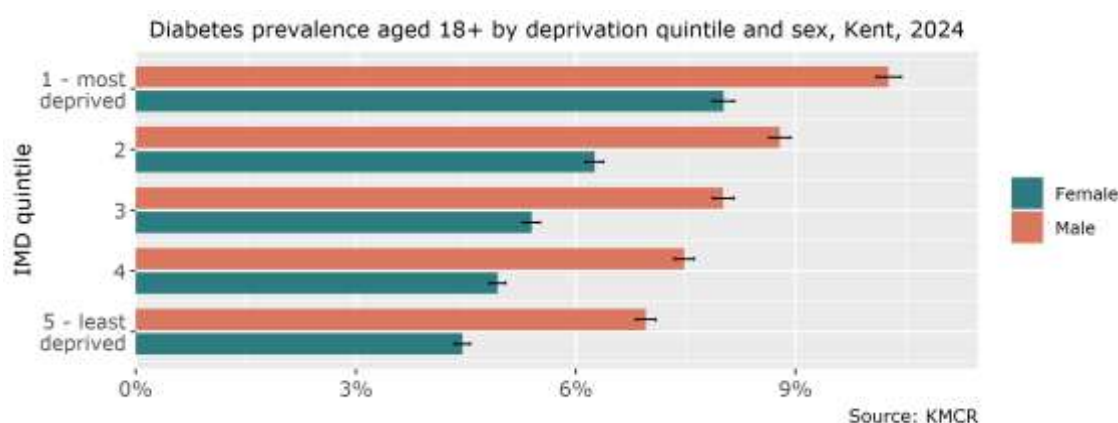


Figure 12. Age-standardised prevalence of diabetes by deprivation and sex, Kent, 2024

In the most deprived quintile, diabetes prevalence increases at a faster rate as age increases such that prevalence in the 45-64 age group is higher in the most deprived compared to other deprivation quintiles, as shown in figure 13.

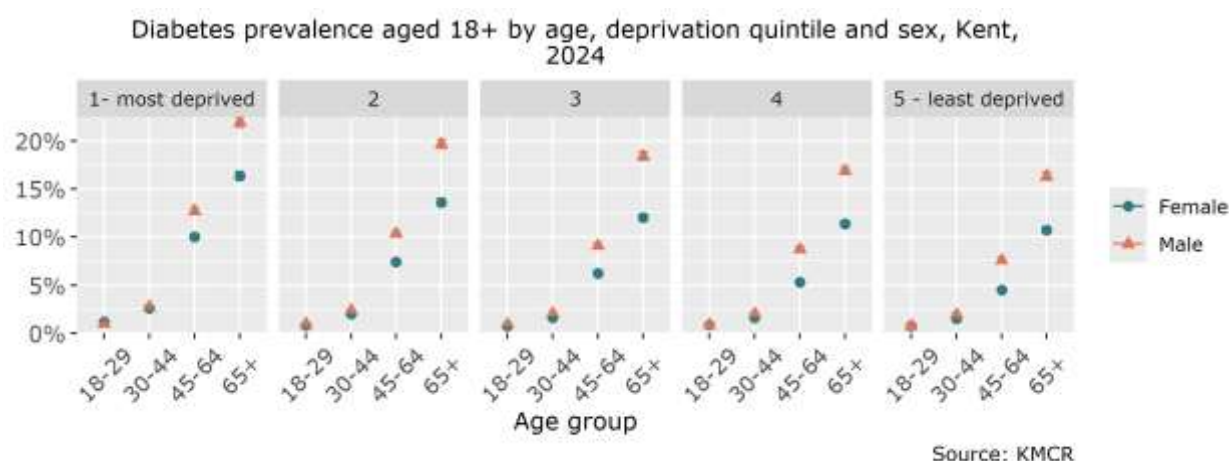


Figure 13. Prevalence of diabetes by age, deprivation and sex, Kent, 2024

4.2.1.6 Excess weight in Year 6

Figure 14 shows that the prevalence of excess weight in school year 6 is higher for males in the most deprived and least deprived 20% of the population. Prevalence for males and females is higher in the most deprived compared to the least deprived.

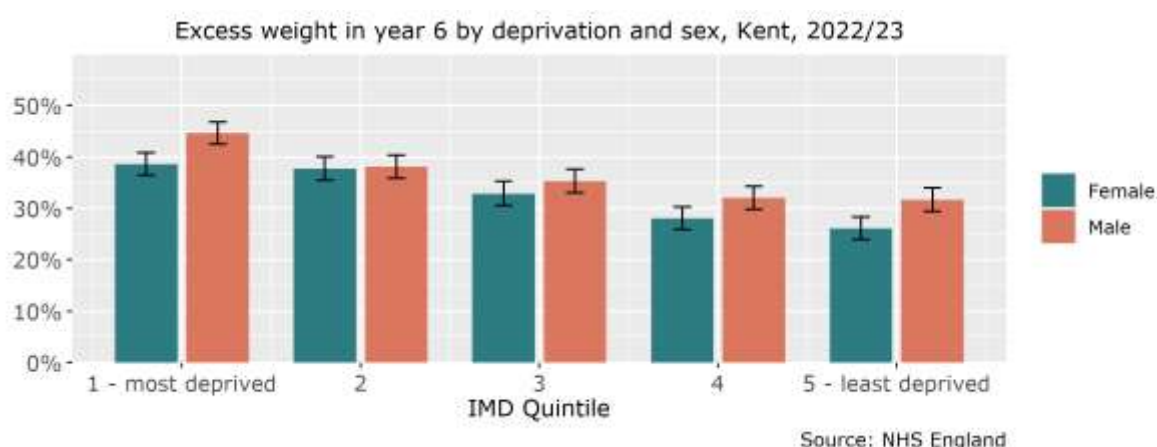


Figure 14. Percentage of school year 6 pupils measured as overweight or obese by deprivation and sex, Kent, 2022/23

4.2.1.7 Hypertension prevalence

Hypertension prevalence increases with age with crude rates appearing grossly similar across deprivation quintiles, as shown in figure 15. Rates in males are higher than females in all deprivation quintiles for the 45-64 year olds age bracket.

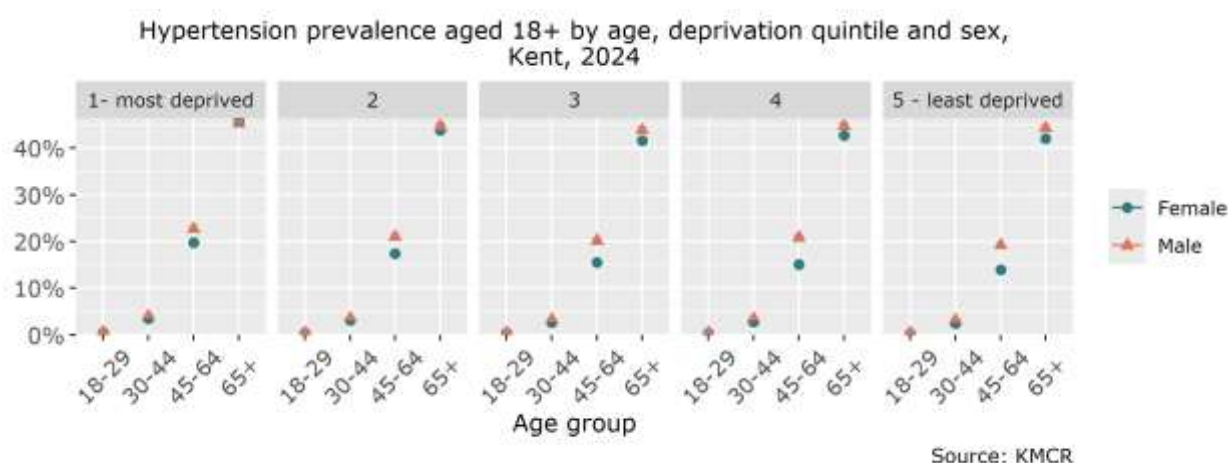


Figure 15. Prevalence of hypertension by age, deprivation and sex, Kent, 2024

Figure 16 shows that males have significantly higher rates in all deprivation groups and the gap between males and females increases as deprivation reduces. There is not a clear social gradient but males and females in the most deprived 20% of the population have the highest rates of hypertension.

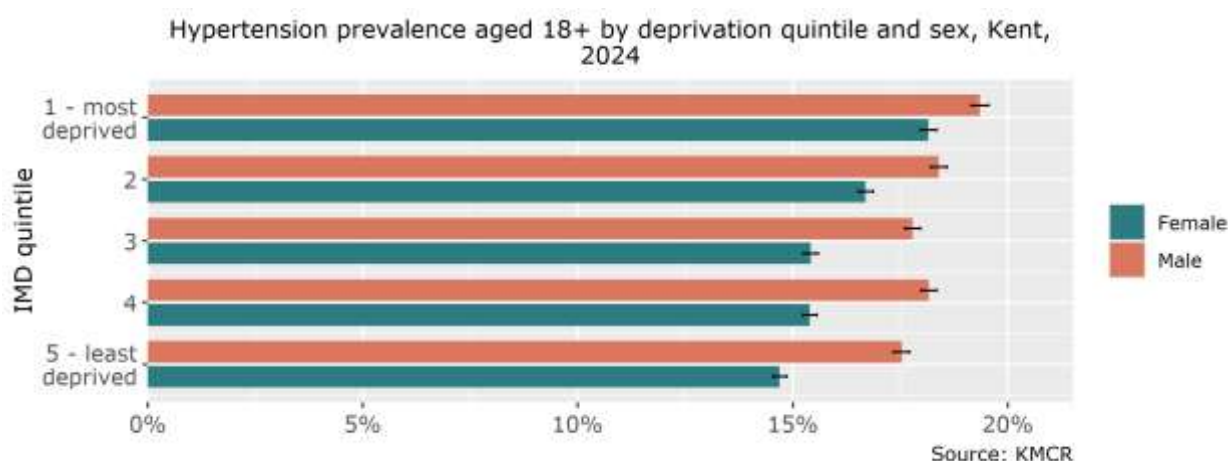


Figure 16. Age-standardised prevalence of hypertension by deprivation and sex, Kent, 2024

4.2.1.8 People with two or more long-term conditions under the age of 65 years

Figure 17 shows that in the 45-64 age group, the number of people with at least two long-term conditions is approximately 50% higher in the most deprived compared to the least deprived. Rates by sex are similar or slightly higher for females apart from in the 45-64 age group in the least deprived 40% of the population where the male rate is higher.

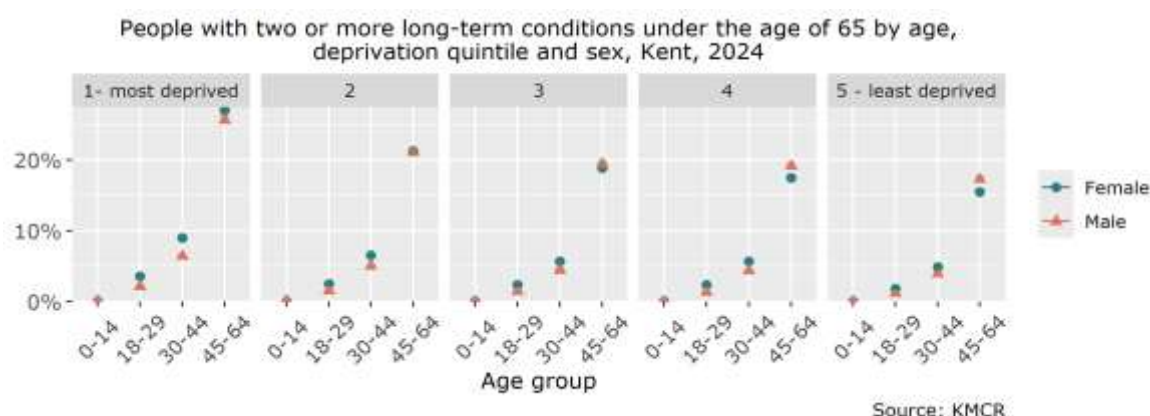


Figure 17. Prevalence of people with at least two long-term conditions before the age of 65 by age, deprivation and sex, Kent, 2024

Figure 18 shows that when age is standardised, the number of people with at least two long-term conditions below the age of 65 is considerably higher in the most deprived 20% of the population. There is also a significant difference between males and females in the most and second most deprived 20% of the population.

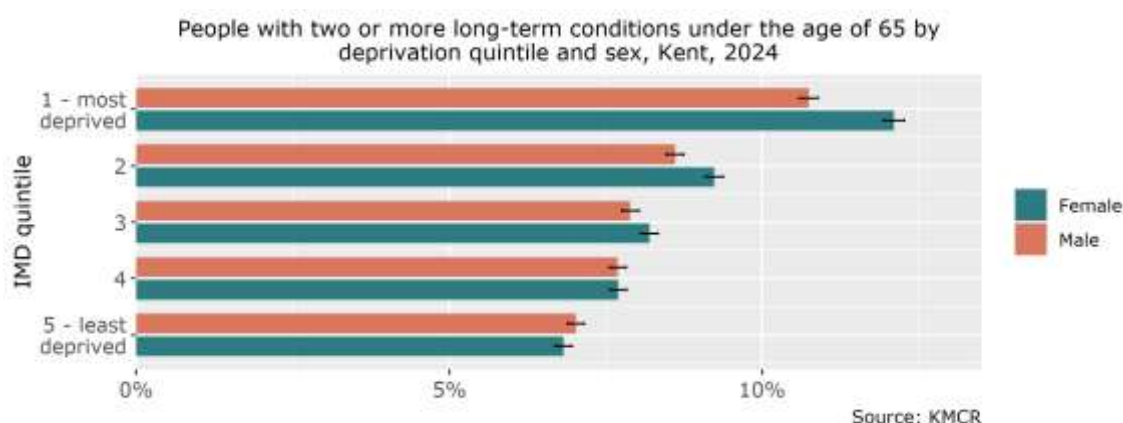


Figure 18. Age-standardised prevalence of people with at least two long-term conditions before the age of 65 by deprivation and sex, Kent, 2024

4.2.1.9 Hospital admissions for people with a mental health condition

Figure 19 shows that rates tend to increase with age in males, whereas rates are similar across all ages in females. The gap between males and females tends to decrease with age.

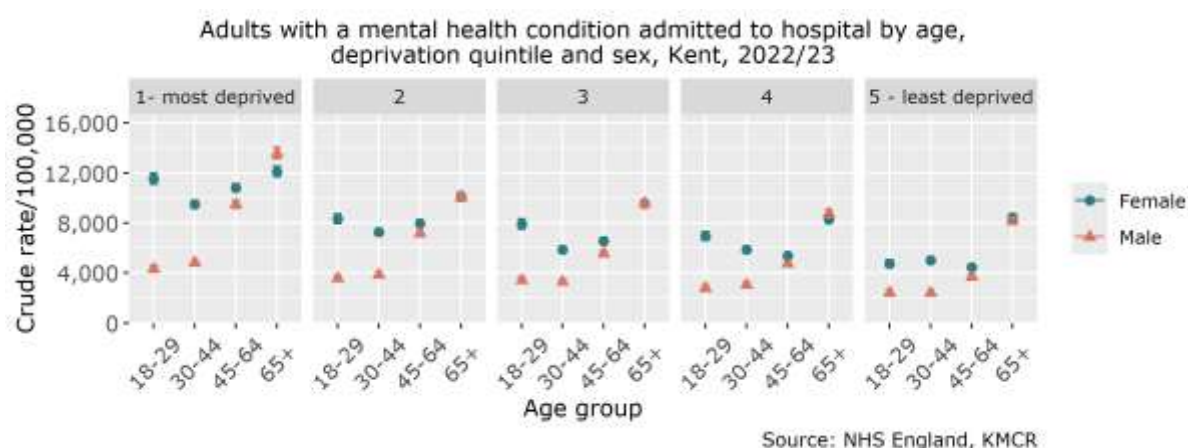


Figure 19. Crude rate of hospital admissions for people with a mental health condition by age, deprivation and sex, 2022/23

Figure 20 clearly shows the deprivation gradient and the consistent gap between males and females.

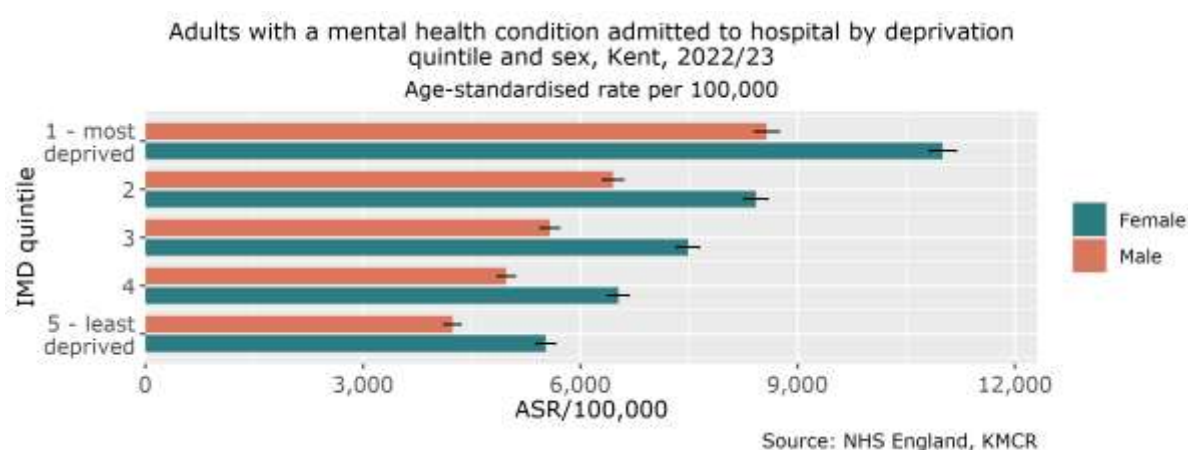


Figure 20. Age-standardised rate of hospital admissions for people with a mental health condition by deprivation and sex, Kent, 2022/23

4.2.1.10 Obesity-related hospital admissions

Figure 21 shows that females have higher admission rates across all deprivation groups. The gap between males and females is biggest in the most deprived and smallest in the least deprived. There is a clear deprivation gradient for females that is not evident for males.

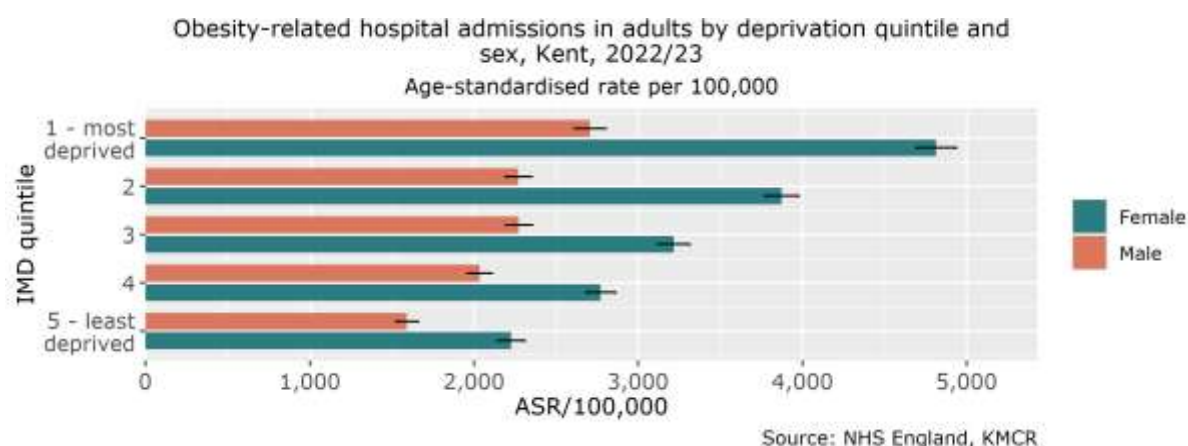


Figure 21. Age-standardised rate of obesity-related hospital admissions by deprivation and sex, Kent, 2022/23

4.2.1.11 Emergency hospital admissions

Figure 22 shows that there is a very similar pattern in emergency hospital admissions by age and sex in each deprivation quintile. Females have higher rates between the ages of 18 and 44, males have the highest rates over the age of 65.

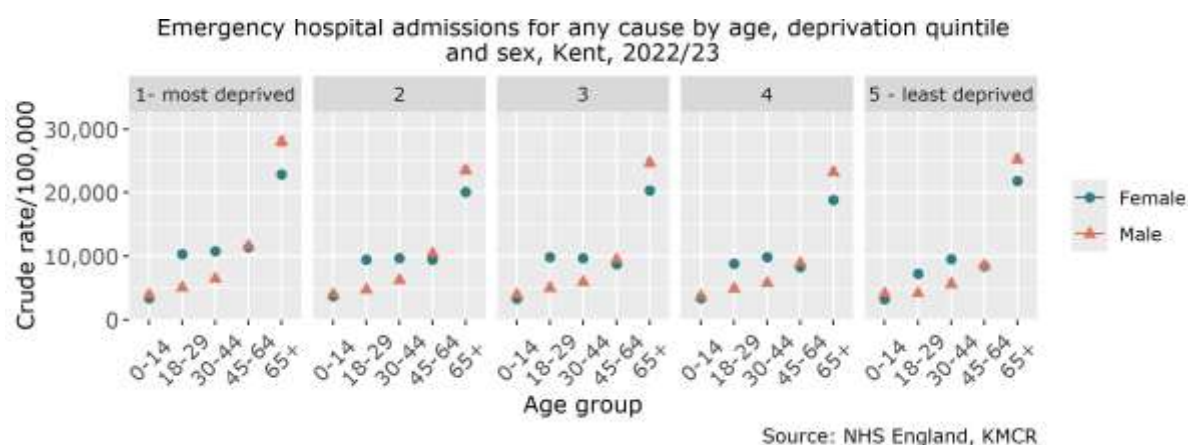


Figure 22. Crude rate of emergency hospital admissions by deprivation and sex, Kent, 2022/23

4.2.1.12 A&E attendances

Figure 23 shows that there is a clear deprivation gradient in A&E attendances for males and females. In each deprivation quintile, females have higher rates than males.

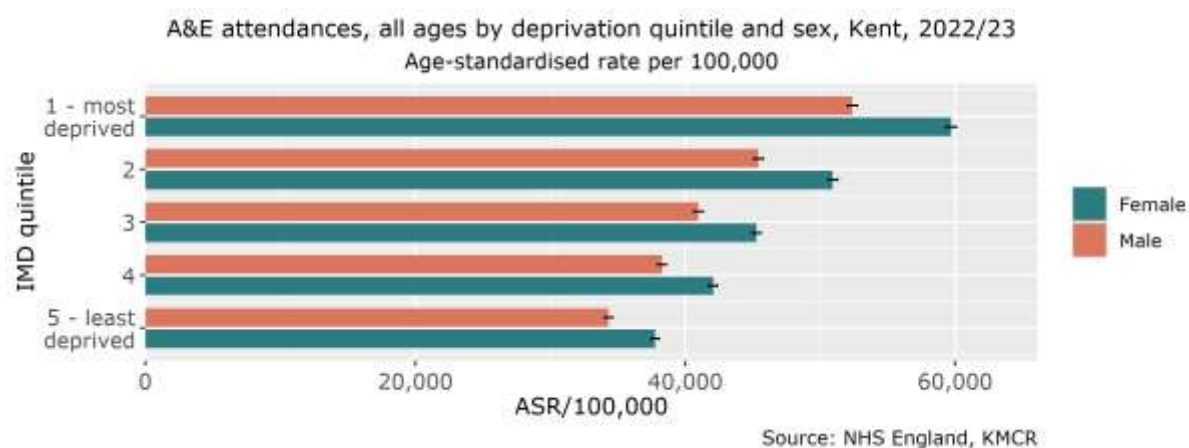
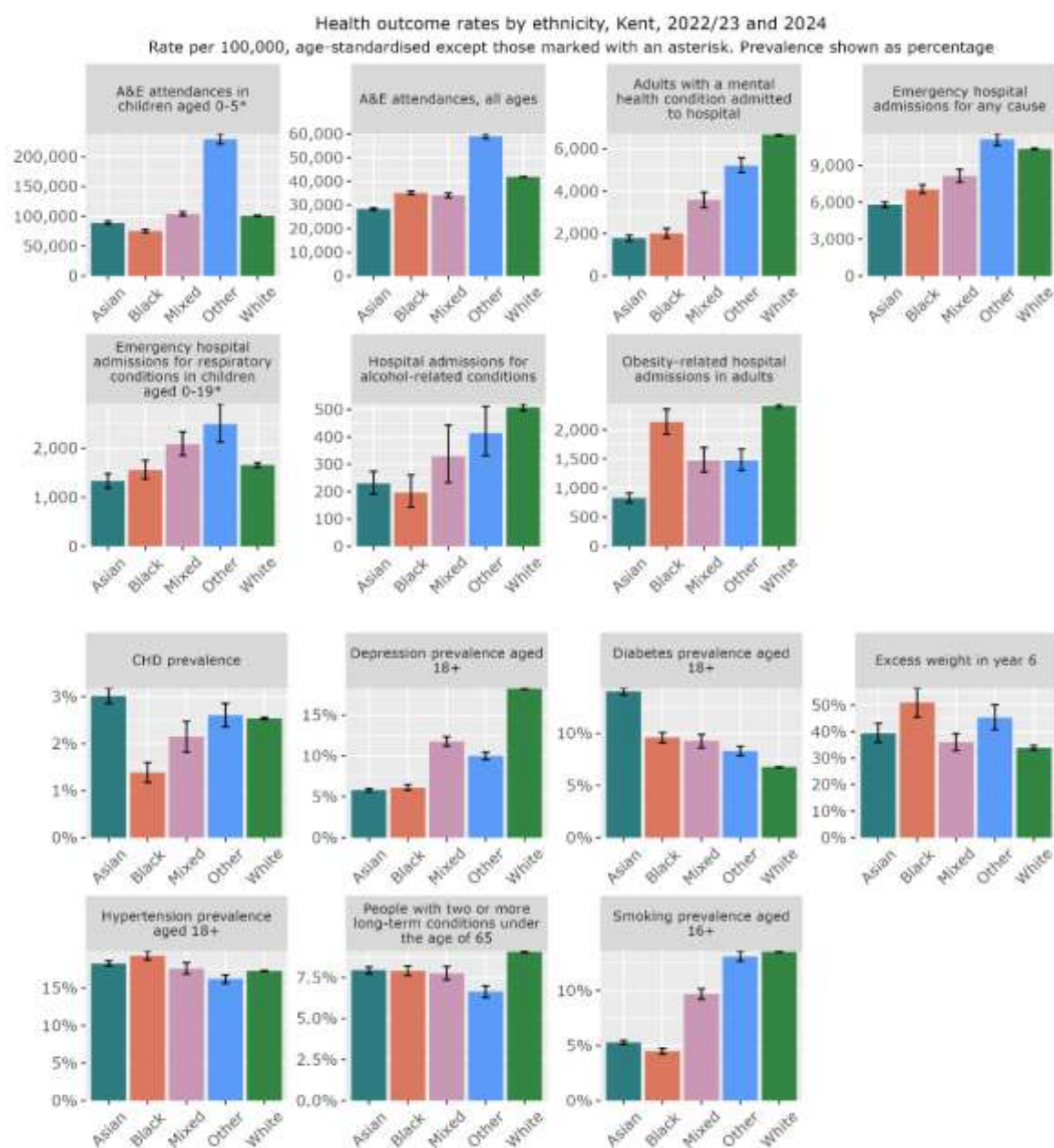


Figure 23. Age-standardised rate of A&E attendances by deprivation and sex, Kent, 2022/23

4.2.2 Inequality by Ethnicity

The relationship between health outcomes and ethnicity is not as clear and consistent as it is with deprivation. There are clear differences in rates of some diseases between ethnic groups but there is no consistency in which ethnic group has better or worse rates (Figure 24).



Source: NHS England, KMCR

Figure 24. Health outcome rates in ethnic groups, Kent, 2022/23 and 2024

4.2.2.1 Depression prevalence aged 18 years plus

Rates of depression are higher in the most deprived 20% of the population but a clear deprivation gradient only appears in the White ethnic group (Figure 25).

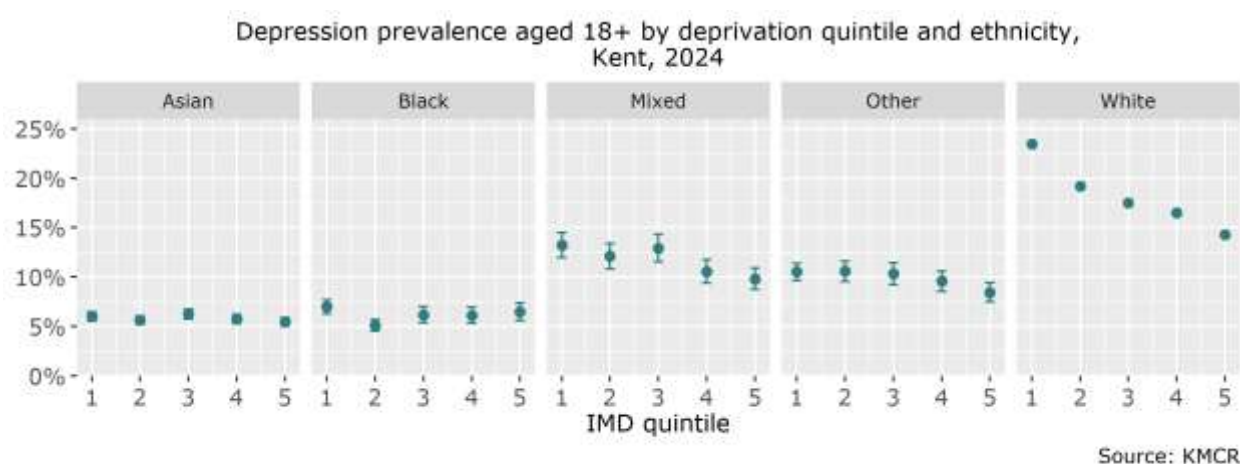


Figure 25. Age-standardised prevalence of depression in over 18 year olds by deprivation and ethnicity, Kent, 2024

Rates of depression by age are also modified by ethnicity. Figure 26 shows that there are no clear differences in rates for different age groups in the Black, Asian, Mixed and Other ethnic groups. In contrast in the White ethnic group rates of depression are highest in the 30-44 years age group and lowest in the over 65 years age bracket.

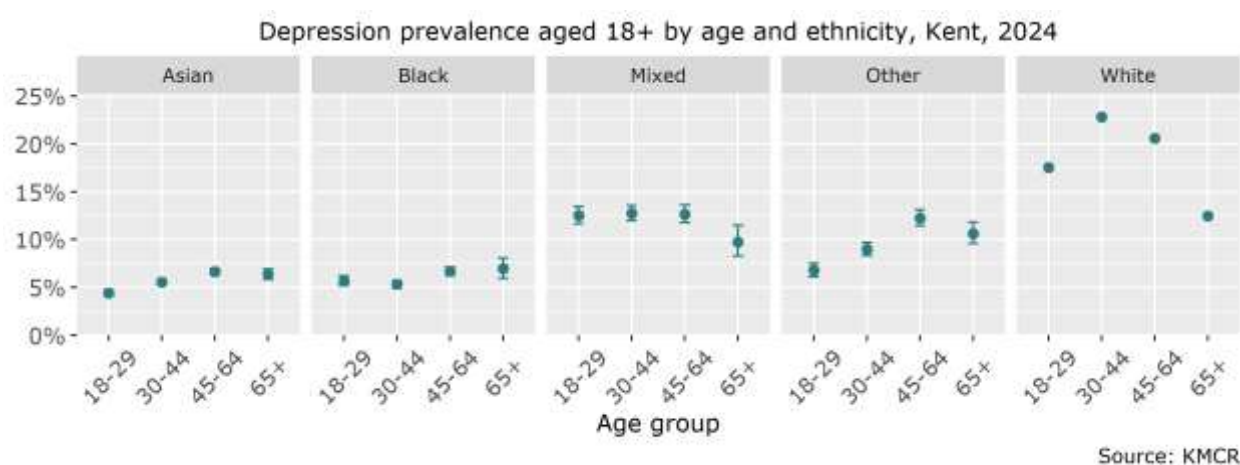


Figure 26. Depression prevalence in over 18 year olds by age and ethnicity, Kent, 2024

Figure 27 shows that rates of depression are higher for females in all ethnic groups.

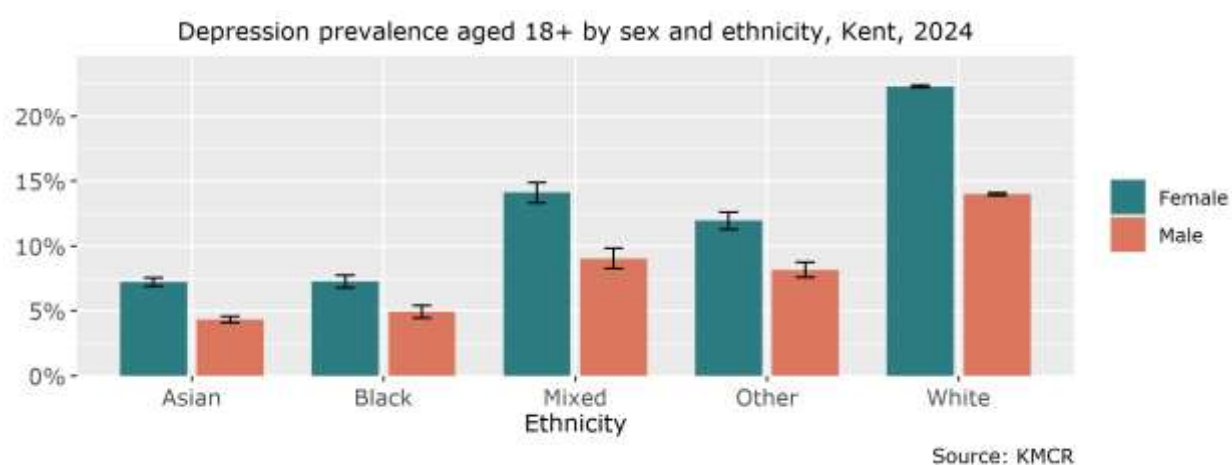


Figure 27. Age-standardised prevalence of depression in over 18 year olds by sex and ethnicity, Kent, 2024

4.2.2.2 Hospital admission episodes for alcohol-related conditions

Figure 12 shows that males have higher rates of admission for alcohol-related conditions in all deprivation groups, however figure 28 suggests that there is an interaction with ethnicity. The clear difference between males and females is not evident in all ethnic groups.

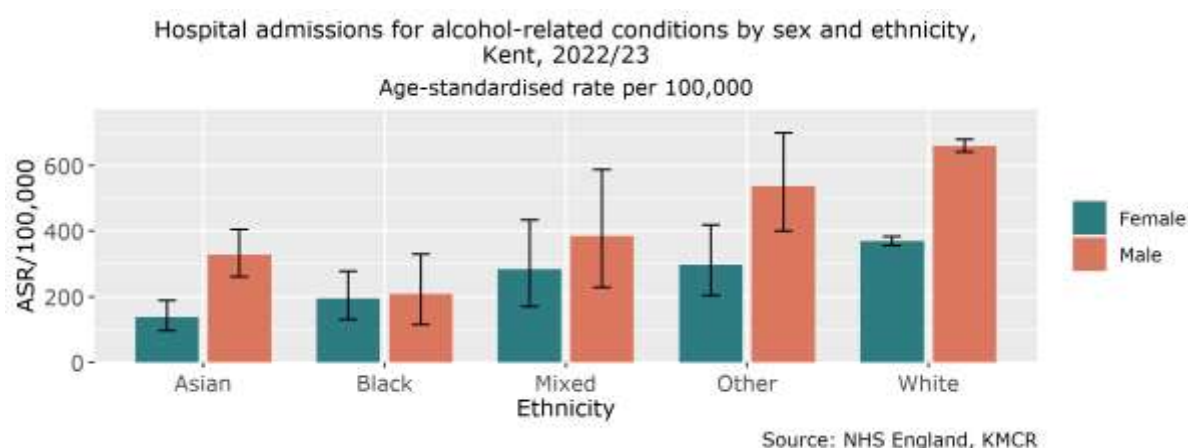


Figure 28. Age-standardised rate of emergency hospital admissions for alcohol-related conditions by sex and ethnicity, Kent, 2022/23

The White ethnic groups has significantly higher rates of admission for alcohol-related conditions compared to all other ethnic groups apart from the Other ethnic group (Figure 29).

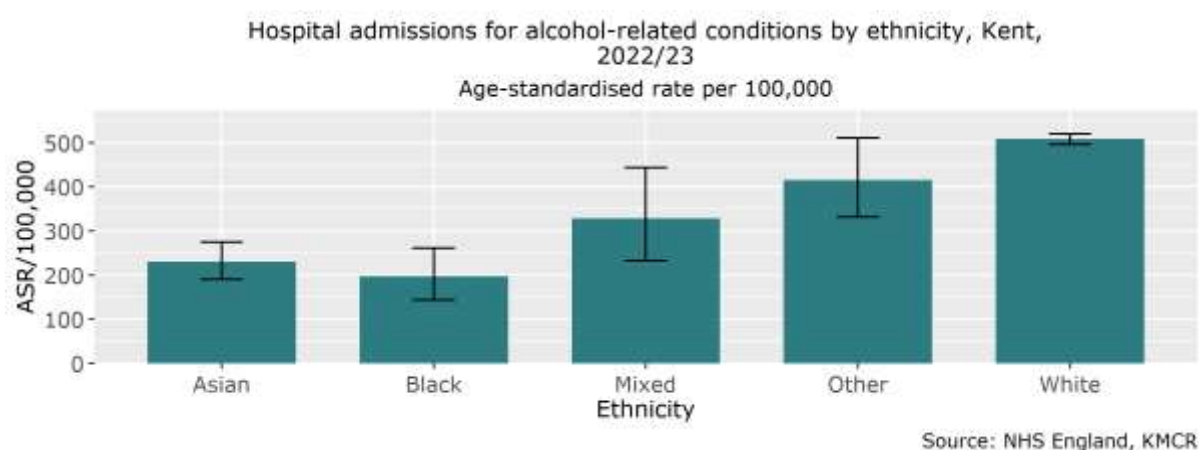


Figure 29. Age-standardised rate of emergency hospital admissions for alcohol-related conditions by ethnicity, Kent, 2022/23

4.2.2.3 Diabetes prevalence

Figure 30 shows that the rate of increase in diabetes prevalence with age is much faster in the Asian ethnic group compared to other ethnic groups.

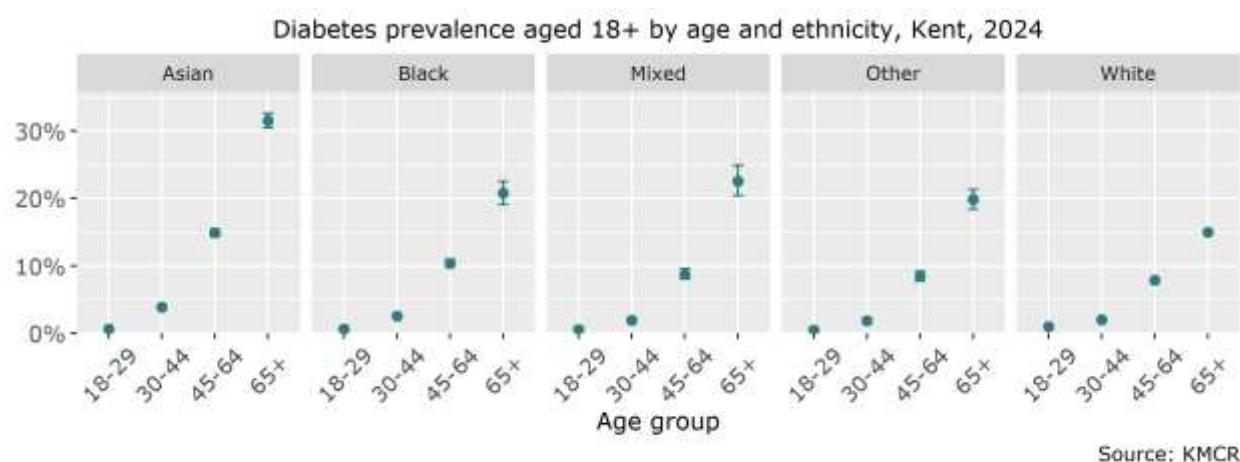


Figure 30. Diabetes prevalence by age and ethnicity, Kent, 2024

4.2.2.4 Excess weight in Year 6

Figure 31 shows that the prevalence of excess weight in school year 6 is similar for males and females in the non-White ethnicities. In the White ethnic group, prevalence is significantly higher for males.

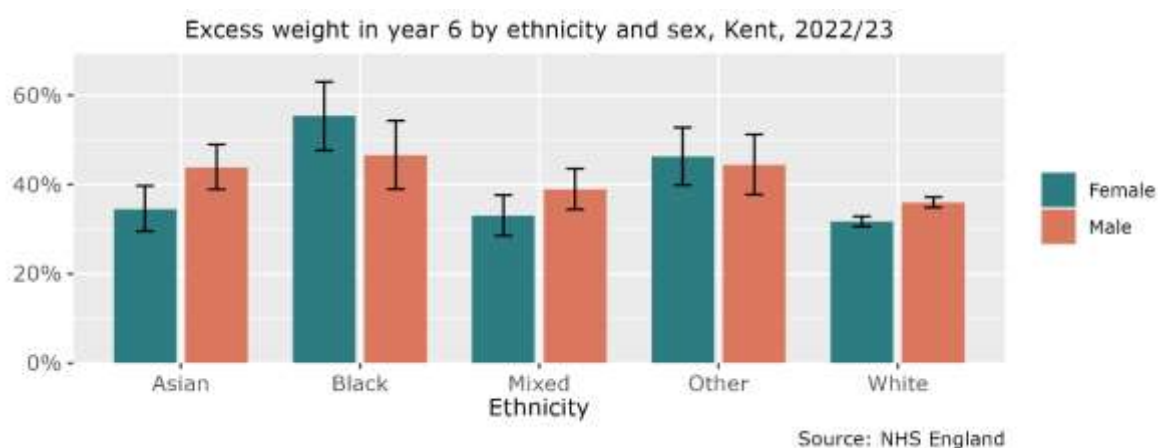


Figure 31. Percentage of school year 6 pupils measured as overweight or obese by ethnicity and sex, Kent, 2022/23

4.2.2.5 People with two or more long-term conditions under the age of 65 years

Figure 32 shows that there is a significantly higher rate of males with two or more long-term conditions before the age of 65 compared to females in the Asian Black ethnic groups. In the White ethnic group, females have a higher rate. In the Mixed and Other ethnic groups, the male and female rates are similar.

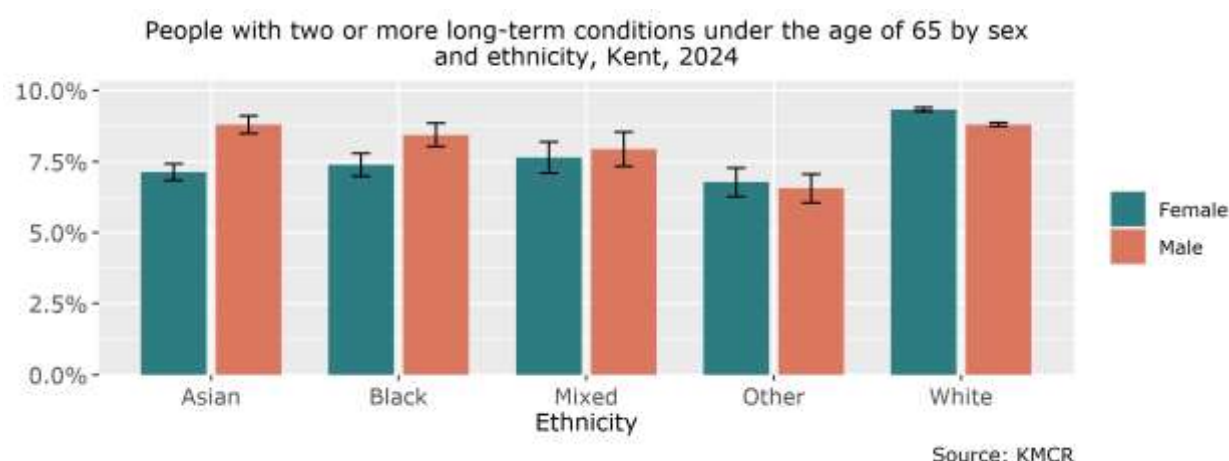


Figure 32. Age-standardised prevalence of people with at least two long-term conditions before the age of 65 by sex and ethnicity, Kent, 2024

4.2.2.6 Smoking prevalence aged 16 years plus

Smoking prevalence shows similar patterns by age and gender across all deprivation groups, however, ethnicity appears to modify prevalence by age and deprivation. Figure 33 shows that all ethnic groups apart from Black have a significant drop in prevalence in the 65+ age group. In all other age groups, prevalence rates are similar within the Black, Mixed and Asian ethnic groups whereas in the Other and White groups, there are significant differences between age groups.

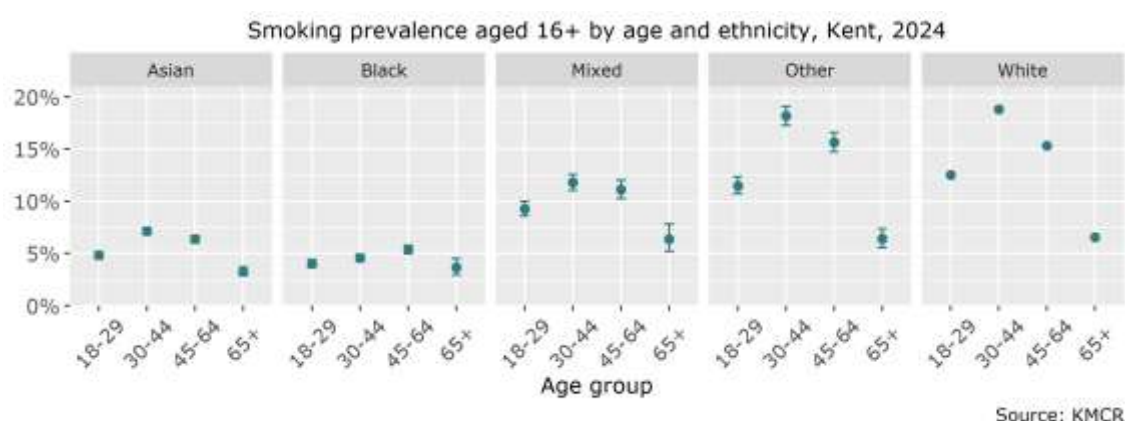


Figure 33. Prevalence of smoking by age and ethnicity, Kent, 2024

Figure 34 shows that prevalence is higher in males across all ethnic and deprivation groups. However, the difference between males and females is much lower in the White ethnic group compared to the other ethnic groups. Females in the White ethnic group have higher smoking rates than all other ethnic groups whereas males in the White ethnic group have similar rates to males in the Other ethnic group.

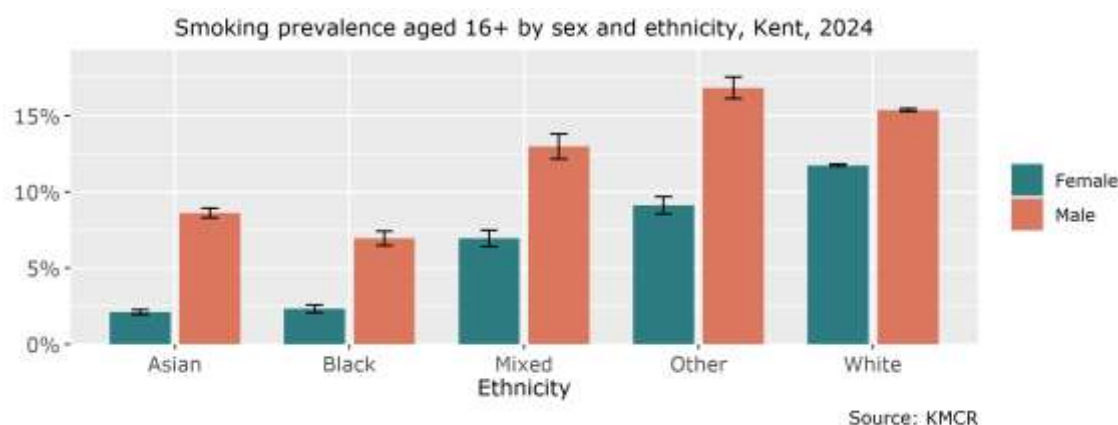


Figure 34. Age-standardised prevalence of smoking by sex and ethnicity, Kent, 2024

5 Socio-environmental

Variations in the socio-environmental circumstances in which people live can affect health outcomes. Rurality, access to natural greenspace, and household overcrowding are considered in this analysis. Where possible, the interaction with socio-economic and demographic inequality is explored.

5.1 Kent Population

Figure 35 shows that the majority of the Kent land mass is rural. There are a number of relatively large distinct areas classified as urban, which are separated from each other by rural land.

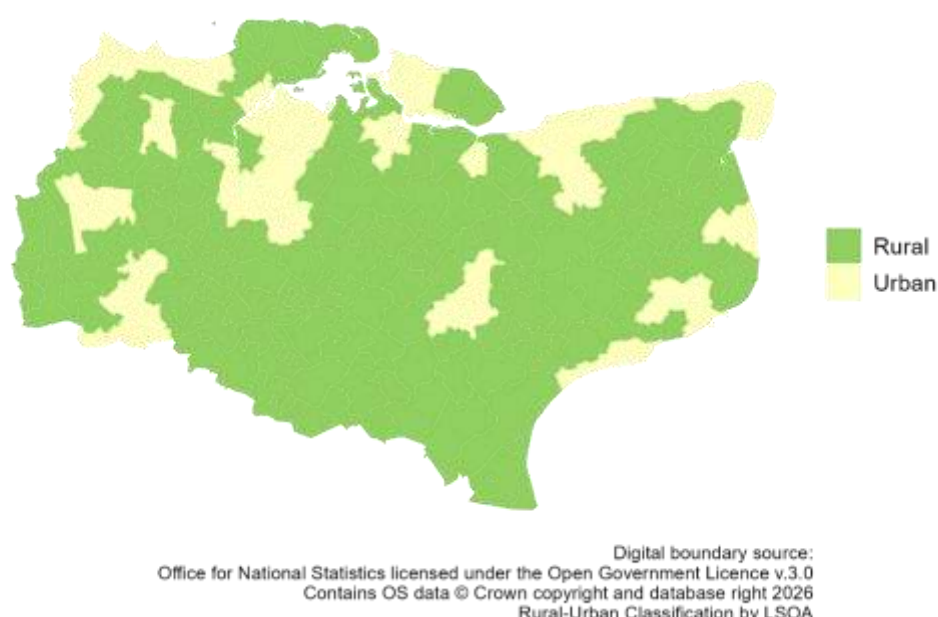


Figure 35. Rural-urban classification by lower super output area, Kent, ONS 2011 [8]

Figure 36 shows that the majority of the population is concentrated in the urban areas.

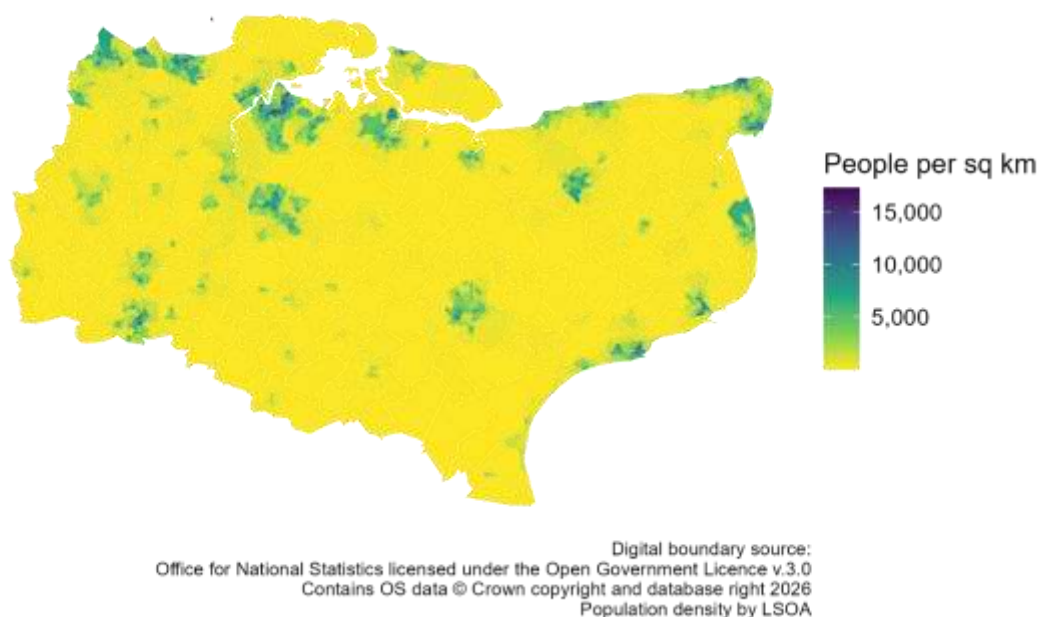


Figure 36. Population density by lower super output area, Kent, ONS 2025 [9]

The Accessible Natural Green Space Standards (ANGSt) [10] is a set of guidelines developed in the United Kingdom to ensure that urban residents have access to natural green spaces. There are different levels of the standards according to the size of accessible green spaces and the time taken to access them. This analysis focuses on the doorstep standard: accessible greenspace at least 0.5 hectares in size within 200 metres (less than a 5 minute walk).

Figure 37 shows that doorstep greenspace access tends to be best in and around urban areas. Beyond the urban areas, large areas of Kent have poor greenspace access.

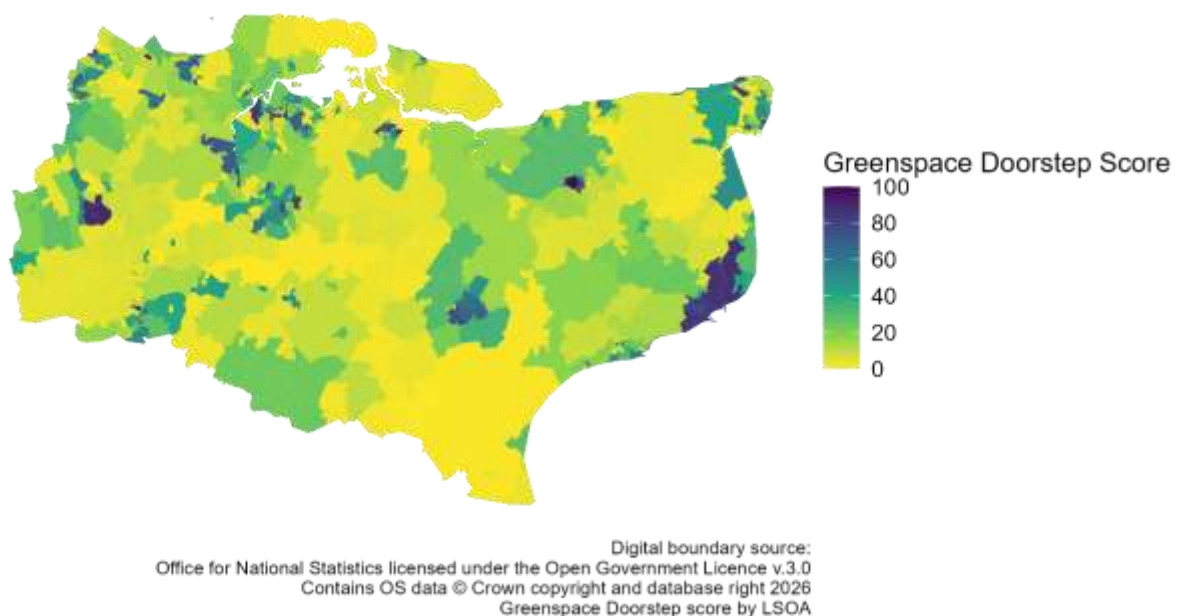


Figure 37. Access to natural greenspace by lower super output area, Kent, Natural England 2021

In the most deprived decile an average of 40% of the total small areas (Lower layer Super Output Areas (LSOA)) are meeting the ANGSt doorstep standard (Figure 38). The percentage area meeting the ANGSt doorstep standard reduces as deprivation reduces but is similar across deciles four to ten.

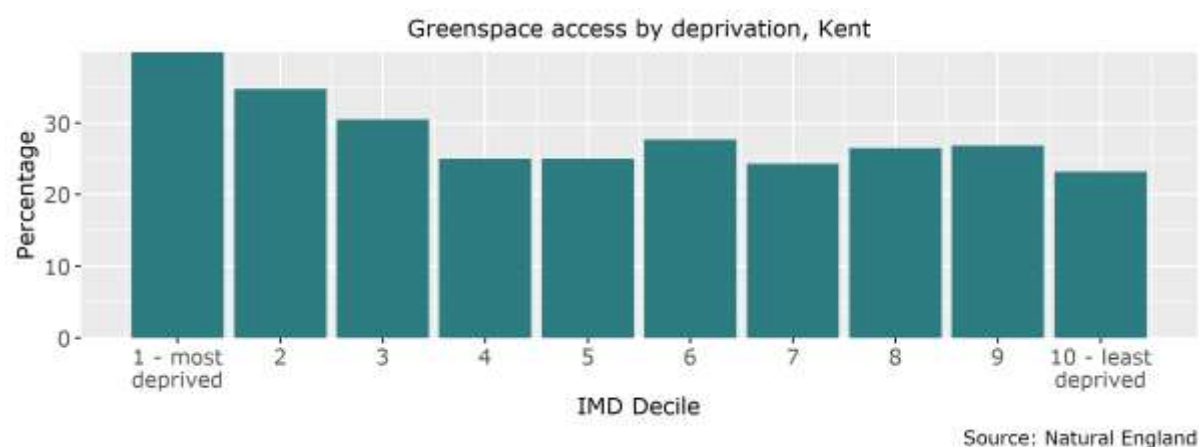


Figure 38. Percentage of Lower layer Super Output Areas (LSOA) covered by the ANGSt doorstep standard by deprivation, Kent, 2021

Census 2021 provides a measure of household overcrowding [11]. A household is considered overcrowded if it has fewer bedrooms than is required according to the number, ages and relationships of household members.

Figure 39 shows that overcrowding tends to be relatively low across Kent. Higher rates are found within urban areas; Dartford and Gravesham have more widespread high rates of overcrowding.

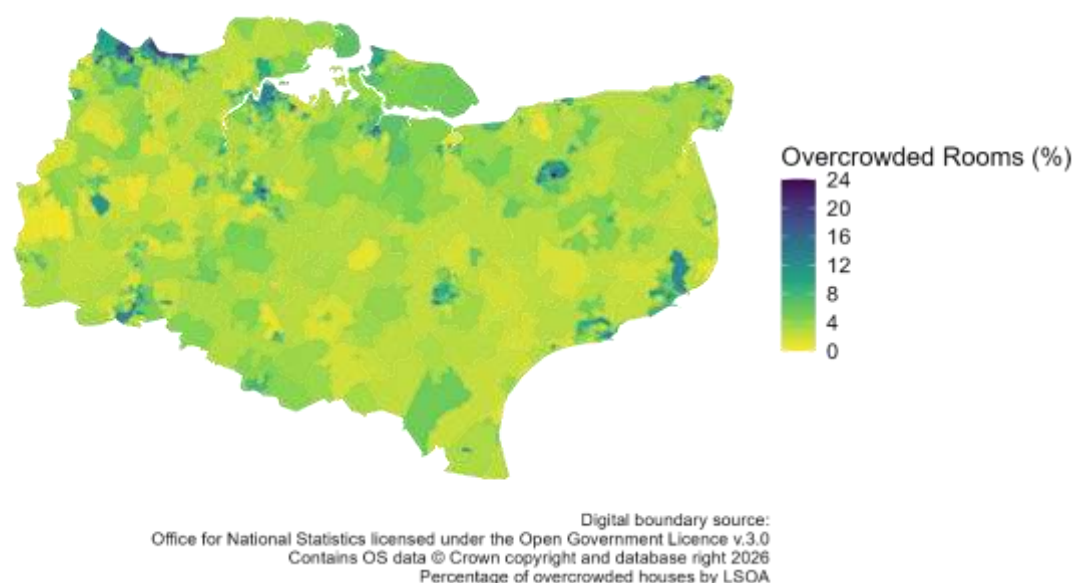


Figure 39. Household overcrowding by lower super output area, Kent, ONS 2021

Household overcrowding follows a deprivation gradient: there is a greater proportion of overcrowded households in areas of higher deprivation (Figure 40).

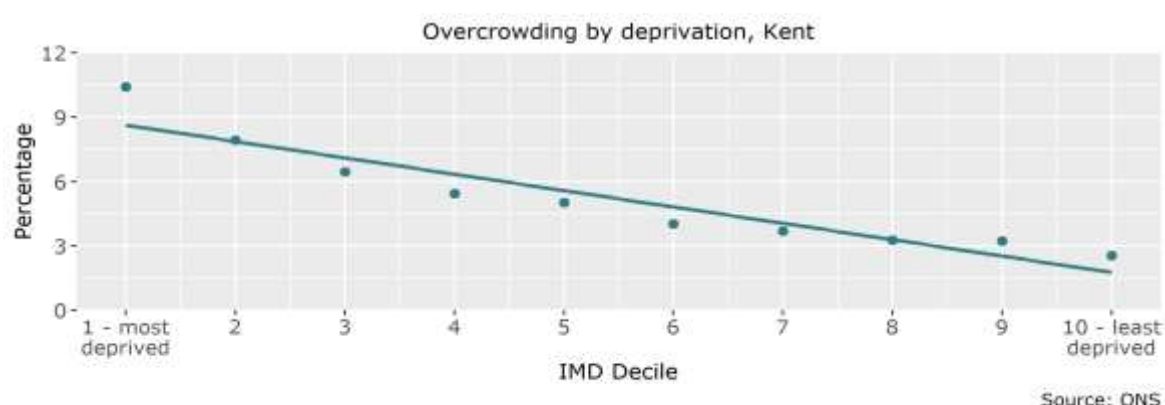


Figure 40. Percentage of overcrowded households by deprivation, Kent, 2021

5.2 Health Outcomes

Figure 41 shows that health outcomes tend to be worse in urban areas.

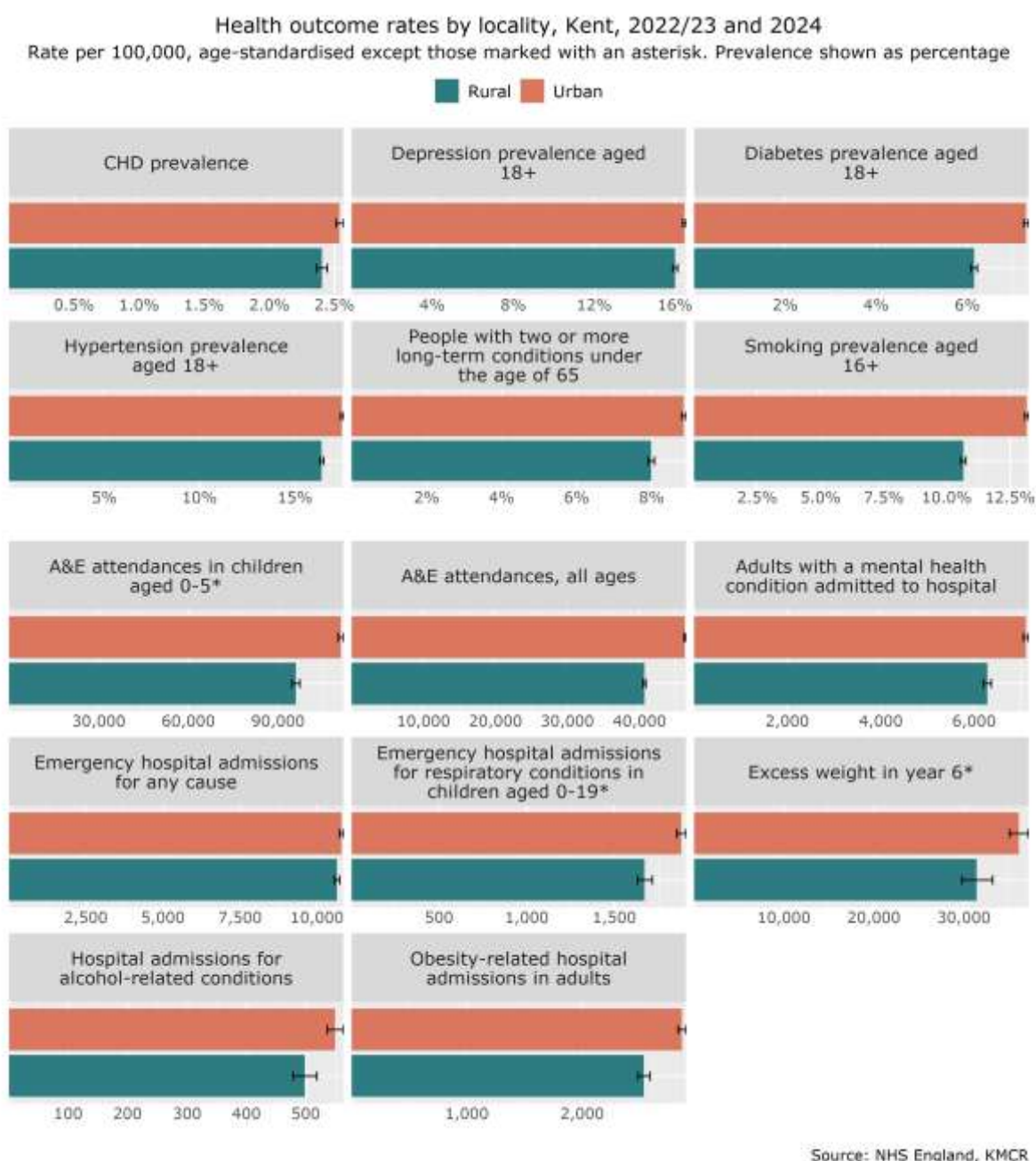


Figure 41. Health outcome rates by rural-urban classification, Kent, 2022/23 and 2024

Figure 42 shows that all health outcomes with the exception of emergency hospital admissions for any cause, are worse in coastal areas.

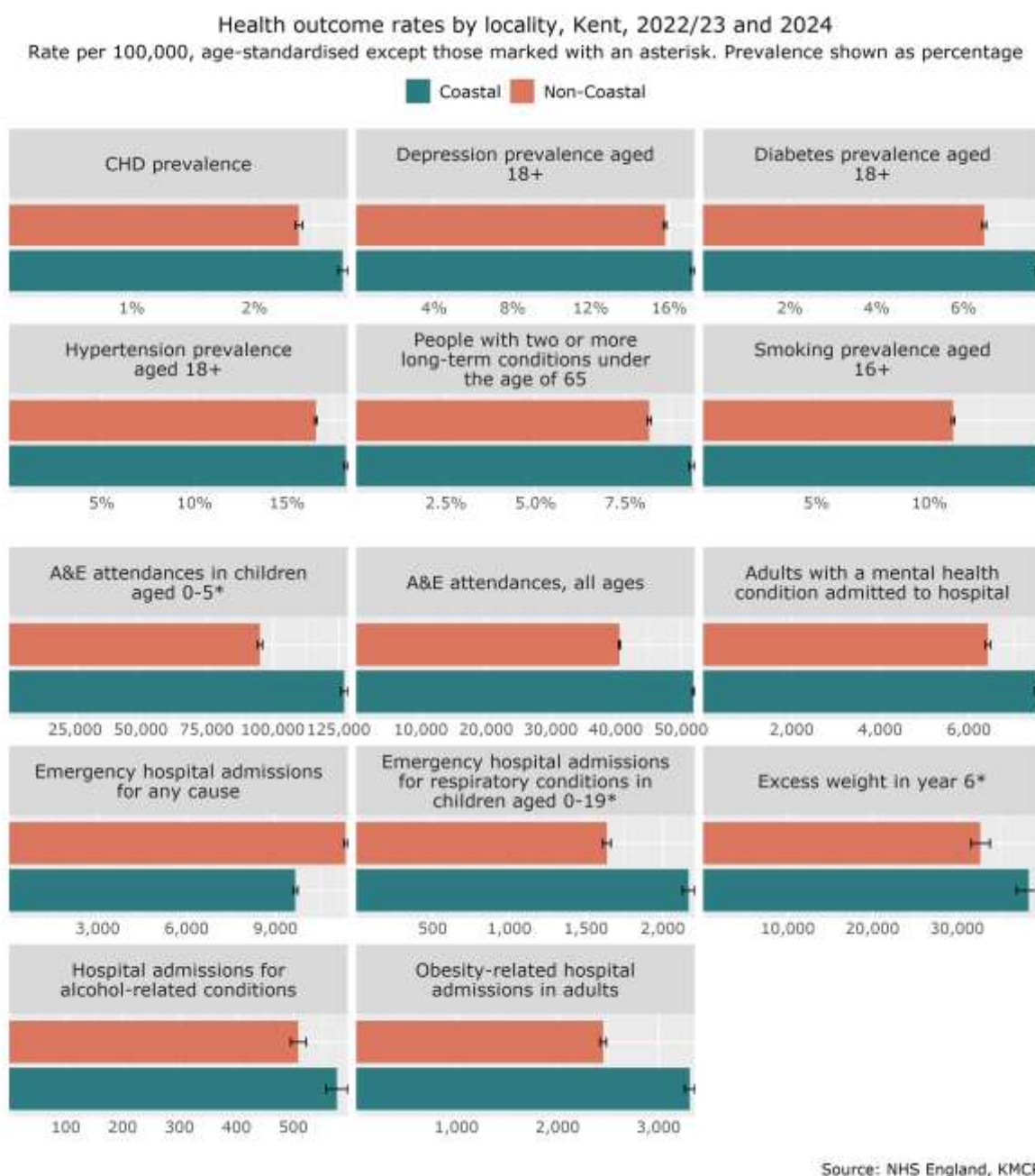


Figure 42. Health outcome rates by rural-urban classification, East Kent, 2022/23 and 2024

5.2.1 Hospital admissions for respiratory conditions in children aged 0-19

Emergency hospital admissions for respiratory conditions in people aged 0-19 are higher in areas classified as urban. However, this is modified by sex; the rate for males is higher in urban areas but similar to females in rural, as shown in Figure 43.

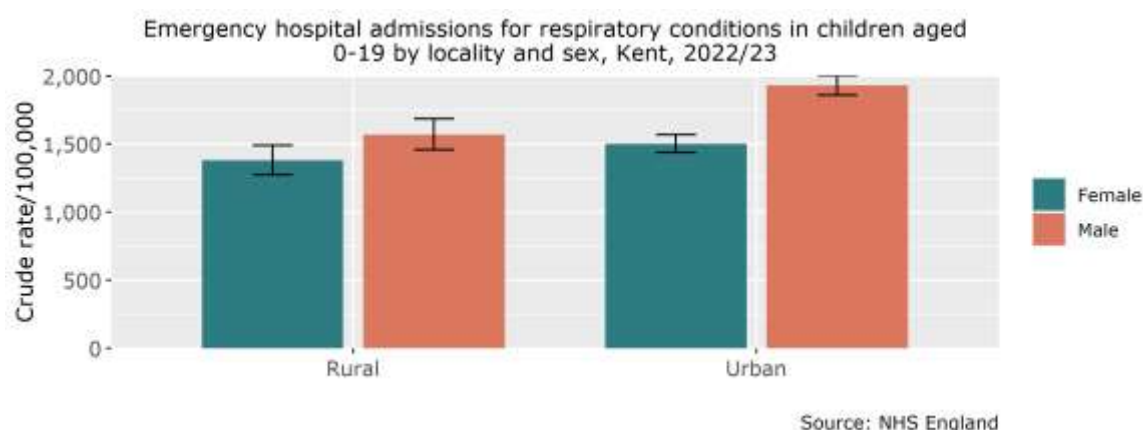


Figure 43. Crude rate of emergency hospital admissions for respiratory conditions for people aged 0-19 by locality and sex, Kent, 2022/23

Figure 44 shows that in areas with the lowest rates of overcrowding, there is a clear difference in the rates of emergency hospital admissions for respiratory conditions in children aged 0-19 when split by locality – non-coastal areas have the highest rates. However, this difference by locality is not evident in areas where overcrowding is lowest.

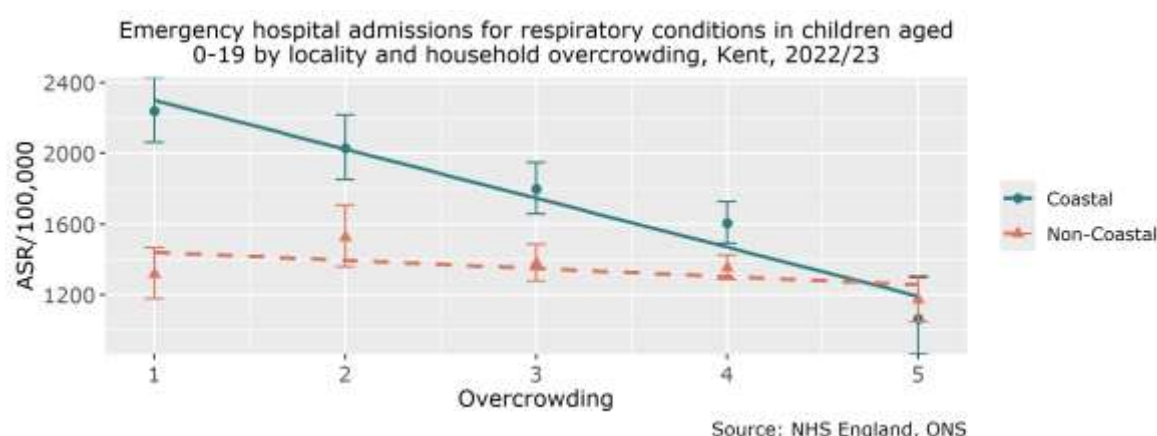


Figure 44. Crude rate of emergency hospital admissions for respiratory conditions for people aged 0-19 by locality and sex, Kent, 2022/23

5.2.2 Smoking prevalence adults aged 16 plus

Figure 45 shows that in each deprivation quintile, smoking prevalence is higher in areas with the highest overcrowding, evidenced by the downward slopes from left to right in Figure 45 (in deprivation quintile 4, the value for the most overcrowded areas is missing). This explains why there is an upward slope from left to right. All other data points in deprivation quintile 4 show that smoking prevalence decreases as overcrowding decreases.

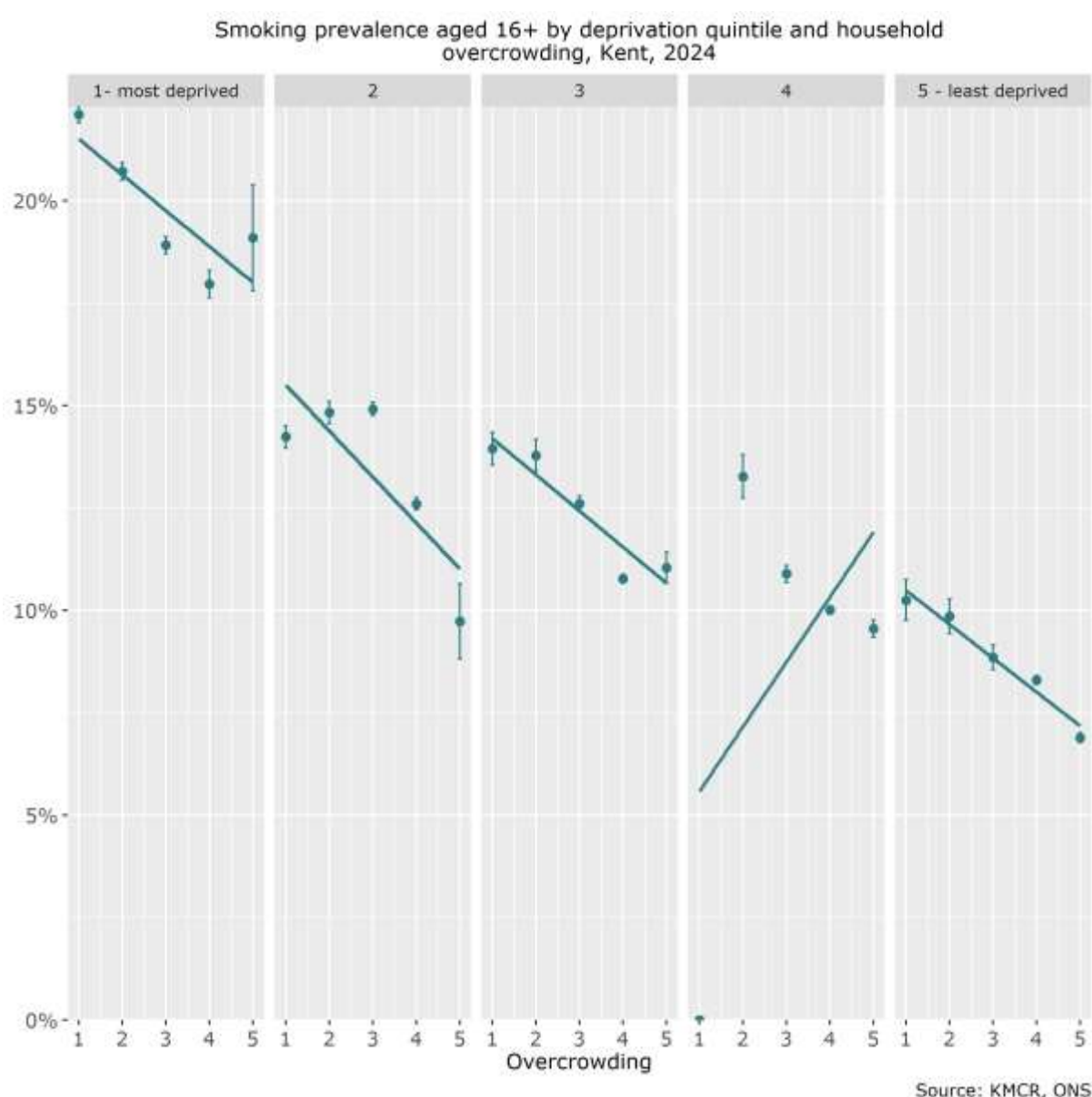


Figure 45. Smoking prevalence by deprivation quintile and household overcrowding, Kent, 2024

5.2.3 Depression prevalence aged 18 years plus

There is a significant difference in the relationship between depression prevalence, ethnicity and urban-rural classification. Figure 46 shows that in the White ethnic group, depression prevalence is lower in rural areas. In the Asian and Black groups, depression prevalence is lower in urban areas.

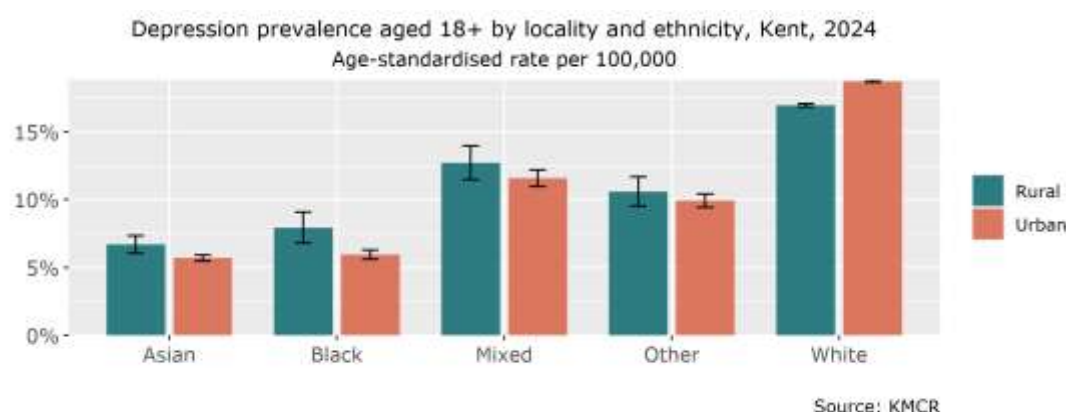


Figure 46. Age-standardised rate of depression in over 18 year olds by locality and ethnicity, Kent, 2024

5.2.4 Obesity-related hospital admissions

Deprivation appears to exert a greater effect on obesity-related hospital admissions in non-coastal areas. This is evidenced by the steeper decline in admissions between the most and least deprived for non-coastal areas in Figure 47.

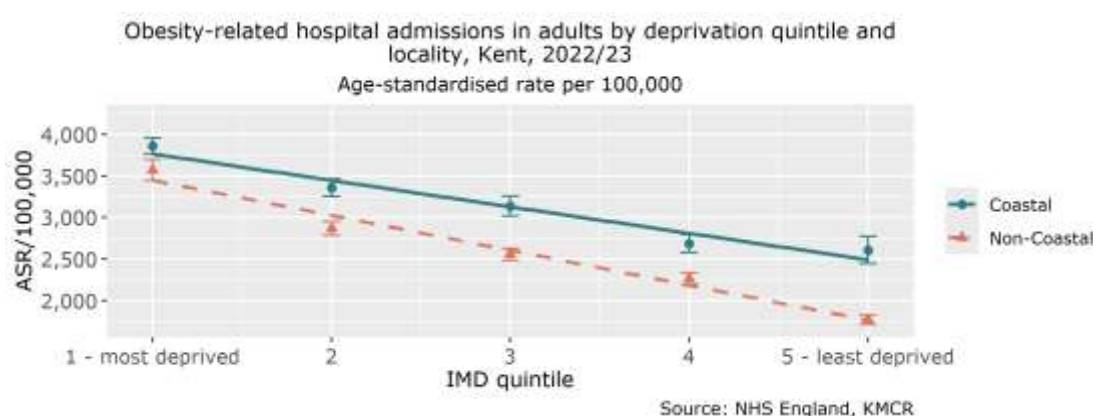


Figure 47. Age-standardised rate of obesity-related hospital admissions by locality and deprivation, Kent, 2024

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The logo for the Kent Public Health Observatory is displayed within a teal, trapezoidal shape. It features the text "KENT PUBLIC HEALTH" in a sans-serif font above the word "OBSERVATORY". A stylized apple icon, composed of a circle with a small leaf, is positioned between the two lines of text, partially overlapping the "O" in "OBSERVATORY".

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