

ORIGINAL ARTICLE

Socioeconomic variation in injury in children and older people: a population based study

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Objectives: To compare hospital admission rates for all causes and specific causes of injury in children and the elderly by a measure of economic deprivation.

Study design: All emergency admissions for Welsh residents from 1997-99 were located to one of 865 electoral tracts, which were grouped into fifths using a measure of socioeconomic deprivation. Standardised admission rates for all ages and 0-14, 15-75, and 75+ year groups for each quintile were calculated with 95% confidence intervals.

Results: There were 90 935 admissions in a population of 2.84 million yielding a crude admission rate of 1601/100 000/year and a standardised rate of 1493/100 000. The ratio of admissions in deprived and affluent areas varied with category of injury and age group. In general, socioeconomic variations in injury rates were much smaller in older people than in children with the exception of pedestrian related injuries where the rates were similar. The largest variations were for injuries sustained in assaults or self inflicted.

Conclusions: The relationship between socioeconomic position and injury varies by cause and age group. This should be considered when developing area based preventive interventions or monitoring the effectiveness of policies to reduce inequalities in injury occurrence.

The strong link between injury mortality and socioeconomic status is well documented.¹⁻⁸ However, the relationship between non-fatal injuries and socioeconomic position is less clear cut, with several papers describing a link,⁹⁻¹⁴ while others suggest any such links are not strong.¹⁵⁻¹⁷ One of the difficulties in studying non-fatal injuries is that use of medical services is often used as a proxy but there is evidence in the UK that less affluent children may be more readily admitted to hospital. This may confound the relationship between deprivation and injury occurrence.¹⁸ However, in countries without comprehensive health insurance or coverage, the reverse may be true: that is, less affluent children being less likely to be hospitalised.^{19, 20} Moreover, most of the research in this area has focused on children and there is a dearth of information on the relationship between non-fatal injuries and socioeconomic position in other age groups, particularly older people.

The aim of this study was to compare hospital admission rates in small areas across Wales and to relate these rates to deprivation in children and the elderly for the major causes of injury.

METHODS

Data were drawn from the Patient Episode Database for Wales (PEDW) for 1997-98 and 1998-99. All records with an *International Classification of Diseases*, 10th revision (ICD-10) S or T code were included. PEDW is a centralised database of all hospital admissions to Welsh residents and contains details such as address of residence, admission, and discharge dates, ICD-10 and procedure codes. Using the postcode of the home address, people were assigned to electoral tracts (844 divisions in Wales, average population 3360). Electoral tracts or divisions were then assigned to five equally sized deprivation groups based on the distribution of the Townsend index of deprivation.²¹

The Townsend index is a composite area based score reflecting unemployment rates, household overcrowding, access to a car, and non-owner occupied housing. Each variable is

weighted equally and the index has a mean of zero and a standard deviation of 1. The most affluent fifth of electoral tracts had Townsend scores of -6.5 to -2.7 and the most deprived had scores from +2.2 to +16.4. The population of the electoral tract fifths were as follows: 745, 201; 605, 675; 541, 682; 459, 947; and 482, 635. Analysis of discharges by all causes and by main categories of external causes (ICD-10), was carried out for all lengths of stay, and for all ages, under 15, 15-75, and 75+ year olds. Analyses are provided for all intents and separately for assault (X60-X84) and self harm (X85-Y09) injuries.

Analyses by cause combine intentional and non-intentional and are grouped into pedestrian (V01-V09) and non-pedestrian road transport injuries (V10-V79), falls (W00-W19), burns and scalds (T20-T32), and poisonings (T36-T50). The main objective of the analyses is to compare children with older people, but it was decided to include data on the remaining age group for the sake of completeness. Analysis was limited to emergency admissions only to prevent double counting of people who may have been subsequently admitted for secondary elective procedures.

Previous research in the UK has shown that less affluent children may be more readily admitted to hospital after an injury and that 4+ day admissions are a better, but not perfect, indicator of severity.¹⁸ However, analysis by 4+ day lengths of stay showed similar results to all lengths of stay and have been omitted. Directly standardised rates per 100 000 population using the World Health Organisation world standard population were calculated to facilitate international comparisons.²²

For age subgroups we used the world standard population distribution within each age group to produce rates and 95% confidence intervals. Standardised hospitalisation ratios and 95% confidence intervals were also calculated to examine whether the results in each fifth of electoral tracts differed from the Welsh average.

Abbreviations: ICD, *International Classification of Diseases*, PEDW, Patient Episode Database for Wales

RESULTS

Over the two year study period, 90 935 injury discharges after emergency admission occurred among 2.84 million people. Ninety percent had a valid external cause code assigned; falls accounted for 37.1%, poisonings 22.5%, road transport injuries 7.1%, and burns and scalds 0.5%. Unintentional injuries accounted for 85.7% and deliberate self harm contributed 9.7% and assaults 4.6%; 18.3% of injury admissions were under 15 year olds and a 19.9% involved 75+ year olds.

Table 1 shows the number of people, world standardised rate, and 95% confidence intervals, by age group and cause of injury, for all emergency admissions. For all admissions, and admission related to self harm, assaults, falls, pedestrian injuries, poisoning and burns, there are socioeconomic gradients with higher rates in the more deprived communities for all younger age groups. For older people only pedestrian injuries and assault related injuries show a substantial socioeconomic gradient.

Table 2 shows the standardised hospitalisation ratios and 95% confidence intervals for each category and group. If the 95% confidence interval does not include 100 then the group differs from the Welsh average.

DISCUSSION

This study shows that the relationship between socioeconomic position and hospital admissions for injury is affected by age and by cause of the injury. In general, socioeconomic variations in injury admissions are substantially lower in older people than in childhood. In particular, there is little evidence of a substantial influence of socioeconomic position on the occurrence of all injuries or on most specific causes of injury in older people. Because of the large sample even small differences between groups will be statistically significant. The small difference between affluent and deprived areas for all injuries, injuries due to self harm, poisoning, or falls in the elderly is not of any public health significance and suggests that intervention strategies need to be targeted at the entire community.

Limitations

The relationship between deprivation status and injury in the elderly could be biased by their movement into group homes outside their original area of residence. We analysed the location of all nursing and residential homes in two typical areas of Wales and found that the distribution was 19.4% (most affluent), 25%, 13.9%, 18.1%, and 23.6% across the fifths of electoral tracts. As only 8.8% of people aged 75 and over in Wales live in such accommodation, the magnitude of any bias caused by such movement is likely to be small and would not substantially affect our reported results.²³

Deaths that occur at the place of injury or en route to hospital pose difficulties for all researchers. In Wales such deaths are not included in the hospital utilisation database. We analysed published statistics on deaths (ICD-9 codes) involving Welsh residents in the year 2000 and the number of deaths after hospital admission during the same period, to see what effect this may have on our results. In that year, 20 suicide victims died in hospital compared with a total of 256 recorded on death certificates. If undetermined deaths (ICD-10: Y10–Y34 and ICD-9: E980–989) are also included then the comparison is 21 versus 345. For road transport related injuries (ICD-10: V01–V79, ICD-9: E810–819, E826–829) 28 in-hospital deaths occurred compared with 200 recorded on death certificates. Clearly, most suicide or road transport related deaths occur at the scene or before entering hospital and this analysis can say little about these deaths. Unfortunately, as the death and hospitalisation databases are not linked in Wales we cannot adjust for this factor. However, as there are many more admissions than deaths (ratio for self harm admissions/suicide is 12:1 and

for road transport related admissions/deaths it is 13:1) the exclusion of these data could not materially affect the results reported.

Admission rates for pedestrian injuries are substantially higher in more deprived areas for all age groups. This suggests that pedestrian safety initiatives targeted to the most deprived communities will benefit all age groups.

It should be noted our analysis is based on the home address of patients rather than the location of the injury. However, there is evidence that in children pedestrian injuries tend to occur near the home and so the use of the home address as a proxy for location is reasonable in this instance.²⁴ The variation in pedestrian injuries between affluent and deprived areas that we found is similar to that reported recently from a region of England using a similar approach.¹⁴

It is interesting to contrast the distribution of pedestrian and non-pedestrian road traffic crash injuries. There is no relation between deprivation status and the likelihood of hospital admission for injury as a car occupant. However, this analysis does not take into account exposure. People in poorer areas may have less access to cars (and hence be at a lower risk of being in a crash) but may be more likely to be injured in a less safe vehicle. Larger, more expensive cars, have better crash protection features.²⁵

The largest difference between affluent and deprived areas is for admissions after assault and self harm. Excess assault related admissions were found for both children and older people, no doubt reflecting the more dangerous external social environment in deprived areas. In contrast, the patterns of self inflicted injuries is different, showing a substantial effect for children from deprived neighbourhoods, but little or no effect in older people from the same areas. This must reflect differences in the internal social environment between age groups in the same areas.

The majority of admissions for self harm were as a result of intentional poisoning (8295/8798, 94%). The rate ratio for such poisonings for all ages was similar to that for intentional poisoning (2.99 v 2.91). However, it is often difficult to assess intentionality in cases of poisoning. A detailed examination of the causes behind the findings is beyond the scope of this paper.

There is also a substantial excess of burn and scald related admissions in the less affluent areas. In case specific analyses the rate ratios for the most deprived communities are highest in children but there is also an excess in other age groups. Sixty two percent of all burn or scald cases involved children compared with 7% in those over 75 years, indicating that children are a priority for burn prevention. Our results are similar to those reported by Hippisley-Cox *et al.*¹⁴

It should also noted that ours is an ecological analysis in which an area based attribute (deprivation) is applied to all individuals in that area. This relationship may be different had individually based socioeconomic measures such as social class or income or educational levels been used. However, the ecologic data should prove useful in choosing interventions and age groups when area based interventions are appropriate. They can also be used to monitor the effectiveness of programmes aimed at reducing inequalities in injury occurrence.

The findings of this study suggest that sweeping generalisations about the relationship between injury occurrence and socioeconomic position are best avoided and that patterns vary by cause of injury and age group affected.

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Table 1 Number of admissions, world standardised admission rates, and 95% confidence intervals (CI) by age group, deprivation status, and cause

Deprivation fifth/cause	All ages		0–14 years		15–75 years		75+ years	
	No	Rate (95% CI)	No	Rate (95% CI)	No	Rate (95% CI)	No	Rate (95% CI)
All admissions								
Deprived	29026	3840.72 (3808.29 to 3873.15)	5729	3614.55 (3520.95 to 3708.15)	19123	3717.00 (3664.31 to 3769.68)	4174	9684.06 (9390.27 to 9977.85)
Less deprived	20474	3250.41 (3217.20 to 3283.61)	3845	3341.40 (3235.78 to 3447.02)	12488	2976.51 (2924.31 to 3028.72)	4141	9344.73 (9060.10 to 9629.35)
Middle	16304	2837.89 (2805.12 to 2870.67)	2802	2872.67 (2766.30 to 2979.04)	9818	2606.94 (2555.22 to 2658.67)	3684	8599.22 (8321.54 to 8876.91)
Less affluent	13484	2743.67 (2708.77 to 2778.56)	2284	2784.35 (2670.16 to 2898.55)	7978	2492.15 (2437.46 to 2546.83)	3222	9146.83 (8830.99 to 9462.67)
Affluent	11647	2256.24 (2225.32 to 2287.16)	2015	2352.42 (2249.71 to 2455.14)	6792	1983.74 (1936.56 to 2030.91)	2840	8718.06 (8397.42 to 9038.69)
Self harm								
Deprived	3641	490.84 (474.90 to 506.79)	64	39.36 (29.79 to 48.93)	3538	711.31 (687.87 to 734.74)	38	83.62 (57.04 to 110.21)
Less deprived	1916	322.12 (307.69 to 336.54)	37	28.45 (19.28 to 37.62)	1849	465.25 (444.04 to 486.45)	30	64.86 (41.65 to 88.07)
Middle	1469	281.75 (267.34 to 296.16)	27	24.10 (15.01 to 33.19)	1428	408.07 (386.90 to 429.23)	14	31.77 (15.13 to 48.42)
Less affluent	1127	257.58 (242.54 to 272.62)	20	20.64 (11.59 to 29.68)	1088	372.96 (350.80 to 395.12)	19	54.81 (30.17 to 79.46)
Affluent	645	134.91 (124.50 to 145.32)	12	11.06 (4.80 to 17.32)	608	193.92 (178.51 to 209.34)	25	72.09 (43.83 to 100.35)
Assaults								
Deprived	1769	246.11 (234.64 to 257.58)	100	63.86 (51.34 to 76.38)	1661	336.25 (320.08 to 352.42)	8	19.45 (5.97 to 32.93)
Less deprived	962	174.04 (163.04 to 185.04)	61	53.96 (40.42 to 67.50)	896	233.62 (218.33 to 248.92)	5	12.16 (1.50 to 22.82)
Middle	657	137.34 (126.84 to 147.84)	47	50.00 (35.71 to 64.30)	607	180.88 (166.49 to 195.27)	3	7.44 (−0.98 to 15.85)
Less affluent	500	121.84 (111.16 to 132.52)	18	22.85 (12.29 to 33.41)	477	170.54 (155.23 to 185.84)	5	13.21 (1.63 to 24.79)
Affluent	295	69.85 (61.88 to 77.82)	9	10.31 (3.57 to 17.05)	284	99.13 (87.60 to 110.66)	2	6.51 (−2.51 to 15.54)
Falls								
Deprived	9458	1078.84 (1057.09 to 1100.58)	2214	1383.95 (1326.30 to 1441.60)	4158	733.58 (711.28 to 755.88)	3086	7223.79 (6968.91 to 7478.66)
Less deprived	7401	961.64 (939.73 to 983.55)	1506	1289.27 (1224.15 to 1354.38)	2963	621.52 (599.14 to 643.90)	2932	6632.88 (6392.79 to 6872.97)
Middle	6361	884.18 (862.45 to 905.91)	1142	1154.52 (1087.56 to 1221.48)	2515	579.65 (556.99 to 602.30)	2704	6318.58 (6080.42 to 6556.75)
Less affluent	6011	974.58 (949.94 to 999.22)	1052	1251.71 (1176.07 to 1327.35)	2373	636.89 (611.27 to 662.52)	2586	7365.79 (7081.89 to 7649.69)
Affluent	4536	722.79 (701.76 to 743.83)	840	953.85 (889.34 to 1018.35)	1727	441.18 (420.37 to 461.99)	1969	6098.50 (5829.13 to 6367.88)
Non-pedestrian RTAs								
Deprived	1332	195.25 (184.76 to 205.73)	315	189.94 (168.96 to 210.91)	970	197.63 (185.19 to 210.07)	47	102.70 (73.34 to 132.06)
Less deprived	1113	202.85 (190.93 to 214.77)	238	191.07 (166.79 to 215.34)	828	208.49 (194.29 to 222.69)	47	101.01 (72.13 to 129.89)
Middle	1015	208.88 (196.03 to 221.73)	201	187.58 (161.65 to 213.52)	772	219.35 (203.88 to 234.82)	42	94.26 (65.75 to 122.76)
Less affluent	949	225.41 (211.07 to 239.75)	187	205.40 (175.96 to 234.84)	692	232.73 (215.39 to 250.07)	70	187.79 (143.80 to 231.78)
Affluent	859	190.72 (177.97 to 203.47)	147	157.30 (131.87 to 182.73)	671	206.07 (190.48 to 221.66)	41	115.82 (80.37 to 151.27)
Pedestrian RTAs								
Deprived	423	63.16 (57.14 to 69.18)	177	108.04 (92.12 to 123.96)	201	39.59 (34.12 to 45.06)	45	103.21 (73.06 to 133.37)
Less deprived	247	46.26 (40.49 to 52.03)	90	75.26 (59.71 to 90.81)	130	31.25 (25.87 to 36.62)	27	62.32 (38.81 to 85.82)
Middle	189	39.94 (34.25 to 45.64)	70	68.44 (52.41 to 84.47)	94	25.16 (20.07 to 30.24)	25	59.27 (36.04 to 82.51)
Less affluent	169	41.73 (35.44 to 48.02)	56	64.55 (47.64 to 81.45)	92	29.74 (23.66 to 35.81)	21	57.49 (32.90 to 82.08)
Affluent	121	28.27 (23.23 to 33.30)	41	43.88 (30.45 to 57.32)	63	19.69 (14.83 to 24.55)	17	51.66 (27.10 to 76.22)
All poisoning								
Deprived	8231	1180.10 (1154.61 to 1205.60)	1012	663.63 (622.74 to 704.52)	7060	1433.86 (1400.41 to 1467.31)	159	352.54 (297.74 to 407.34)
Less deprived	4581	839.11 (814.81 to 863.41)	615	575.20 (529.74 to 620.66)	3834	969.03 (938.36 to 999.70)	132	289.74 (240.31 to 339.17)
Middle	3368	703.19 (679.45 to 726.94)	431	479.08 (433.85 to 524.31)	2810	811.90 (781.88 to 841.92)	127	295.94 (244.47 to 347.42)
Less affluent	2608	638.22 (613.73 to 662.71)	312	427.83 (380.36 to 475.31)	2168	737.52 (706.48 to 768.57)	128	358.68 (296.55 to 420.82)
Affluent	1689	400.39 (381.29 to 419.48)	253	341.34 (299.28 to 383.40)	1330	425.04 (402.20 to 447.88)	106	319.11 (258.36 to 379.86)
All burns								
Deprived	188	33.69 (28.87 to 38.51)	120	81.09 (66.58 to 95.60)	56	10.74 (7.93 to 13.55)	12	27.32 (11.86 to 42.78)
Less deprived	109	27.51 (22.34 to 32.67)	73	71.65 (55.21 to 88.08)	27	6.26 (3.90 to 8.63)	9	19.06 (6.61 to 31.51)
Middle	83	24.53 (19.25 to 29.81)	54	62.62 (45.92 to 79.32)	25	6.43 (3.91 to 8.95)	4	9.24 (0.18 to 18.30)
Less affluent	65	21.73 (16.45 to 27.01)	36	51.59 (34.74 to 68.44)	24	7.37 (4.42 to 10.32)	5	14.24 (1.76 to 26.73)
Affluent	51	15.44 (11.20 to 19.68)	25	34.89 (21.21 to 48.57)	21	5.92 (3.39 to 8.45)	5	15.78 (1.95 to 29.61)

RTAs, road traffic accidents.

Table 2 Standardised hospitalisation ratios (SHR) and 95% confidence intervals (CI) by age group and deprivation status

Deprivation fifth	All ages	0–14 years	15–74 years	75+ years
	SHR (95% CI)	SHR (95% CI)	SHR (95% CI)	SHR (95% CI)
All admissions				
Deprived	122.4 (121.04 to 123.86)	117.0 (114.00 to 120.06)	128.5 (126.64 to 130.28)	106.4 (103.16 to 109.61)
Less deprived	104.4 (102.94 to 105.80)	107.9 (104.5 to 111.32)	103.8 (102.02 to 105.66)	102.8 (99.692 to 105.96)
Middle	92.6 (91.18 to 94.02)	92.8 (89.35 to 96.22)	91.9 (90.064 to 93.699)	94.4 (91.385 to 97.484)
Less affluent	91.1 (89.54 to 92.61)	90.3 (86.62 to 94.03)	88.2 (86.281 to 90.152)	99.7 (96.228 to 103.11)
Affluent	76.6 (75.23 to 78.01)	75.5 (72.233 to 78.829)	71.1 (69.377 to 72.758)	95.4 (91.908 to 98.927)
Self harm				
Deprived	154 (149.01 to 159.01)	149.9 (113.47 to 186.37)	154.3 (149.24 to 159.41)	134.8 (91.945 to 177.67)
Less deprived	101.6 (97.082 to 106.18)	108.5 (73.549 to 143.48)	101.4 (96.784 to 106.03)	108 (69.371 to 146.69)
Middle	88.7 (84.132 to 93.201)	91.6 (57.063 to 126.18)	89.2 (84.597 to 93.852)	52.2 (24.84 to 79.492)
Less affluent	80.5 (75.77 to 85.166)	77.8 (43.713 to 111.93)	80.5 (75.67 to 85.231)	84.5 (46.507 to 122.5)
Affluent	43.3 (39.913 to 46.589)	42.3 (18.361 to 66.213)	42.2 (38.807 to 45.509)	120.7 (73.358 to 167.95)
Assaults				
Deprived	152.7 (145.59 to 159.83)	144.9 (116.46 to 173.24)	153.2 (145.81 to 160.55)	159.1 (48.839 to 269.3)
Less deprived	106.9 (100.16 to 113.67)	121.5 (91.035 to 152.03)	106.1 (99.153 to 113.05)	97.6 (12.052 to 183.19)
Middle	83.9 (77.528 to 90.366)	110.2 (78.723 to 141.76)	82.6 (76.009 to 89.147)	60.7 (–7.988 to 129.38)
Less affluent	76.5 (69.77 to 83.177)	50.6 (27.226 to 73.982)	77.7 (70.699 to 84.639)	121.7 (15.027 to 228.4)
Affluent	42.9 (37.967 to 47.748)	24 (8.305 to 39.609)	43.9 (38.792 to 49.003)	52.7 (–20.322 to 125.64)
Falls				
Deprived	113.2 (110.9 to 115.46)	112.3 (107.61 to 116.96)	118.5 (114.88 to 122.08)	107.3 (103.53 to 111.1)
Less deprived	100.8 (98.551 to 103.15)	104.4 (99.117 to 109.66)	101.1 (97.421 to 104.7)	98.9 (95.337 to 102.5)
Middle	94.1 (91.825 to 96.452)	93.4 (87.95 to 98.78)	94.5 (90.778 to 98.162)	94.2 (90.612 to 97.711)
Less affluent	106 (103.31 to 108.67)	102.3 (96.104 to 108.47)	104.7 (100.53 to 108.96)	108.8 (104.6 to 112.98)
Affluent	80.4 (78.039 to 82.718)	77.2 (71.99 to 82.433)	73 (69.527 to 76.41)	90 (85.992 to 93.939)
Non-pedestrian RTAs				
Deprived	93.8 (88.75 to 98.823)	102.4 (91.102 to 113.72)	91.7 (85.97 to 97.517)	84.9 (60.617 to 109.15)
Less deprived	98.5 (92.744 to 104.32)	102.7 (89.656 to 115.75)	98.2 (91.479 to 104.85)	86.5 (61.74 to 111.18)
Middle	102.2 (95.897 to 108.47)	101.8 (87.704 to 115.84)	103.9 (96.547 to 111.2)	79.8 (55.69 to 103.98)
Less affluent	113 (105.79 to 120.16)	110.5 (94.673 to 126.35)	110.4 (102.19 to 118.65)	158.7 (121.56 to 195.93)
Affluent	97.1 (90.586 to 103.57)	80.8 (67.72 to 93.838)	101.3 (93.646 to 108.98)	101.1 (70.135 to 132.01)
Pedestrian RTAs				
Deprived	137.8 (124.65 to 150.91)	142 (121.08 to 162.93)	131.8 (113.59 to 150.03)	150.6 (106.57 to 194.56)
Less deprived	100.1 (87.641 to 112.62)	97.2 (77.137 to 117.31)	104.7 (86.666 to 122.65)	90.3 (56.244 to 124.37)
Middle	86.7 (74.3 to 99.009)	89 (68.125 to 109.81)	85 (67.837 to 102.21)	86.6 (52.646 to 120.53)
Less affluent	91.5 (77.703 to 105.29)	83.8 (61.857 to 105.76)	98.1 (78.052 to 118.14)	87.1 (49.869 to 124.41)
Affluent	62.9 (51.662 to 74.064)	57.5 (39.91 to 75.121)	63.7 (47.944 to 79.387)	76.4 (40.095 to 112.76)
All poisoning				
Deprived	147.6 (144.4 to 150.76)	127.2 (119.41 to 135.09)	152.2 (148.65 to 155.75)	110.5 (93.324 to 127.68)
Less deprived	104.3 (101.2 to 107.29)	109.4 (100.79 to 118.09)	104 (100.69 to 107.28)	91.4 (75.779 to 106.95)
Middle	87.5 (84.53 to 90.436)	90.8 (82.248 to 99.397)	86.8 (83.635 to 90.057)	90.8 (75.042 to 106.64)
Less affluent	80.6 (77.48 to 83.663)	80.3 (71.407 to 89.231)	79.4 (76.017 to 82.698)	109.9 (90.82 to 128.88)
Affluent	49.4 (47.05 to 51.759)	62.8 (55.078 to 70.559)	45.7 (43.267 to 48.181)	98.8 (79.976 to 117.59)
All burns				
Deprived	130.8 (112.12 to 149.52)	124.8 (102.43 to 147.07)	140.6 (103.80 to 177.48)	155.8 (67.64 to 243.93)
Less deprived	102.3 (83.09 to 121.50)	110.3 (85.00 to 135.60)	82.8 (51.58 to 114.06)	115.9 (40.19 to 191.66)
Middle	90 (70.60 to 109.31)	97.2 (71.27 to 123.12)	85.6 (52.06 to 119.19)	53.2 (1.06 to 105.39)
Less affluent	85.8 (64.92 to 106.62)	80.6 (54.28 to 106.96)	96.5 (57.89 to 135.11)	79.9 (9.87 to 149.96)
Affluent	65.6 (47.63 to 83.66)	55 (33.47 to 76.63)	79.2 (45.33 to 113.08)	86.8 (10.71 to 162.86)

RTAs, road traffic accidents.

Key points

- The relationship between socioeconomic position and injury occurrence is not constant and varies by age group and cause of injury.
- Socioeconomic gradients for pedestrian and assault related injuries are common to both children and older people.
- Children, but not older people show a distinct socioeconomic gradient in the incidence of hospitalisations for self harm.
- Falls in older people appear to be little influenced by socioeconomic position.

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