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Surveying the population

HEALTH TOPICS IN THE CENSUS OF POPULATION
AND OTHER SURVEYS

Mary Shaw, Danny Dorling and Jenny Grundy

The census
Health topics in other general surveys
Population surveys focusing specifically on health and illness

This chapter describes the health information available from the census of population and other official surveys. Surveys which collect such information are of two types: general surveys, where health questions are included among many other different topics, and surveys which focus specifically on health issues. In addition to the census, nine general surveys are regularly undertaken by the Office for National Statistics (ONS): the General Household Survey, the Family Expenditure Survey, the Family Resources Survey, the Survey of English Housing, the Labour Force Survey, the International Passenger Survey, the National Travel Survey, the Omnibus Survey and the National Food Survey. These are often described as continuous surveys, meaning that they have been undertaken regularly, annually or more frequently, for many years and therefore provide information on time trends. The amount of health information in these surveys varies from one or two single questions in the census to the considerable health component in the General Household Survey, which includes questions on the use of health services as well as self-reported illness.

Surveys which focus exclusively on health-related topics may also be part of long-running series. The survey of Infant Feeding has been undertaken every 5 years since 1975, and the Adult Dental Health survey every 10 years since 1968. With the recent introduction of the National Diet and Nutrition Surveys, the Health Surveys for England and Scotland and the Health Education Monitoring Survey, the number of continuous surveys focusing exclusively on health-related topics has increased. From time to time, important occasional, large-scale surveys are undertaken, for example the Office of Population Censuses and Surveys (OPCS) Surveys of Disability (described in Chapter 4) and the OPCS Psychiatric Morbidity Survey. The introduction of
market testing means that some surveys originally undertaken by OPCS and its successor the ONS, such as the Health Survey for England, are now contracted out. They are usually contracted to consortia of market research companies and academic institutions.

### The census

#### Counting the population

The census is a count of the number of people normally resident in the UK on a particular night. Using the household as its basic unit of enumeration, the census asks questions about the social and economic condition of the population. It also collects information on the number of houses in the country, family structure and employment. In 1991, questions on ethnicity and health were added, except in Northern Ireland where questions about religion and fertility were included but not the question on ethnic group. It is, thus, a ‘snapshot’ of the population on one night of the year. In order to gain as complete as possible a set of results, the census was made compulsory through an Act of Parliament, with an assurance to the public that the information collected is both confidential and anonymous. The 1920 Census Act gave the Registrars General for England and Wales and for Scotland a general authority and duty to conduct censuses at intervals no shorter than 5 years. Despite this, each census requires secondary legislation, an Order in Council which determines the date, the broad topics on which questions will be asked and by whom, and to whom returns should be made.

The 2001 census will be very similar to the 1991 census, but a number of questions will be asked for the first time. A general health question will be included, in which respondents will be asked to assess whether their own health in the preceding 12 months has been ‘Good’, ‘Fairly good’ or ‘Not good’. Respondents will be asked if they provide unpaid personal help for a friend or relative with a long-term illness, health problem or disability, and the time spent each week in providing such care. This will provide information about the number of carers. An ethnic origin question (discussed in Chapter 4) will be asked in Northern Ireland. The census white paper proposed a question on religion, which will probably be included, and a question on income, which was subsequently dropped. Further information on the 2001 census can be found on the census web site, the address of which is given at the end of this chapter.

The data are used for a wide range of purposes by many different groups of people. The census is used as a basis for revenue distribution to local authorities. They, in turn, use data from it in planning public services, such as education, transport and health. In addition to this, the census acts as a ‘gold standard’ against which other social surveys can be judged. Detailed information about the way the census was undertaken in 1991 and the questions asked can be found in A Census user’s handbook and The 1991 census user’s guide.
Despite the size and scope of the census, it is now accepted that approximately 1.2 million people living in Britain avoided being included in the 1991 census. The OPCS discovered this when it compared the census count with the updated mid-year population estimates and found a shortfall which could not be accounted for by deaths or out-migration. Unfortunately, but not surprisingly, the same people also managed to avoid enumeration in the official census validation survey carried out shortly after the census in order to establish its accuracy. Thus, relatively little is known with great certainty about the nature of the ‘missing million’. The ‘Estimating with confidence’ project at the universities of Manchester and Southampton has established a ‘gold standard’ estimate of the likely geographical distribution of these people. The estimates can be accessed on the MIMAS, formerly known as MIDAS, computer system at Manchester University, and the contact address is given at the end of this chapter. Because the ‘missing million’ are not a random sample of the population, studies which ignore this group are likely to produce biased results. Young men and elderly women were particularly likely to be missed by the 1991 census. Thus, the effects of this omission need to be taken into account.

In the UK, three organizations are responsible for censuses. The ONS, formerly the OPCS, takes censuses in England and Wales. Censuses for Scotland and Northern Ireland are taken by the General Register Office for Scotland (GRO(S)) and the Northern Ireland Statistics and Research Agency (NISRA), of which the Census Office Northern Ireland (CO(NI)) is part. The first census was taken in 1801, and a decennial census has been conducted ever since, with the exception of 1941. Individual records of nineteenth-century censuses are available for historical research and family histories.

The nineteenth full census was held on Sunday, 21 April 1991 and the twentieth will take place on Sunday, 29 April 2001. These dates are not as arbitrary as they might seem. The enumeration year is fixed, but the day is flexible, and experience has shown that picking a date in April produces the best response. The optimum date is one when people are likely to be at their usual address, with reasonable weather and daylight hours, and avoiding local and national elections. The day should also be reasonably consistent with previous censuses and in time to produce the results by a specified deadline.

The scale of the survey is reflected in the fact that it took some 118,000 enumerators to distribute the forms for the 1991 census. Expenditure on the census over the 10-year period from 1986–87 to 1995–96 was estimated to be £117 million. At the peak of work, it was estimated that as many as one in 400 people in Britain were being paid to work on the census, and the completed census forms took up some 12 miles of shelving space.

Between censuses, mid-year population estimates are derived from the previous census, birth and death registration data, data about internal migration, which are collected by the NHS Central Register when people change their general practitioners, and data about international migration, which are taken from the International Passenger Survey, as well as claims for political asylum. At times of rapid change, for example when many people are moving around the country in search of work, population estimates for particular areas can become inaccurate. In many decades there have been demands for
5-yearly censuses and in 1966 a mid-term sample was undertaken. Others were planned for 1976 and 1986, but fell victim to public expenditure cuts.

**Health information and the census**

From 1851 onwards, attempts were made to collect information about the ‘infirmities’ which we now describe as problems with seeing and hearing, mental illness and learning difficulties. Due to the problems which affected reporting rates, not least the stigma attached to these conditions, the question was dropped in 1921. In the 1971 census, only temporary sickness from work was recorded as illness. In 1981, ‘permanently sick or disabled’ was added as a residual category of economic activity, but it was not possible for children or people who had retired to be included in this category. The absence of this information for 1981 is particularly unfortunate in areas with high proportions of retired people. The 1991 census was the first which asked everyone in the population, ‘Do you have any long-term illness, health problem or handicap which limits your daily activities or the work you can do? Include problems which are due to old age’. The aim of this question was to collect information about morbidity and the need for health and social services at a local level, instead of using death rates as a proxy measure.

As the census is a unique source of data at a very local level, it is used by all levels of government for resource allocation. If the censuses were not taken, the process of resource allocation would be even more uncertain than it is. The piloted version of the limiting long-term illness question correlated well with general practitioner consultation rates and so it has been proposed as a nationally consistent indicator of health service needs. Despite the fact that they are the most comprehensive available, census data should not be interpreted uncritically. There has been no definitive study of how the census measure of limiting long-term illness compares to surveys which use interviews or clinical examinations. Because the word ‘limiting’ was used in the question, some people who might otherwise classify themselves as ill might have been deterred from ticking this census box.

The wording of the census question is crucially important. It aims to collect data about chronic illness. Any condition from asthma to arthritis could be included. Of course, some people with either of these conditions may not consider them serious enough to answer ‘yes’, while other people with conditions which a medical practitioner might not describe as an illness may have been inclined to do so. As with all self-reported measures of illness, therefore, we need to be aware of the ‘iceberg of disease’ concept. This refers to the large proportion of symptoms and disease which is not reported to medical practitioners. Because of differences in the way people perceive and report symptoms, measures of illness can vary independently of the prevalence of disease.

There are additional reasons to be wary of self-reported data. Self-reporting of limiting long-term illness has been found to vary by social group, for example by age and social class. When these groups are unevenly distributed
geographically, this may lead to bias.\textsuperscript{11} There may also be gender differences in reporting.\textsuperscript{12} It may also be the case that the reporting of limiting long-term illness may reflect local labour market conditions. In areas of high long-term unemployment, higher rates of positive response to this question occurred, even after controlling for deprivation and regional difference.\textsuperscript{13} This casts doubt on the use of this measure as an objective indicator of health care needs which can be used for resource allocation at the national level. Changes to the benefit system and sick-pay may also affect reporting. Similarly, a person's knowledge about the system for allocating resources may affect the way they answer questions.\textsuperscript{7}

As well as information about the health of individuals, the census also collects data on the number and characteristics of people living in institutions or 'communal establishments'. The definition covers a wide range of institutions, including long-term homes for elderly people, psychiatric and other long-stay hospitals, hostels, barracks and prisons.\textsuperscript{2} In the 1991 census, an important distinction was drawn between NHS or local authority hospitals or homes and non-NHS or local authority hospitals, nursing homes and residential care. A total of 186,136 people aged 85 years and over reporting a limiting long-term illness was enumerated in non-household establishments.\textsuperscript{14} Of these, 8 per cent were living in a NHS hospital or home, 22 per cent in local authority homes, 30 per cent in non-NHS nursing homes and non-local authority homes, and 37 per cent in residential homes. Also in 1991, people sleeping rough were enumerated separately by category, but only small numbers were found. For example, in Great Britain, only thirty-six 16 to 17 year olds sleeping rough were enumerated.\textsuperscript{15} This gross underenumeration is discussed in Chapter 6.

The housing tables also include information about types of dwellings, distinguishing, for example between flats and houses and whether dwellings are permanent or non-permanent. Non-permanent accommodation is that which is not constructed of permanent building materials such as brick or concrete. In most cases, non-permanent accommodation refers to static caravan parks or houseboats, although travellers living under plastic sheets would also count if that were their permanent home.

A final point to remember when interpreting census data is whether results are reported at the individual or household level. For example, people aged over 45 suffering from a limiting long-term illness were more likely than others to be living in a household with others with a limiting long-term illness. Thus, the household as well as the individual frequency of illness may need to be considered, especially for the allocation of resources.\textsuperscript{16}

**Accessing published census data**

Census data for England, Wales and Scotland are published jointly, whereas Northern Ireland data are published separately. Despite their drawbacks, census data are undoubtedly an invaluable source of information about the population. Data from the census are published in two ways, by area and by
subject. Tabulations are produced for a range of geographical areas, including counties, former regional health authorities, and parliamentary constituencies. The county volumes are often available in the offices of local councils and in some public libraries. Reports are also produced containing national data on a wide range of topics including a specific report on *Persons with limiting long-term illness*. The content of tables from this report is shown with examples in Table 2.1. The following reports on specific topics include data about ‘long-term illness’ in one or more tables. Some useful tables from these volumes are listed in Table 2.2.

- Persons living in communal establishments
- Children and young adults
- Persons aged 60 and over
- Housing and the availability of cars
- National migration
- Regional migration
- Household and family group

The most detailed information about health is found in *Limiting long-term illness, Communal establishments*, and the *Report for England, regional health authorities, Parts I and II*.

The following volumes may also contain information relevant to health issues:

- Historical tables
- Sex, age and marital status
- Ethnic group and country of birth
- Usual residence
- Economic activity
- Workplace/transport
- Qualified manpower

The information presented in these tables is somewhat daunting at first sight, but the basic arrangement is consistent throughout. In most of the tables, information is tabulated by age, sex, marital status, region, economic position, social class, ethnic group, long-term illness, housing conditions including amenities and tenure, employment and education.

For people such as researchers interested in statistics about a large number of very small areas, electronic datasets are available. The 1991 census is the first for which anonymised individual records were made available. The sample of anonymised records (SARs) consists of a 2 per cent sample of the population and a separate 1 per cent sample of households. Researchers are given access to the individual records, which allow analyses to be done more flexibly to answer specific questions. For instance, how more or less likely is a woman born in Bangladesh to be ill than a woman born in Scotland and does this vary by age and/or by current district of residence?
### Table 2.1  Examples of data in the 'Limiting long-term illness' volume of the 1991 census

<table>
<thead>
<tr>
<th>Table number</th>
<th>Geographical area</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age, sex and marital status: number of residents in household with a limiting long-term illness</td>
<td>Great Britain, England and Wales, England, regions, metropolitan counties, Inner London, Outer London, regional remainders, Wales and Scotland</td>
<td>In Great Britain, 583,372 people aged 85 and over were enumerated; of these, 364,161 (or 62%) had a limiting long-term illness</td>
</tr>
<tr>
<td>2. Communal establishments: number of people with a limiting long-term illness by age and sex</td>
<td>Great Britain, England and Wales, England, Wales, Scotland</td>
<td>In England, 43,459 people were classed as camping or sleeping rough at the census; of these, 11,321 reported a limiting long-term illness</td>
</tr>
<tr>
<td>3. Ethnic groups: number of people with limiting long-term illness by age, sex and nine ethnic groups</td>
<td>Great Britain, England and Wales, England, Wales, Scotland</td>
<td>To answer the question 'Which ethnic group reported the highest proportion of ill children?': on average, only 2% of children aged between 0 and 4 years reported a limiting long-term illness, ranging from almost 4% of Black African children to only 1.3% of Chinese children</td>
</tr>
<tr>
<td>4. Economic activity: number of people with limiting long-term illness by age, sex and economic situation</td>
<td>Great Britain, England and Wales, England, Wales, Scotland</td>
<td>In Great Britain, among men in the age group 40–44 who were retired, 33% suffered from a limiting long-term illness, compared to 3.5% for the male population as a whole in this age group</td>
</tr>
<tr>
<td>5. Tenure and amenities: number with limiting long-term illness by household, age, sex, region and tenure</td>
<td>England and Wales, England, Wales</td>
<td>For Great Britain as a whole, 42% of households with no bath, shower or inside toilet and no central heating contain someone with a limiting long-term illness, compared with 25% of households which possess these amenities</td>
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<tr>
<td>6. Housing: number with limiting long-term illness by household, age, sex and type of housing</td>
<td>Great Britain, England and Wales, England, Wales, Scotland</td>
<td>Less than 0.5 per cent of households lived in non-permanent accommodation, but 30% of these had at least one ill person in the household</td>
</tr>
<tr>
<td>7. Household composition: households with residents with limiting long-term illness, by age, sex, household type, economic activity of the head of household and number of dependants</td>
<td>Great Britain, England and Wales, England, Wales, Scotland</td>
<td>There were 6,674,358 households enumerated in Great Britain with at least one resident with a limiting long-term illness; of these, 1,058,284 (16%) have one or more dependent children</td>
</tr>
</tbody>
</table>

Table 2.2 Other tables from the 1991 census containing data about limiting long-term illness

<table>
<thead>
<tr>
<th>Table</th>
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</thead>
<tbody>
<tr>
<td>12. Limiting long-term illness in households by age, sex, regional health authority</td>
</tr>
<tr>
<td>13. Limiting long-term illness in communal establishments by age, sex, regional health authority</td>
</tr>
<tr>
<td>14. Limiting long-term illness by economic position, age, sex, regional health authority</td>
</tr>
<tr>
<td>29. Dependants and limiting long-term illness by age, economic activity and regional health authority</td>
</tr>
<tr>
<td>45. Households with pensioners: housing; household composition by number of households up to 0.5 persons per room, facilities and limiting long-term illness by regional health authority</td>
</tr>
<tr>
<td>12. Limiting long-term illness and ethnic group: by sex, age and regional health authority</td>
</tr>
<tr>
<td>13. Limiting long-term illness by household composition, sex, age, number of children in the household and regional health authority</td>
</tr>
<tr>
<td>16. Limiting long-term illness in communal establishments — persons 60 and over with limiting long-term illness</td>
</tr>
<tr>
<td>19. Cars and pensioners — households with residents by age, sex, marital status, number of cars and persons with limiting long-term illness</td>
</tr>
<tr>
<td>3. Type of establishment, migrants and limiting long-term illness; the table contains information on numbers of ill people in various establishments by sex, age, resident/visitor, staff/non-staff and countries (England and Wales, England, Wales, Scotland)</td>
</tr>
<tr>
<td>Source</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>OPCS 1991 census. <em>Communal establishments Great Britain</em>. Volume II. London: HMSO, 1993</td>
</tr>
<tr>
<td>OPCS 1991 census. <em>Children and young adults. Great Britain</em>. Volume I. London: HMSO, 1993</td>
</tr>
<tr>
<td>OPCS 1991 census. <em>Persons aged 60 and over. Great Britain</em>. London: HMSO, 1993</td>
</tr>
</tbody>
</table>
The Office for National Statistics Longitudinal Study

The ONS Longitudinal Study, formerly known as the OPCS Longitudinal Study, links the census records of a 1 per cent sample of the population of England and Wales with birth, death and cancer registrations. It started in 1971, and the sample is made up of people born on four dates during any year. Using the National Health Service Central Register, it links census data with births and deaths, taking into account immigration and emigration. Records of Longitudinal Study members have now been linked with 1971, 1981 and 1991 census data. The structure of the Longitudinal Study is shown in Fig. 2.1. It has an advantage over most cohort studies in that the sample size is over 500,000 and much non-response is avoided, although there may be some problems with the linking of data and sample bias.

The Longitudinal Study was set up to be used for a wide range of mortality and fertility analyses based on the demographic, social, economic and environmental factors recorded at the census. This allows an assessment of the association between factors such as social class, employment status and adult mortality rates, or between parents’ social circumstances and birth spacing and infant mortality.

The inclusion of cancer registrations was intended to enable analysis by occupation at different stages in the life cycle. Data on subjects such as occupation, employment status and housing conditions can now be linked over a 20-year period, from 1971 to 1991, and are currently being linked to mortality data for the 1990s. These data will eventually be linked to the 2001 census. The inclusion of a question identifying people from ethnic minority groups in the 1991 census offered the potential to ask questions such as how work and housing conditions for ethnic minorities relate to, for example, cancer incidence in these groups. In addition, the question on long-term illness should lead to an analysis of how its incidence among people with various census characteristics is associated with subsequent mortality. At the time of writing, data from the 1991 census, and hence records on long-term illness, have been added relatively recently, so extensive analyses of this information have yet to be published.

The complexity and confidentiality requirements of the Longitudinal Study mean that people who wish to analyse data have to make a specific application, but support is provided to people who do so. Contact details can be

![Fig. 2.1](image_url) The events in the life of a member of the ONS Longitudinal Study (LS). (Source: Office for National Statistics.)
found at the end of this chapter. A detailed description of the Longitudinal Study data together with an assessment of the quality and completeness of the data was published by OPCS in 1995.\textsuperscript{17} Information about the Longitudinal Study can be obtained through the Longitudinal Study User Group and Longitudinal Study Support Programme and there are also Longitudinal Study Working Papers and User Guides.\textsuperscript{18–21}

Longitudinal Study data and publications cover a wide range of topics, including general and methodological, social and economic change, demographic studies, migration, gerontological studies, ethnicity, housing, inequalities in health and mortality, and cancer studies. Findings are published in the Longitudinal Study series listed below, as well as in articles in a wide range of journals. A review of the Longitudinal Study was published in 1999 and it included a comprehensive list of publications containing analyses of the data.

**The Longitudinal Study series**


**Health topics in other general surveys**

**The General Household Survey**

The General Household Survey is an annual survey conducted since 1971 by the OPCS and now by the ONS. For funding reasons, it was suspended for 1997–8. After pressure from a wide range of users inside and outside government, it was decided to reinstate the survey in 1998. Data were collected in 1998–9 but not in 1999–2000. The suspensions mean that there has been a
break in the continuous nature of the survey and that its long-term future was in doubt.22 After a review and much lobbying by its many users, the ONS has since announced plans to continue the General Household Survey for 5 years from 2000–1 onwards.

In the General Household Survey, information is collected on a wide range of subjects, including household composition, accommodation, migration, employment, education, travel and health. The sample of approximately 17,000–20,000 is different every year, rather than being a panel or cohort study. There is a multistage sampling process, with electoral wards as the primary sampling units. It is designed to produce representative results over a spectrum of social and geographical conditions. The sample covers England, Wales and Scotland. Reports are published annually. Since 1994, they have had the title Living in Britain. Northern Ireland has a similar survey, the Continuous Household Survey.

In the General Household Survey, people are asked ‘Do you have any long-standing illness, disability or infirmity?’, wording which is somewhat different from that in the census. Those who reply positively to this question are then asked, ‘Does this illness or disability limit your activities in any way?’. There is also a question on acute sickness or restricted activity, referring to whether the respondent has had to cut down on the things he or she usually does due to illness or injury in the preceding 2 weeks. The survey therefore produces three different statistics on self-reported illness, long-standing illness or disability, limiting long-standing illness or disability and restricted activity in the 14 days prior to the interview.

Use of health services is also covered in the form of a question on consultations with a general practitioner in the preceding 2 weeks, attendance at outpatient services at hospital visits, excluding ante-natal or post-natal over the previous 3 months, and in-patient hospital stays over the previous year. It also asks, in some years, about private health insurance and use of private health care. The association between self-reported illness and health service use can thus be investigated. Other health-related questions, such as those about smoking and birth-control, are not asked every year. While the General Household Survey obviously has a much smaller sample size than the census and cannot tell us about illness at a small area level, it can be used for monitoring regional differences and national trends. From 2000 onwards, there will be a continuous element and a number of additional sections, varying from year to year.

Questions asked every year:

- Long-standing illness or disability prevalence
- Acute sickness: prevalence and duration of restricted activity
- Health in general in 12 months before interview
- GP consultations in 2 weeks before interview, including site of consultation
- Whether a prescription was given
- Out-patient attendances in 3 months prior to interview
future was the ONS has for 5 years

wide range migration, approximately 1 or cohort as the pri- 
sults over a rs England, they have y, the Con-
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on consultation at out-
als over the year. It also vate health ice use can loose about the General the census for moni-
t, there will trying from

Stays in hospital as in-patient in the last 12 months.

Asked every 2 years or less often:

*Contraception:* current use of contraception
- Whether woman/partner has been sterilised
- Whether women/partner would have difficulties in having more children

*Health behaviours:* personal rating of own drinking behaviour
- Prevalence of cigarette, pipe and cigar smoking
- Number and type of cigarettes smoked
- Whether ever smoked cigarettes, cigars and pipes regularly

*Dentistry:* whether has any natural teeth
- Whether goes to dentist for check-ups or only when having trouble

*Elderly people:* use of health and social services by persons over 65
- Difficulties with sight or hearing in persons aged 65 or over, which has been asked intermittently.

Health topics included 1971 to 1996:

*Family information/fertility:* marriage, cohabitation, childbirth, contraception, sterilisation and infertility

*Chronic health problems:* chronic sickness including long-standing illness or disability, prevalence, effects, contact with health services. Health in general in 12 months prior to interview

*Short-term health problems* in 14 days prior to interview: prevalence and effects

*Use of health services:* GP consultations, reason for the consultation and outcome, out-patient attendances, day-patient visits, in-patient spells, mobility aids

*Accidents:* accidents at home

*Elderly people:* social support and elderly people, informal carers

*Sight and hearing:* tinnitus

*Dental health:* natural teeth, visits to dentists

*Drinking and smoking.*

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**General Household Survey publications**


The Labour Force Survey

The Labour Force Survey (LFS) was first undertaken in 1973 by the Department of Employment. It is now commissioned by the Department for Employment and Education and undertaken by the ONS. Its primary aim is to gather information about employment and unemployment among men aged 16-64 years and women aged 16-59, using definitions compatible with other European countries. It also covers many health-related topics, as well as information about housing and education. The questions asked about employment and unemployment in the Labour Force Survey are described in Chapter 5. The socio-demographic information collected includes nationality and housing tenure. Until recently, the Labour Force Survey was the only major survey to gather information about people’s self-defined ethnic group. From time to time, as part of the survey, supplementary or trailer surveys are undertaken on topics of particular interest. In the past, the topics have included detailed questions on housing, asked in 1988 and 1991, and questions on occupational health, asked in 1990 and 1993/4. Both are described in Chapter 6. The Labour Force Survey, therefore, collects useful information about work, social circumstances and health of people of working age.

The size of the health-related component of the Labour Force Survey expanded during the 1990s. The survey asks whether respondents are limited in the type of work they can do and, if so, the type of health problem or disability they have. In 1993/4, a new question was introduced, asking respondents whether they expected the problem to last more than a year. The aim was to provide a reliable measure of long-term illness or disability. This question has been used to collect information about employment and disability. In addition, by including a question about whether respondents suffered from any illness or disability that was caused or made worse by work, the survey is now a major source of information about occupational health. This is discussed in more detail in Chapter 6. Questions about sickness absences are routinely included. In 1997, new disability questions were introduced to monitor the 1995 Disability Discrimination Act.

The Labour Force Survey was conducted biannually until 1983 and then annually between 1984 and 1991. Since 1992, it has been undertaken quarterly. The sample now consists of a quarterly survey of approximately 15,000 private households in Great Britain, with a ‘booster’ survey carried out between March and May of over 44,000 private households in Great Britain and 4000 in Northern Ireland. Thus, the spring quarter is based on over 60,000 private households. As well as private households, people living in NHS accommodation and students in halls of residence are also sampled. Information about the students is obtained by proxy from their parents when they are interviewed as part of the normal survey. People at the 12,000 sample addresses are interviewed on five separate occasions at quarterly intervals. Respondents may not always be interviewed directly, and informants from the same households may be used as proxies. The first interviews are face to face, but subsequent interviews are carried out by telephone.
Labour Force Survey publications

London: TSO.
Office for National Statistics. *Labour market trends* (formerly *Employment gazette*).
Includes studies of special groups such as ethnic minorities, people with disabilities and self-employed people.

Health-related topics in other general surveys

Of the seven continuous large-scale surveys undertaken by the ONS, the National Food Survey, the National Travel Survey, the Omnibus Survey, the Family Expenditure Survey and the Family Resources Survey contain questions related to health, either on a regular or an ad hoc basis. These are shown in Table 2.3; some are discussed elsewhere in this book. A programme of National Diet and Nutrition Surveys is described in Chapter 6. The Department of the Environment, Transport and the Regions' English House Condition Survey also covers health-related topics.

Table 2.3 Health-related topics in ONS' continuous surveys

<table>
<thead>
<tr>
<th>Survey</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Food Survey</td>
<td>Chapter 6: Consumption and expenditure on different types of food</td>
</tr>
<tr>
<td>National Travel Survey</td>
<td>Chapter 7: 'Transport disabled'; journeys made on foot and by bicycle</td>
</tr>
<tr>
<td>Omnibus Survey</td>
<td>Chapter 5: Prevalence of back pain; adult drinkers' behaviour and knowledge; residual medicines</td>
</tr>
<tr>
<td>Family Expenditure Survey</td>
<td>Chapter 4: Expenditure on private medical insurance, private medical, nursing, dental and optical fees; NHS charges</td>
</tr>
<tr>
<td>Family Resources Survey 1996/7</td>
<td>Chapter 6: Prevalence of disability and take-up of disability benefits</td>
</tr>
<tr>
<td>English House Conditions Survey</td>
<td>Chapter 6: Illness and disability; use of aids and adaptations</td>
</tr>
</tbody>
</table>
Publications from ONS' continuous surveys


Population surveys focusing specifically on health and illness

Health surveys for England and Scotland, the Health and Well Being Survey for Northern Ireland, and the Welsh Health Survey

The Health Survey for England, which started in 1991, is an annual survey series commissioned by the Department of Health. It is designed to monitor progress towards two 'Health of the Nation' targets relating to blood pressure and obesity, to estimate the proportions of people in England with specified health conditions, to estimate the prevalence of risk factors associated with these conditions, and to examine differences between population subgroups, notably those defined by age, sex, region and social class. Since 1995, the survey has been used to measure the heights of children at different ages, replacing the National Study of Health and Growth. The coverage and topics for surveys are shown in Table 2.4.

The 1997 survey concentrated on young people aged between 2 and 24 years. The survey collected self-reported information about health-related behaviours such as smoking and drinking, self-reports of health conditions and symptoms, reports of doctor-diagnosed conditions and use of services.

The survey’s scope has expanded over the years. For 1991 to 1994, it measured height, weight, blood pressure and waist and hip circumference. From 1995 to 1997, lung function was included. Blood samples were also obtained from people aged 11 upwards. In 1996, saliva samples from children were analysed for cotinine, an indicator of smoking. The 1998 survey returned to cardiovascular disease as the main topic. In 1999, the survey continued to concentrate on cardiovascular disease, diabetes, physical activities and respiratory disease and also focused on ethnic minorities. From 1991 to 1993, the surveys were undertaken by the OPCS. Following market testing, responsibility for the survey then transferred to the Joint Health Survey Unit of Social and Community Planning Research, now known as the National Centre for
Table 2.4  Topics in the Health Survey for England

<table>
<thead>
<tr>
<th>Year</th>
<th>Sample</th>
<th>Coverage</th>
<th>Topics</th>
</tr>
</thead>
</table>
| 1991–4 | 1991: about 3000  
1992: about 4000  
1993: about 16 000  
1994: about 16 000 | 16 years and over | Cardiovascular risk factors |
| 1995–1996 | 16 000 adults  
3600 children       | 2 years and over | General health, smoking, drinking and blood pressure, respiratory conditions, accidents and, in 1995, disability |
| 1997   | 8000 adults  
8000 children       |             | Children and young people               |
| 1998   | 16 000 adults  
3600 children       |             | Cardiovascular disease                  |
| 1999   | 8000 adults  
8000 adults from ethnic minorities  
4000 children from ethnic minorities |             |                                         |

Social Research, and the Department of Epidemiology and Public Health at University College, London.

The 3-yearly Health Survey for Scotland is similar to the Health Survey for England. It was first undertaken in 1995–6 by Social and Community Planning Research and the Department of Epidemiology and Public Health at University College, London. The 1995 survey involved interviews with over 7900 adults aged 16–64 and concentrated on cardiovascular disease, health behaviours and risk factors.

The Northern Ireland Health and Well-Being Survey was first undertaken in 1997. As well as collecting similar information to that in the Health Survey for England, the Northern Ireland survey also investigates perceptions of health and mental health.

Wales has its own Welsh Health Survey, which was first undertaken in 1994–5 and covered different topics from the Scottish and English surveys. This survey was undertaken by the South East Institute of Public Health. The report covers a number of areas, including the use of and satisfaction with hospital, general practitioners and community services, and illness treated by a doctor, including heart disease, diabetes, chest conditions and mental illness. Questions were also asked about lifestyle factors, including smoking, diet and exercise, whether an individual was a carer, improvements to the NHS, purchase of ‘over the counter’ medicines and knowledge of first aid. In addition, the survey used the questions from a standardized health and well-being questionnaire, the SF36. A special feature of the survey was the inclusion of an additional sample of people with learning disabilities. The Welsh
Survey was a postal survey with a sample size of 50,000, of which approximately 28,000 were returned. It was repeated in 1998.

Data sets from the surveys are deposited at the Data Archive at the University of Essex. The address of the archive is given at the end of this chapter.

**Publications from Health Survey programmes**


**Other population survey series focusing on health and illness**

The government has commissioned a number of other health surveys on specific topics. These are shown in Table 2.5. Surveys of adult and children’s dental health are undertaken every 10 years and include an examination by a dentist, in addition to interviews. From 1975 onwards, OFCS undertook an ‘infant feeding’ survey every 5 years. The sample is identified from birth registrations and mothers are sent a series of questionnaires. As well as asking how their children are fed at various stages of the first year of life, questions are asked about the mothers’ lifestyles, including smoking and drinking habits, and also about their socio-economic background. In 1995, the survey included a separate survey of Asian parents.

A biennial survey of smoking among secondary school children has been undertaken since 1982. Children aged between 11 and 15 years are asked about their smoking behaviour and complete a diary in which they record all
Table 2.5 Survey series focusing on health and illness

<table>
<thead>
<tr>
<th>Title</th>
<th>Geographical areas</th>
<th>Status</th>
<th>Sample size</th>
<th>Topics covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Diet and Nutrition Survey Programme</td>
<td>England, Wales and Scotland</td>
<td>Ongoing programme for different age groups, adults, children and elderly people</td>
<td>About 2500 in each group</td>
<td>Dietary intake by social class and other socio-demographic variables; dental examination in elderly people and in children</td>
</tr>
<tr>
<td>Smoking among secondary school children</td>
<td>England, Wales and Scotland</td>
<td>Biennial series since 1982</td>
<td>About 3500 in each country</td>
<td>Children aged 11–15; how much they smoke, where they get cigarettes, and smoking behaviour of family and friends; alcohol included from 1994</td>
</tr>
<tr>
<td>Children's attitudes to smoking</td>
<td>England</td>
<td>Annual since 1997</td>
<td>About 4000 aged 11–15 years</td>
<td>Attitudes to smoking and awareness of anti-smoking campaigns</td>
</tr>
<tr>
<td>Health Education Monitoring Survey</td>
<td>England</td>
<td>Annual since 1995</td>
<td>5000–8000 adults</td>
<td>Attitudes to general health, smoking, drinking, physical activity, nutrition, sexual behaviour, social support and civic engagement</td>
</tr>
<tr>
<td>Adult Dental Health Survey</td>
<td>UK</td>
<td>Decennial since 1968</td>
<td>About 7000</td>
<td>Dental experiences, attitudes and knowledge of dental care, loss of teeth, use of dentures, condition of teeth</td>
</tr>
<tr>
<td>Children's Dental Health Survey</td>
<td>UK</td>
<td>Decennial since 1973</td>
<td>17 000 children aged 5–15 years</td>
<td>Dental inspection plus survey of dental history, dental experience and dental care</td>
</tr>
<tr>
<td>Infant Feeding Survey</td>
<td>England, Wales, Scotland and Northern Ireland</td>
<td>Semi-yearly since 1975</td>
<td>11 000</td>
<td>Proportion of mothers who breast feed and how long for; at what age solid foods are introduced</td>
</tr>
</tbody>
</table>
Publications from surveys of health and health-related behaviour

National Diet and Nutrition Survey Programme

Smoking among secondary school children

Children's attitudes to smoking

Health Education Monitoring Survey

Adult dental health survey

Children's dental health survey

Infant feeding survey
cigarettes smoked in the previous week. Saliva samples are also taken. From 1994 onwards, questions were also asked about drinking behaviour.

The Health Education Monitoring Survey is an annual series first carried out in 1995. It was designed to monitor trends in the health-related knowledge, attitudes and behaviour of adults aged 16–74 in England as part of measuring progress towards 'Health of the Nation' targets. Adults were asked about general health, prevention of skin cancer, smoking, drinking, physical activity, nutrition and, in the group aged 16–54 years only, sexual health. A section on drug use and attitude to drugs was included in 1995.

Occasional surveys: the psychiatric morbidity surveys and other ad-hoc surveys

In 1992–3, OPCS did a series of surveys of psychiatric morbidity in adults. The sample included people aged 16–64 years living in England, Scotland and Wales in private households and in institutions, as well as homeless people, which included people in night shelters and people sleeping rough. To date, this is the only large-scale official survey of mental illness in Great Britain. The aim was to estimate the prevalence of various types of mental illness, to identify the nature

**Surveys of psychiatric morbidity and the health of prisoners**

**Surveys of psychiatric morbidity in Great Britain**

**Surveys of the health of prisoners**
and extent of social disabilities associated with mental illness, to investigate the use of health, social and voluntary care services, to examine recent stressful life events which are associated with mental illness, and to investigate the relationship between mental illness and the use of tobacco, alcohol and drugs.

The survey used a standardised questionnaire of psychiatric morbidity, the revised Clinical Interview Schedule, which covers such topics as sleep problems, fatigue, worry, irritability and depression. Eight reports and two bulletins have been published covering the prevalence of mental illness, characteristics of people suffering from mental illness, medication, treatment and use of services, use of alcohol and drugs and the social and financial circumstances of people with mental illness.

In 1997–8, a survey of psychiatric morbidity was undertaken among prisoners. The sample was drawn from all prisons in England and Wales and included men and women on remand as well as sentenced prisoners. Topics covered included prevalence of mental health problems, deliberate self-harm, use of alcohol and drugs and background characteristics and lifetime experiences. This complemented the survey of the physical health of 1000 prisoners in thirty-two prisons in England and Wales which was undertaken in 1994. In this survey, health and health-related behaviour of sentenced male prisoners was compared to those of the general population. Blood pressure, respiratory function, height and weight were measured.

In the mid-1980s, a series of disability surveys was undertaken by the OPCS. These are described in detail in Chapter 4.

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**Contact addresses and web sites**

Census Division  
Office for National Statistics  
Segensworth Road  
Titchfield  
Hampshire PO15 5RR  
Census general enquiries, telephone 01329 813800  
Census internet page: http://www.statistics.gov.uk

General Register Office for Scotland  
Census and Population Statistics Division  
Ladywell House  
Ladywell Road  
Edinburgh EH12 7TF  
Telephone: 0131 334 0380  
Web site: http://www.gro-scotland.gov.uk

The census in Northern Ireland is dealt with by:

Northern Ireland Statistics and Research Agency  
McAuley House  
2–14 Castle Street  
Belfast BT1 1SA  
Telephone: 028 9034 8100  
Web site: http://www.nisra.gov.uk

The most accessible way for researchers to get further information about the census datasets is through MIMAS (Manchester Information and Associated Services) at Manchester University. This has a user-friendly interface called ‘Casweb’ for the 1991 Census Area Statistics.  
Web site: http://www.mimas.ac.uk

Information on the 2001 census can be obtained from Office for National Statistics and details are published in 2001 census information papers and at: Web site: http://www.statistics.gov.uk
to investigate the cent stressful life gate the relationship drugs.

ic morbidity, the es as sleep prob-
ties and two bul-

gnents, treatment und financial cir-

ken among pris-

and Wales and prisoners. Topics berate self-harm, n lifetime experi-

of 1000 prisoners taken in 1994. In male prisoners sure, respiratory

dertaken by the

**Longitudinal Study**
For academic users, access to the longitudinal study can be obtained through the Longitudinal Study User Group and Longitudinal Study Support Programme based at:
Center for Longitudinal Studies (CLS)
6th Floor
Institute of Education
20 Bedford Way
London WC1H 0AL
Web site: http://www.cls.ioe.ac.uk
Email: ls@cls.ioe.ac.uk

**General Household Survey and other**
Office for National Statistics surveys
Information about published data is available from:
Social Survey Division enquiries
Office for National Statistics
1 Drummond Gate
London SW1V 2QQ
Telephone: 020 7533 5500

**Health Survey for England**
Web site: http://www.doh.gov.uk

Academic users can access raw data from:
The Data Archive
University of Essex
Wivenhoe Park
Colchester
Essex CO4 3SQ
Telephone: 01206 872001
Fax: 01206 872003
or through BIRON: http://dawww.essex.ac.uk

**Labour Force Survey**
Quantime Bureau Service, disk and online services
Quantime Ltd
Maygrove House
69-70 Maygrove Road
London NW6 2EG
Telephone: 020 7625 7111

National Online Manpower Information System (NOMIS)
Unit 1L Mountjoy Research Centre
University of Durham
Durham DH1 3SW
Telephone: 0191 374 2468

**References**