

Compendium

Opinions and Lifestyle Survey: 2013

Teetotalism, drinking in the week before interview, binge drinking (heavy episodic drinking) and frequent drinking, including changes in drinking patterns in recent years.



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To be announced

Chapters in this compendium

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2. [Adult Drinking Habits in Great Britain, 2013](#)
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Adult Health in Great Britain, 2013

Teetotalism, drinking in the week before interview, binge drinking (heavy episodic drinking) and frequent drinking, including changes in drinking patterns in recent years.



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1 . Key points

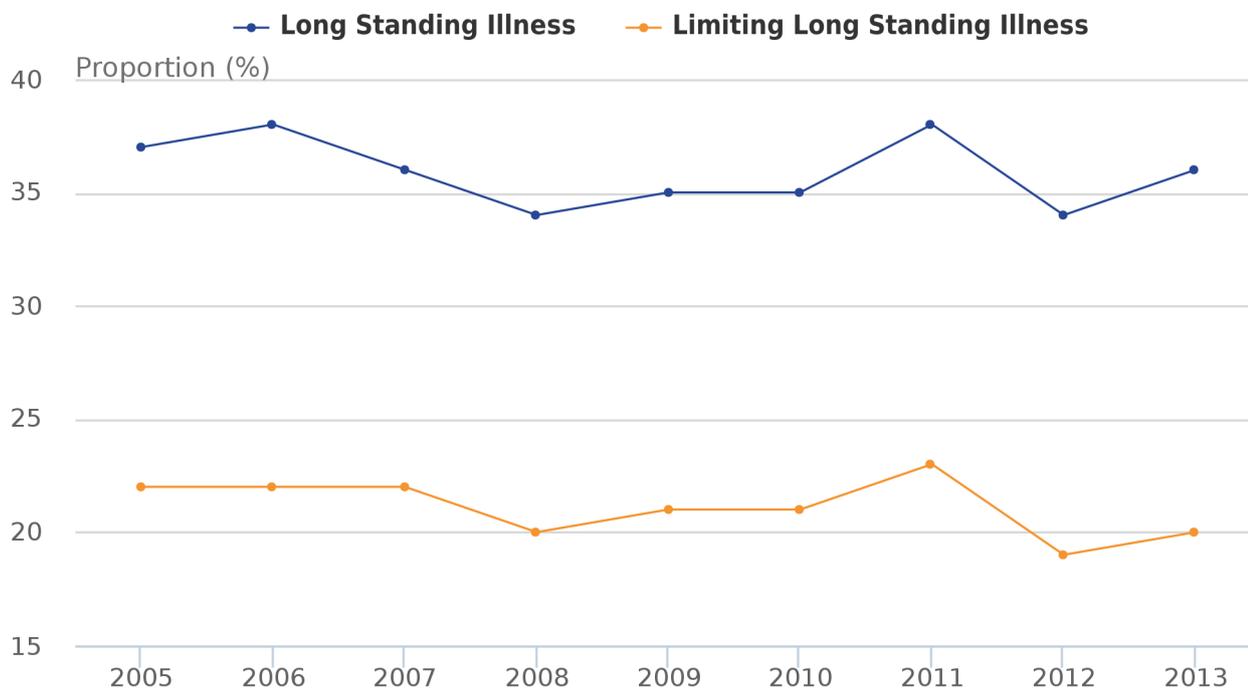
- In 2013 more than one in three adults (36%) reported having a long-standing illness or disability (LSI) and one in five (20%) reported having a limiting LSI
- The likelihood that someone reported having an LSI was closely associated with age. In 2013 69% of people aged 75 and over reported having an LSI. This compared with 15% of people aged 16 to 24
- People living in Wales (27%) were more likely to report having a limiting LSI than those living in either England (19%) or Scotland (20%)
- Cigarette smokers (37%) were more likely to report an LSI than those who had never smoked cigarettes (32%)

2 . Summary

This report looks at self-reported long-standing illnesses and disabilities (LSIs) and self-reported LSIs that limit activities. A long-standing illness or disability (LSI) is anything that someone has considered to have troubled them over a period of time, or that they believe is likely to affect them over a period of time.

In 2013, more than one in three adults in Great Britain (36%) reported having a long-standing illness or disability. This had increased slightly compared with 2012 (34%) but was in line with the levels seen over the 2005 to 2012 period, Figure 1. One in five adults (20%) said that they had a limiting LSI. Although this had fallen slightly since 2005 (22%), there has been little change compared with 2012 (19%).

Figure 1: Self-reported long-standing illness or disability, Great Britain, 2005-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

As expected, older adults were more likely to have reported having an LSI or limiting LSI than those in younger age groups. The likelihood of reporting an LSI is complex and related to a number of other factors. Unemployed people, people on low incomes, cigarette smokers and people living in Wales were more likely to have reported a limiting LSI than others. Within the group of cigarette smokers, higher consumption levels were associated with higher rates of self-reported LSI and limiting LSI.

The association between relationship status and self-reported LSI was complex. People who were married, widowed, divorced or separated reported higher rates of LSI than those who were single or cohabiting. However, age was the driving factor behind these differences. Once age and other factors were taken into account, single people were most likely to have reported having an LSI.

The most commonly reported difficulties caused by long-standing illness were with mobility; stamina breathing and fatigue; and dexterity. There were some differences between men and women in the reported effects of LSI.

3 . Why do these results matter?

More than one in three people in Great Britain live with a long-standing illness or disability. This can affect many areas of a person's life, including [employment, relationships, education and the ability to live independently](#).

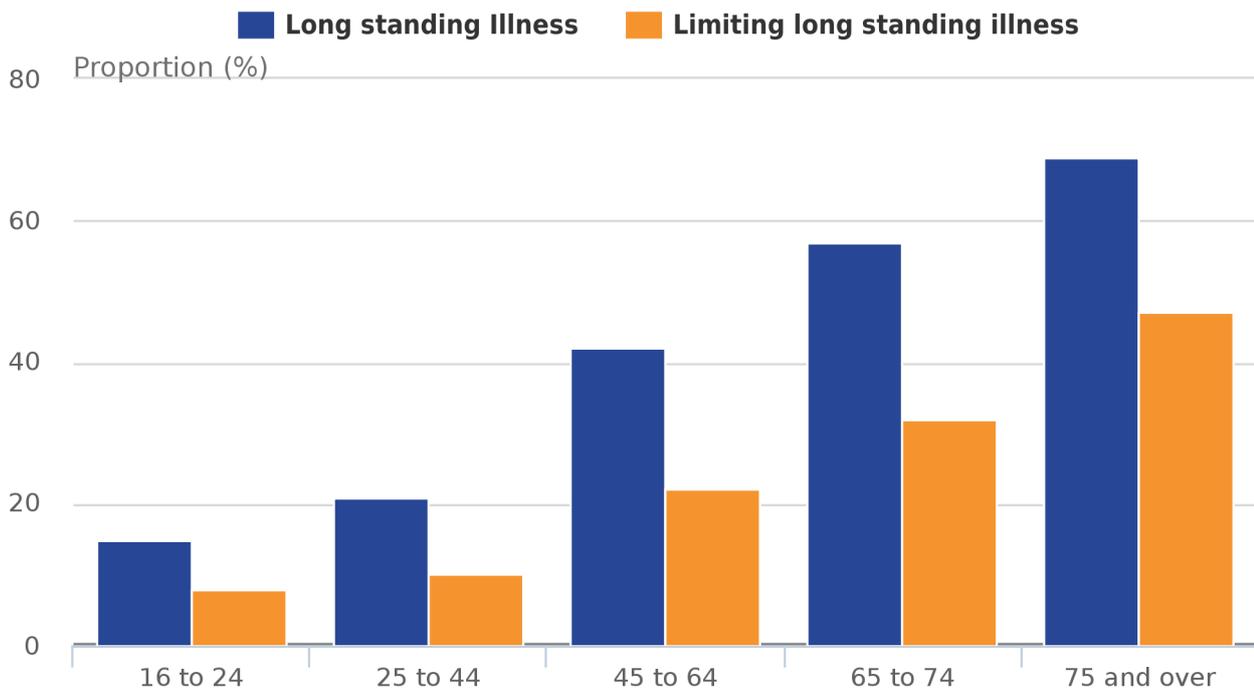
With the [number of older people in the UK increasing](#), long-standing illness and disability is an increasingly important issue for governments and health and social care providers. Long-term conditions account for [70% of health and social care spending and 50% of all GP consultations](#) in England with the [NHS Mandate](#) setting out what NHS England must do to improve the care of people with long-term conditions. The [Welsh Government](#) has a 10 year vision highlighting the need to improve management of long-term conditions in order to provide sustainable and effective health and social care services. NHS Scotland have set out a [National Action Plan](#) highlighting inequalities in health relating to deprivation and lifestyle factors and outlining an integrated approach to improve the quality of care for people with long-term conditions.

4 . Self-reported long-standing illness or disability

Self-reported long-standing illness or disability (LSI), age and sex

The likelihood of reporting an LSI increased with age, Figure 2. Those aged 75 and over were more than four times as likely to have reported an LSI than those aged 16 to 24 (69% vs. 15%). They were also nearly six times as likely to have reported a limiting LSI (47% vs. 8%).

Figure 2: Self-reported long-standing illness or disability, by age, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Overall, men reported lower levels of LSIs (34%) and limiting LSIs (19%) than women (37% and 21%). This continued the trend seen in recent years, Figure 3. However, health is linked with a number of other factors including age, employment status and economic activity. Once the effects of other factors were accounted for, there was no difference in the rates of LSI and limiting LSI between men and women.

Figure 3: Self-reported long-standing illness or disability, by sex, Great Britain, 2005-2013

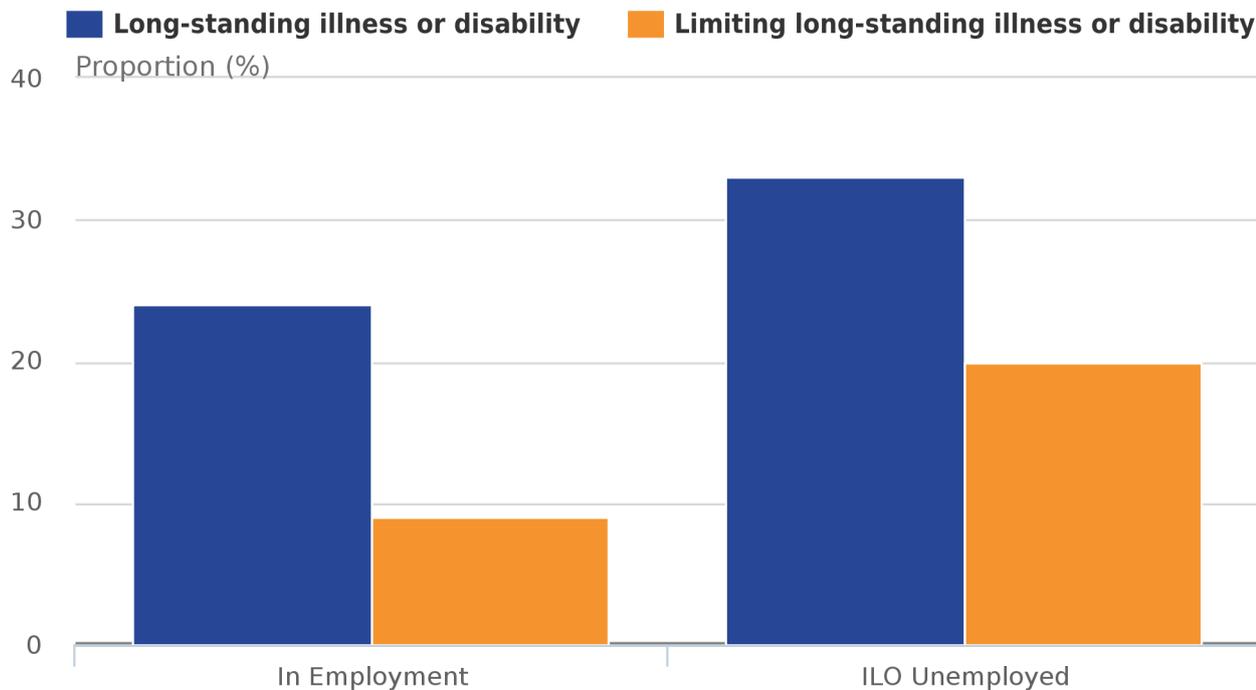


Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Work and self-reported long-standing illness or disability

Unemployed people are defined as those who are not working, but are looking for work. Around one in three people who were unemployed (33%) reported having an LSI, compared with around one in four people in employment (24%). Unemployed people were more than twice as likely as people in employment to have reported a limiting LSI (20% vs. 9%), Figure 4. This reflects findings from the Labour Force Survey, which show that during 2013, the unemployment rate was higher among those who had a disability.

Figure 4: Self-reported long-standing illness or disability, by employment status, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

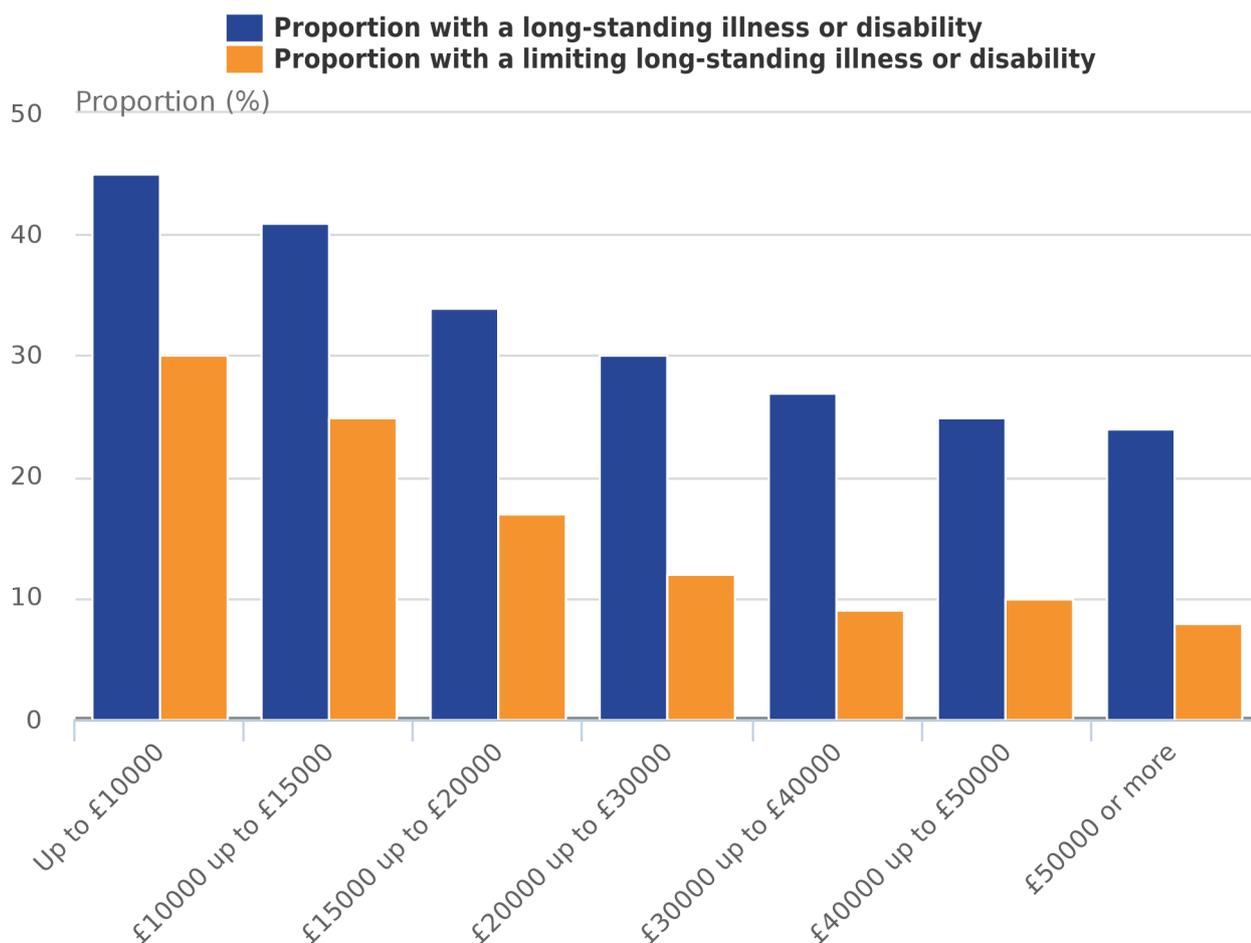
1. International Labour Organisation (ILO) definitions of employment status have been used
2. Unemployed people are those who are not currently in work, but are looking for work

Income and self-reported long-standing illness or disability

Low incomes were associated with higher rates of self-reported LSI. People with an income under £10,000 were nearly twice as likely to have reported an LSI (45%) than those with an income over £50,000 (24%), Figure 5.

Low income was also related to higher reports of limiting LSI and this remained the case once the effect of factors such as region, smoking and employment status had been removed. People with an income under £10,000 were more than three times as likely to have reported a limiting LSI (30%) than those who earned over £30,000 (9%). However, for those belonging to income groups beyond £30,000 a year there was little difference in the rates of self-reported limiting LSIs.

Figure 5: Self-reported long-standing illness or disability and gross annual personal income, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. Gross annual personal income covers all personal income before deductions for tax, National Insurance etc. It relates to income that is directly received (such as pay, benefits or interest from savings) and does not include income from a third party (such as a spouse or partner)

Relationships and self-reported long-standing illness or disability

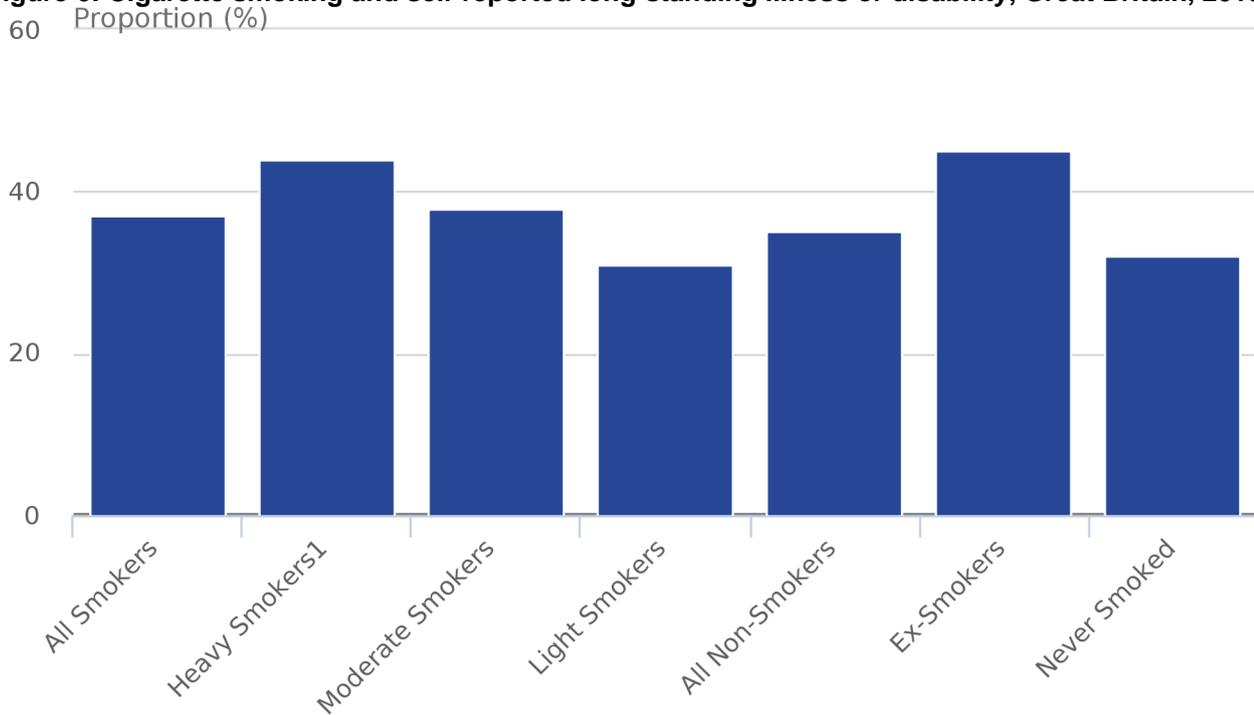
Reports of LSI were higher for those who were married (38%) or widowed, divorced or separated (54%) than people who were single (26%) or cohabiting (25%). However, age is the driving factor behind these differences. Those who are divorced, widowed or separated and, to a lesser extent those who are married, are older on average than those who are cohabiting or single. Once the effects of factors such as age and employment status were removed, single people were between 20% and 30% more likely to report a long-standing illness or disability than those in other relationship groups.

A similar pattern was seen in the association between relationship status and limiting LSI. More than twice as many people who were widowed, divorced or separated reported having a limiting LSI (35%) than single people (15%). However, once other factors such as age were accounted for, single people were 28% more likely to have reported a limiting long-standing illness or disability than people who were married or cohabiting and there was no clear difference between single people and people who were widowed, divorced or separated.

Cigarette smoking and self-reported long-standing illness or disability

Nearly a third of adults (32%) who had never smoked cigarettes reported having an LSI. This was lower than the proportion of cigarette smokers (37%) and ex-smokers (45%), Figure 6.

Figure 6: Cigarette smoking and self-reported long-standing illness or disability, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

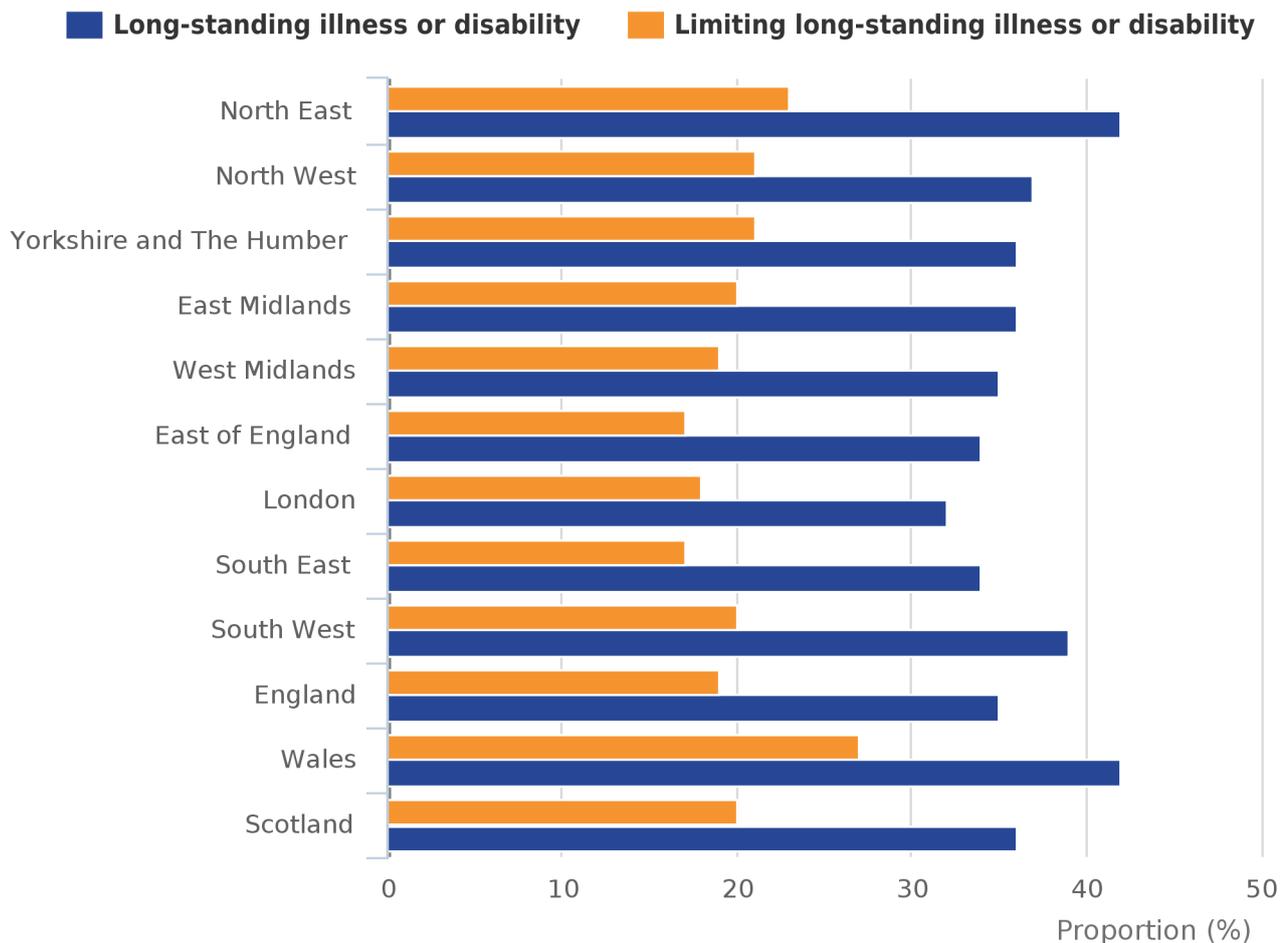
1. Light smokers are those who smoke on average less than 10 cigarettes per day. Moderate smokers smoke at least 10 but fewer than 20 cigarettes per day. Heavy smokers are those who smoke 20 or more cigarettes per day

Within the group of cigarette smokers the rate of self-reported LSI varied. Higher consumption levels were associated with increased likelihood of having reported an LSI. Nearly a third (31%) of light smokers (up to 10 cigarettes per day) reported having an LSI, about the same as the proportion of those who had never smoked cigarettes (32%). This increased to 44% among heavy smokers (20 or more cigarettes per day).

Regional self-reported long-standing illness or disability

Rates of self-reported LSI and limiting LSI were higher in Wales than in England or Scotland. More than one in four adults in Wales (27%) reported having a limiting LSI, compared with around one in five people in England (19%) and Scotland (20%). This remained the case once the effects of factors such as age and employment status had been removed. There was some variation in the rates across England, with rates tending to be higher in the North East (23%). Rates of self-reported limiting LSIs were lowest in the South East (17%), London (18%), and East of England (17%), Figure 7.

Figure 7: Regional self-reported long-standing illness or disability, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

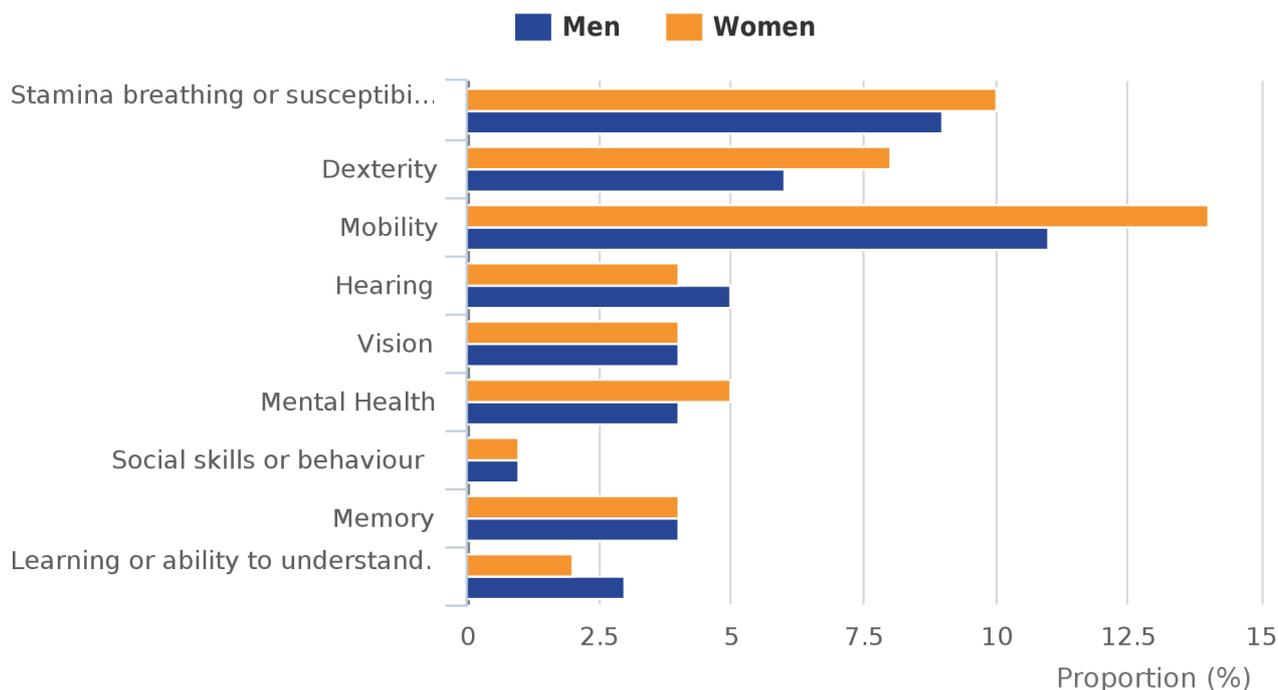
5 . Effects of health conditions lasting 12 months or more

The most commonly reported difficulties caused by long-term health conditions lasting for 12 months or more were issues with mobility (13%), stamina, breathing and fatigue (10%) and dexterity (7%), Figure 8.

Self-reported memory difficulties and physical health conditions increased with age. This was not the case for difficulties with social skills, behaviour, learning and ability to understand or concentrate. People between the ages of 25 and 64 reported mental health difficulties more frequently (5%) than those in younger (3%) or older (2%) age groups. This reflects findings in the [Welsh Health Survey 2013](#) and the [Scottish Health Survey 2013](#) that physical illness increases with age and mental wellbeing tends to be highest in the youngest and oldest age groups.

There were differences between men and women in the reported effects of long-term health conditions. Men reported more hearing difficulties than women (5% vs. 4%), while women reported more difficulties with dexterity (8% vs. 6%) and mobility (14% vs. 11%) than men.

Figure 8: Effects of health conditions lasting 12 months or longer, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. This include health conditions that are expected to last for 12 months or longer if they have not already done so

6. Background notes

1. The Opinions and Lifestyle Survey

The data in this report were collected on the [Opinions and Lifestyle Survey \(OPN\)](#) - an omnibus survey run by the Office for National Statistics. Each survey wave lasts for one month and is open for both government and non-government organisations to run questions.

The OPN is currently the only randomised probability sample omnibus survey in Great Britain and provides a fast, reliable and flexible service to customers.

More information on the survey and survey methodology can be found in the [Opinions and Lifestyle Survey Information Guide \(175.5 Kb Pdf\)](#) .

2. How to commission a module on the survey

Clients can enquire about purchasing modules of questions by emailing the survey manager at opinions@ons.gsi.gov.uk.

3. Comparability

This report provides information on the health of adults in Great Britain, and follows on from the series of releases from the General Household Survey (GHS) and General Lifestyle Survey (GLF).

The OPN and GHS/GLF provide comparable results. However there are some differences in the design and content of the surveys. More information can be found in the [‘Opinions and Lifestyle Survey, Smoking Habits Amongst Adults, 2012’](#) publication.

4. Coherence

There are a number of other sources of long-standing illness and disability data. These have been listed below, together with a brief explanation of the comparability with the OPN.

Health Survey for England (Health and Social Care Information Centre), Welsh Health Survey (Welsh Government) and Scottish Health Survey (Scottish Government)

There are some differences in the questions asked about health between these surveys. In the Welsh Health Survey respondents are asked whether they are currently being treated for any of a range of illnesses. They are also asked whether their daily activities are limited by a health problem or disability lasting (or expected to last) at least 12 months.

In the Scottish Health Survey and the Health Survey for England respondents are asked if they have any physical or mental health condition or illness lasting, or likely to last, for twelve months or more. Those who report having a condition are then asked whether it limits their daily activities. The questions are based on self-perception of illness rather than doctor diagnosis.

5. Reliability

Self-reports of long-standing illness or disability may differ from rates of diagnosed long-standing illness or disability due to differences in the way people perceive their health.

6. Approach to statistical significance

Where estimates for different populations have been described as different throughout this commentary, they have been tested and found to be significantly different at 5% significance level ($p < 0.05$).

95% confidence intervals for each table value have been supplied as a [separate table \(78.5 Kb Excel sheet\)](#). Where historical data have been provided, confidence intervals have been supplied for the last two years (2012 and 2013).

7. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

Adult Drinking Habits in Great Britain, 2013

Teetotalism, drinking in the week before interview, binge drinking (heavy episodic drinking) and frequent drinking, including changes in drinking patterns in recent years.



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1 . Key points in 2013

- More than one in five adults (21%) said that they do not drink alcohol at all. This has increased slightly since 2005 (19%). Young adults (aged 16 to 24) were primarily responsible for this change, with the proportion of young adults who reported that they do not drink alcohol at all increasing by over 40% between 2005 and 2013
- The proportion of adults who binged at least once in the week before interview decreased from 18% in 2005 to 15% in 2013. Young adults were mainly responsible for the decrease in binge drinking, with the proportion who had binged falling by more than a third since 2005, from 29% to 18%
- The proportion of young adults who drank frequently has fallen by more than two-thirds since 2005. Only 1 in 50 young adults drank alcohol frequently in 2013.
- Almost a third of adults in London (32%) said that they do not drink alcohol at all. This was considerably higher than any other region of Great Britain
- Adults in the north of England and in Scotland who drank in the week before interview were more likely to have binged than adults elsewhere in Great Britain

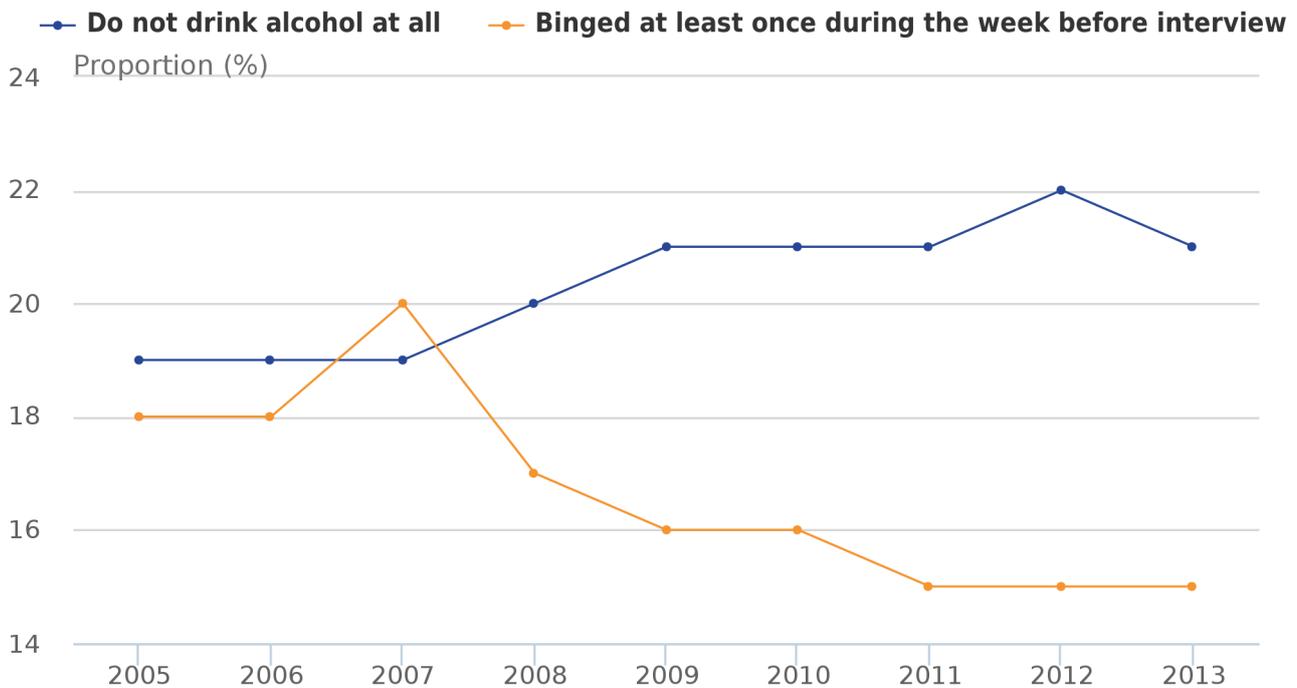
2 . Summary

Between 2005 and 2013 there was a small but gradual increase, from 19% to 21%, in the proportion of adults who said that they do not drink alcohol at all (teetotallers), as shown in Figure 1. Binge drinking also fell over this period, from 18% to 15%, although there has been little change since 2011. The fall in binge drinking over the period was partly because fewer adults chose to drink alcohol and partly because when people did drink they drank less.

Generally, the falls in drinking between 2005 and 2013 were a result of changes among younger adults, with little or no change in older groups.

In 2013 young adults (those aged 16 to 24) became just as likely to be teetotallers as those aged 65 and over (27%). Between 2005 and 2013 there was a rise of over 40% in the proportion of young adults who said that they do not drink alcohol at all. In contrast, when young adults did drink they still remained the most likely group to have binged. 4 in 10 young adults who drank alcohol in the week before interview exceeded 8/6 units (meaning 8 units for men, 6 units for women) on at least one day. This fell in older age groups, to less than 1 in 10 of those aged 65 and over.

Figure 1: Teetotalism and binge drinking amongst adults, Great Britain, 2005-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Notes:

1. Adults are those aged 16 and over
2. Teetotallers are those who said that they do not drink alcohol at all
3. In line with the Government's Alcohol Strategy, men are considered to have binged if they drank more than eight units of alcohol on their heaviest drinking day in the week before interview, and women if they drank more than six units

3 . Why do these results matter?

Alcohol misuse is a leading cause of ill-health in Great Britain. It can contribute to a number of serious health conditions, including cancer, liver disease and heart disease. In 2011/12 there were more than a million [alcohol related hospital admissions](#) in England alone, and it is estimated that alcohol misuse costs the NHS in England approximately [£3.5 billion](#) every year. ONS estimates that in 2013, just over 7,000 deaths registered in England and Wales were alcohol-related. This equates to about 1.4% of all deaths for that period.

Excessive consumption of alcohol is also associated with violent crime. In just over a half of all instances of violent crime in England and Wales in 2013/14, the [victim believed that the perpetrator was drunk](#).

Reducing the harm caused by alcohol is an important priority for the UK Government and devolved administrations. [The Government's Alcohol Strategy](#) highlights the ambitions to reduce the number of adults drinking above the NHS guidelines and to reduce binge drinking (or heavy episodic drinking).

[NHS guidelines](#) suggest that men should not regularly exceed 3-4 units of alcohol per day and that women should not regularly exceed 2-3 units per day. [The Government's Alcohol Strategy](#) defines binge drinking as men who self-report exceeding more than eight units of alcohol on their heaviest drinking day in the week before interview and women who self-report exceeding six units. Two units of alcohol is approximately the same as one pint of normal strength lager, or one medium sized (175 ml) glass of wine.

People’s perceptions of heavy drinking differ from the measures set out in the [Government’s Alcohol Strategy](#). Although 15% of adults reported binge drinking in the week before interview, less than half a percent said that they drink heavily.

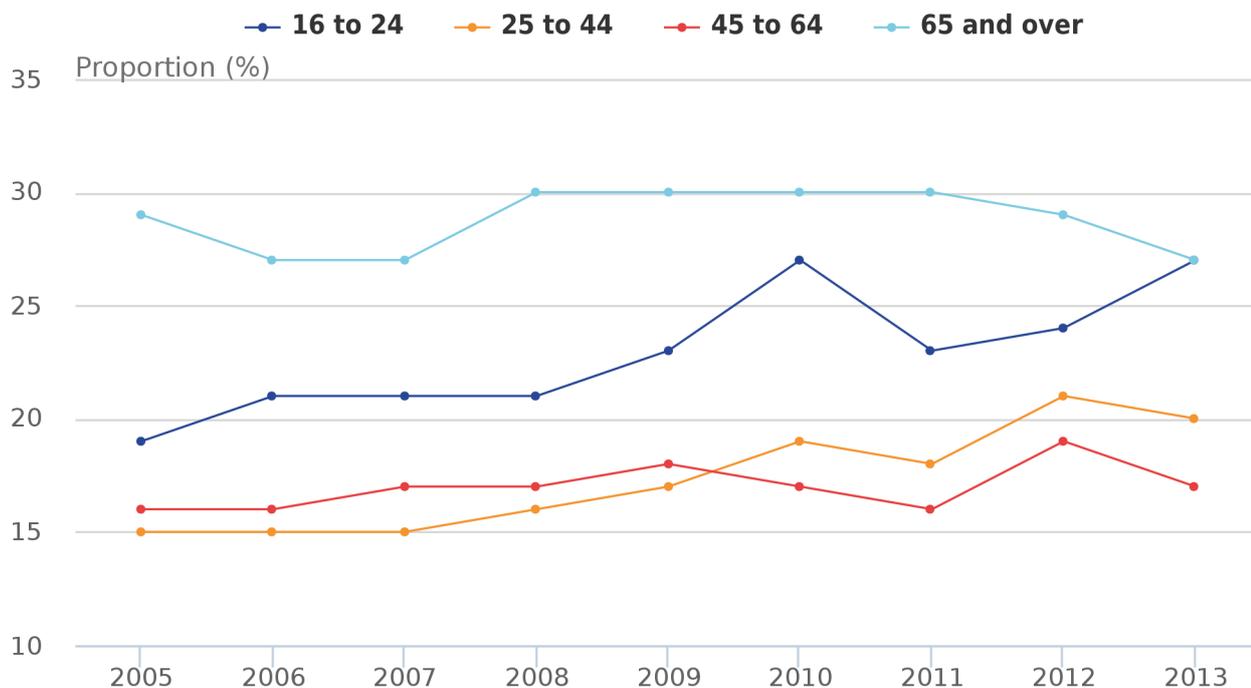
4 . Gradual rise in the proportion of adults who say that they do not drink at all

More than one in five adults (21%) in 2013 said that they were teetotallers (that is, they said that they do not drink alcohol at all). This had slowly increased since 2005, from 19%. This increase in teetotallers between 2005 and 2013 was due to a rise among those aged 16 to 44, with young adults (those aged 16 to 24) seeing a 43% increase over this period.

The rise in teetotalism in younger adults was not reflected among older people

Whilst there has been an increase in teetotalism among those aged 16 to 44 between 2005 and 2013, this has been less noticeable in older age groups with a slight fall seen in those aged 65 and over, Figure 2.

Figure 2: Teetotal adults, by age, Great Britain, 2005-2013



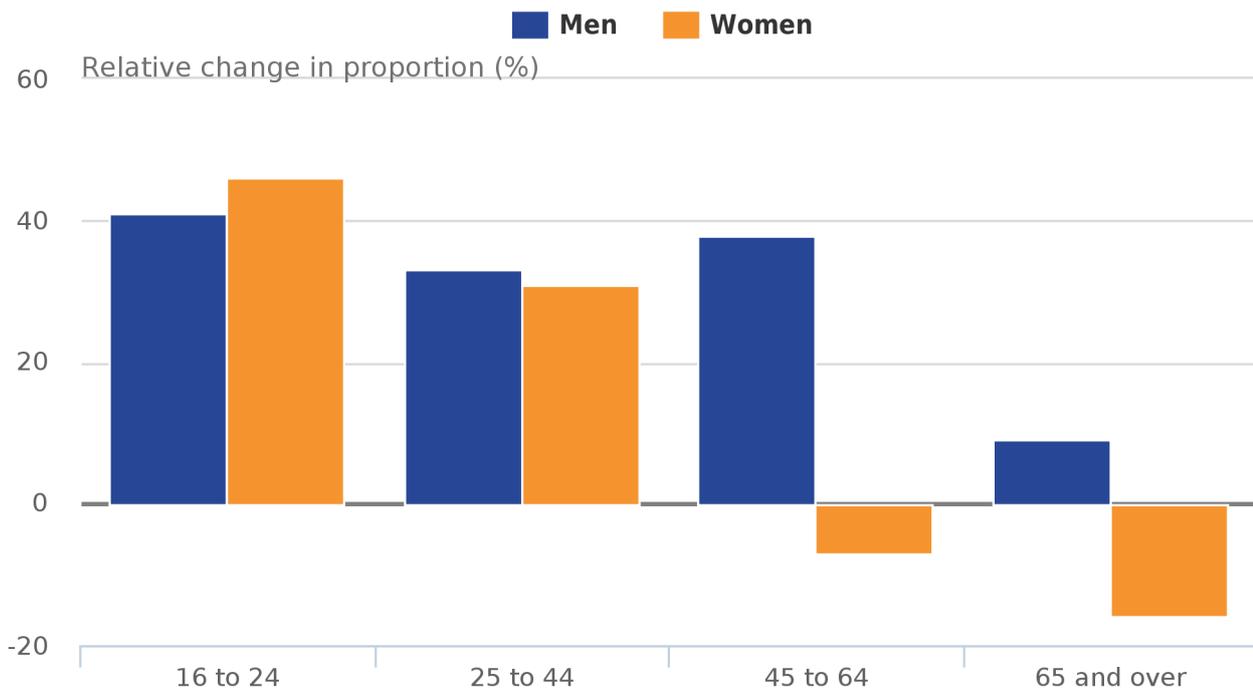
Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Notes:

1. Adults are those aged 16 and over
2. Teetotalers are those who said that they do not drink alcohol at all

Among those aged 65 and over, the change in teetotalism between 2005 and 2013 resulted from a 16% fall in the proportion of women reporting that they do not drink alcohol at all, Figure 3.

Figure 3: Relative change in the proportion of adult teetotallers, by age and sex, Great Britain, 2013



Source: Opinions and Lifestyle Survey, General Household Survey - Office for National Statistics

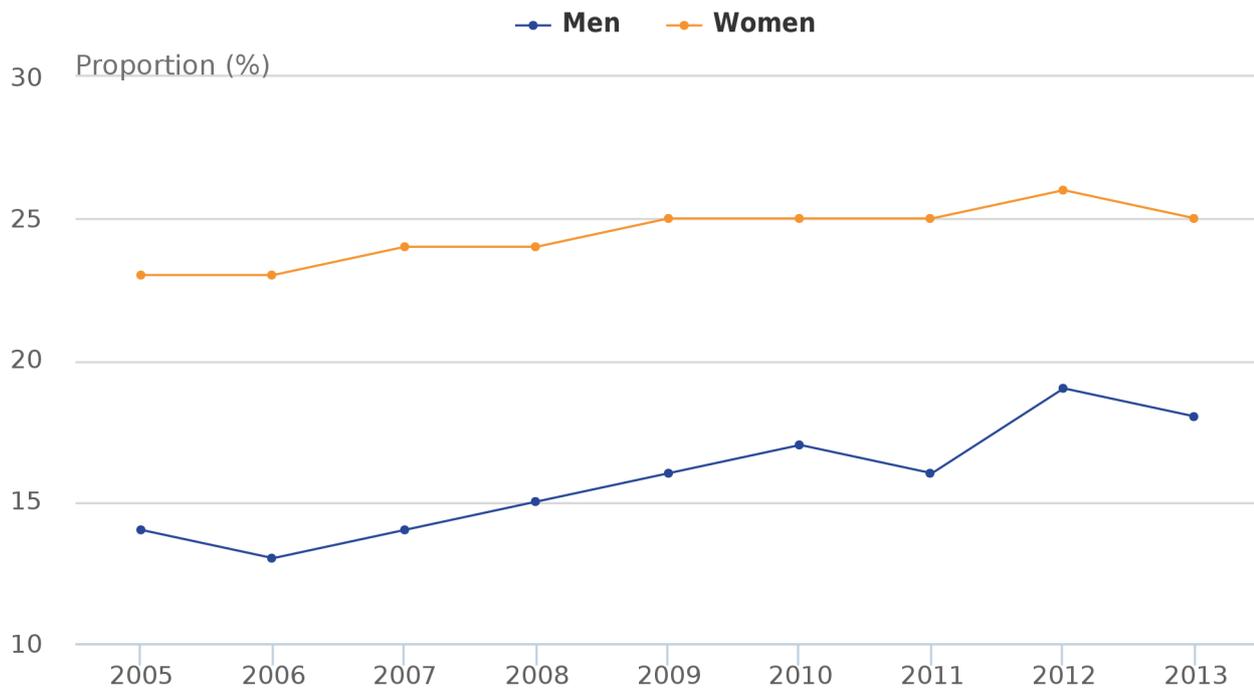
Notes:

1. Teetotallers are those who said that they do not drink alcohol at all

Teetotalism increased among both men and women, but remained more common among women

Women remained more likely than men to be teetotallers (25% vs. 18%), Figure 4, although the proportion has been rising more quickly for men, Figure 4.

Figure 4: Adult teetotallers, by sex, Great Britain, 2005-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Notes:

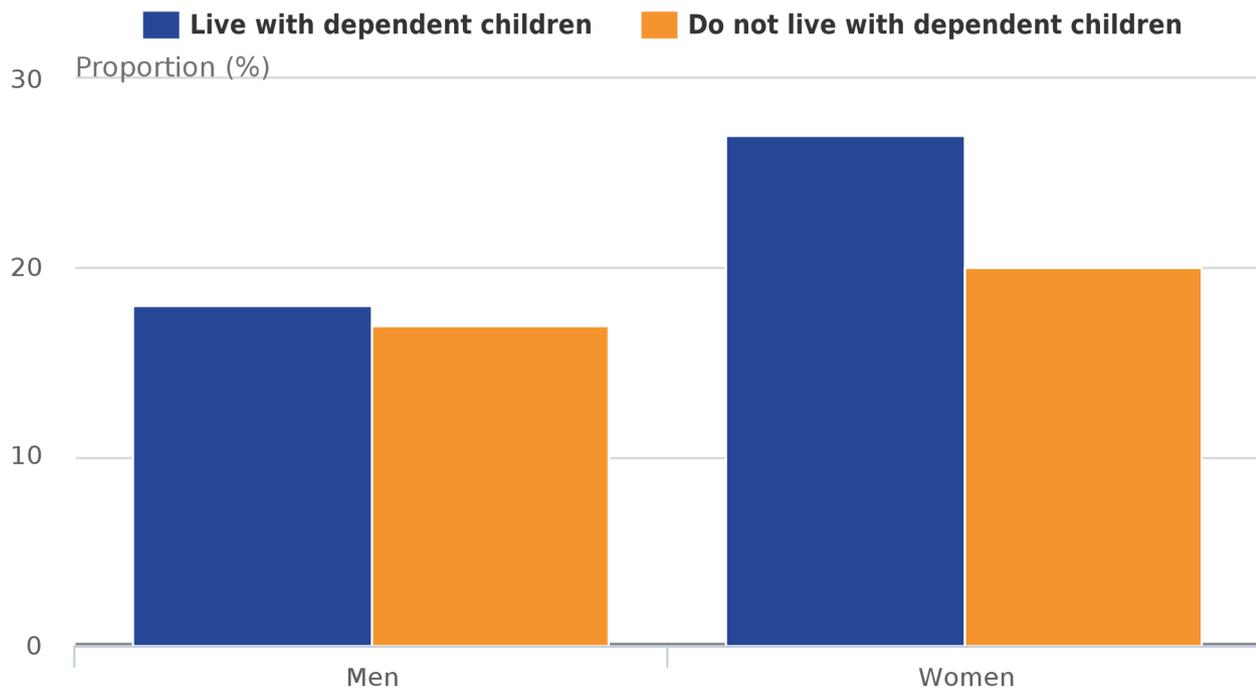
1. Adults are those aged 16 and over
2. Teetotallers are those who said that they do not drink alcohol at all

Women were more likely to be teetotallers if they shared their household with dependent children

The drinking habits of parents can influence those of their children with teenagers [more likely to get drunk](#) if they have seen their parents drunk.

In 2013 women were more likely to be teetotallers if they lived with dependent children, a difference that was not seen among men, Figure 5. More than one in four women aged 16 to 60 who lived with dependent children were teetotallers, compared with about one in five women who did not live with dependent children.

Figure 5: Teetotal adults aged 16-60, by sex and whether dependent children live in the household, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. Teetotalers are those who said that they do not drink alcohol at all
2. Those aged 16 and over have not been classed as dependent children

5 . Binge drinking falls by more than a sixth between 2005 and 2013

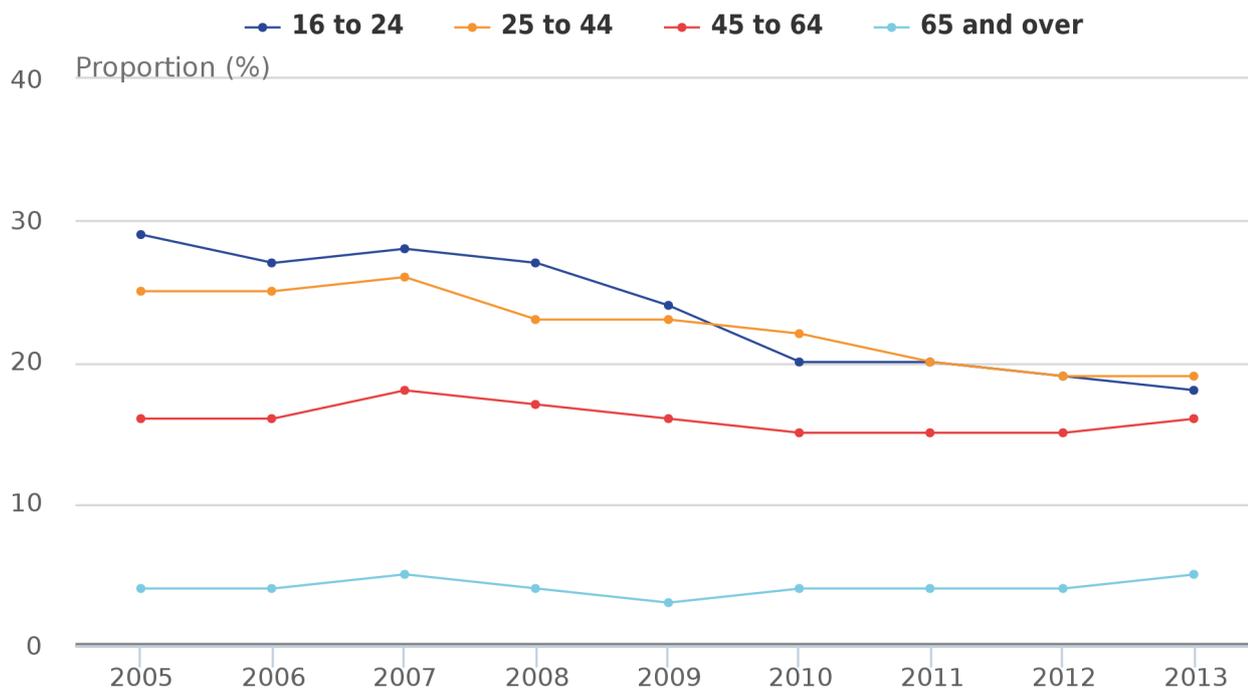
The short term [consequences of binge drinking](#) can include slower reaction times and loss of coordination, which can increase an individual's risk of accident or injury. Longer term, binge drinking is associated with increased risk of strokes, cancers, liver disease and high blood pressure.

Binge drinking among adults decreased from 18% in 2005 to 15% in 2013 but has remained relatively unchanged since 2011.

The fall in binge drinking between 2005 and 2013 was confined to younger age groups

The fall in binge drinking between 2005 and 2013 was only seen among young adults (aged 16 to 24) and those aged 25 to 44, Figure 6. Binge drinking among young adults fell from 29% to 18% over this period, and fell from 25% to 19% among those aged 25 to 44. Despite these falls, binge drinking continued to be more common in these age groups.

Figure 6: Binge drinking among adults, by age, Great Britain, 2005-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Notes:

1. In line with the limits outlined in the Government's Alcohol Strategy, men are considered to have binged if they reported drinking more than eight units of alcohol on their heaviest drinking day in the week before interview, and women if they reported drinking more than six units

The fall in binge drinking between 2005 and 2013 is partially explained by increases in the proportion of young adults and those aged 25 to 44 who were teetotallers. People have also been drinking less frequently. The proportion of young adults who drank frequently (on five or more days) in the week before interview fell by more than two-thirds between 2005 and 2013. In 2013 only 1 in 50 young adults drank frequently in the week before interview. As well as becoming less likely to drink alcohol at all and less likely to drink frequently, young adults also became less likely to binge when they did drink.

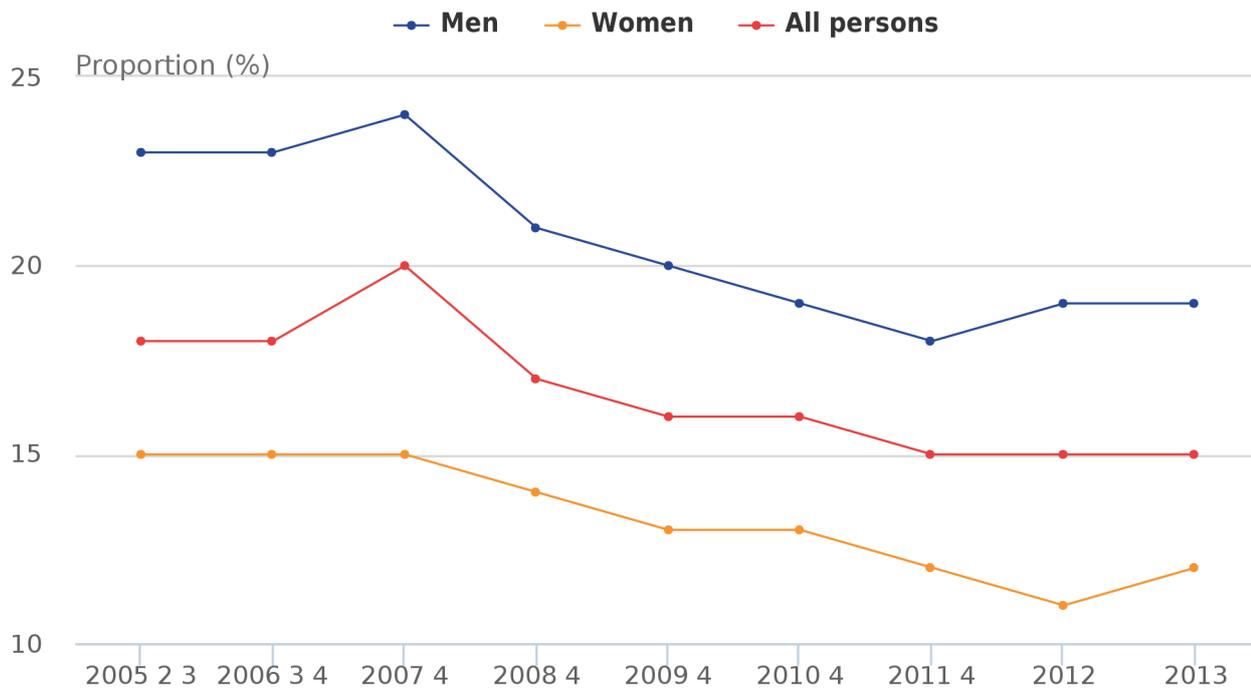
It is difficult to attribute the fall in binge drinking among young people to any particular factor. It is known that [people who start drinking at a younger age](#) are likely to drink more frequently, and in greater quantities, in adulthood.

One possible factor could be that underage drinking has been targeted in recent years. In 2003 changes were made to the [conditions for licensed premises in England and Wales](#), which made it more difficult for underage drinkers to purchase alcohol themselves. Since then, schemes such as [Challenge 21](#) and [Challenge 25](#) have also been introduced in an effort to reduce the availability of alcohol to underage drinkers. Although it is not possible to assess the scale to which such factors may have had an impact on the availability of alcohol to underage drinkers, it is likely that when combined these factors have contributed somewhat to the reduction in drinking among young adults.

Fall in binge drinking among men and women, but men remain more likely to binge

Binge drinking fell among both men and women between 2005 and 2013, with binge drinking continuing to be more common among men (19% vs. 12%).

Figure 7: Binge drinking among adults, by sex, Great Britain, 2005-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

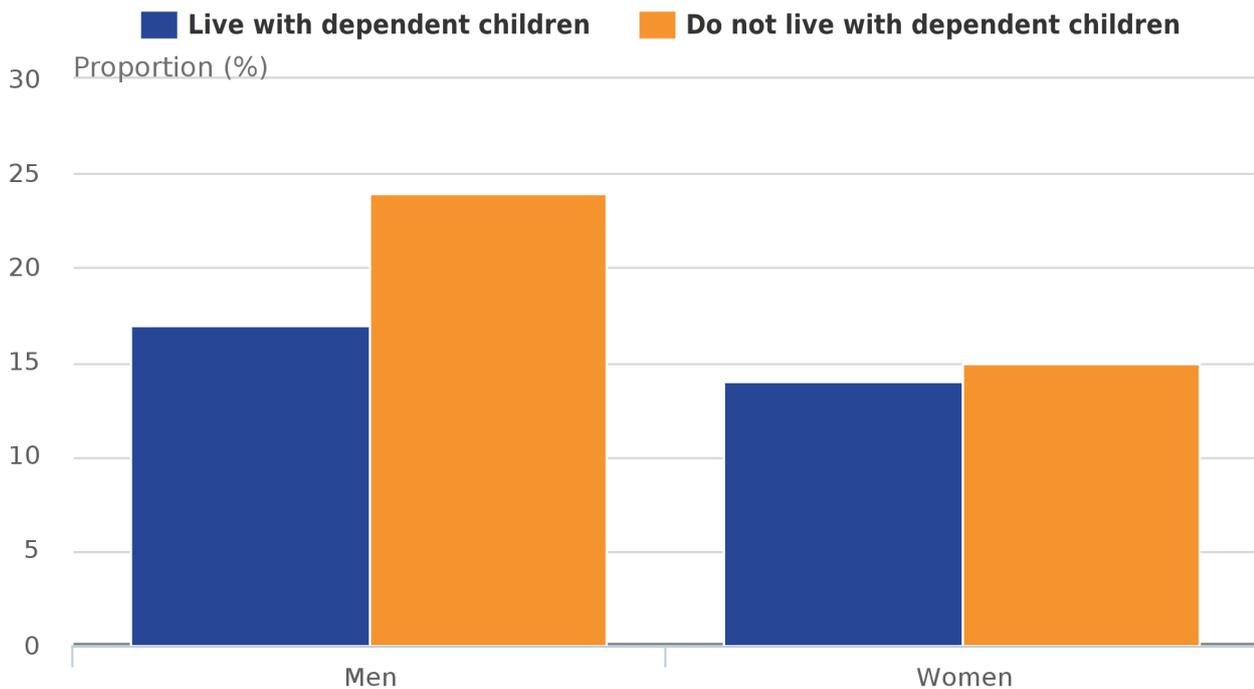
Notes:

1. Adults are those aged 16 and over
2. In line with the limits outlined in the Government's Alcohol Strategy, men are considered to have binged if they reported drinking more than eight units of alcohol on their heaviest drinking day in the week before interview, and women if they reported drinking more than six units

Men were less likely to binge drink if they shared their household with dependent children

In 2013, men were less likely to binge drink if they lived with dependent children (17% vs. 24%), Figure 8, although the reasons for this are unclear. This difference was not present for women, although the likelihood that women had binged was still relatively low. These findings are in contrast to those seen for teetotalism, where women were more likely to be teetotalers if they lived with dependent children with little difference seen in men.

Figure 8: Binge drinking among adults aged 16 to 60, by sex and whether dependent children live in the household, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

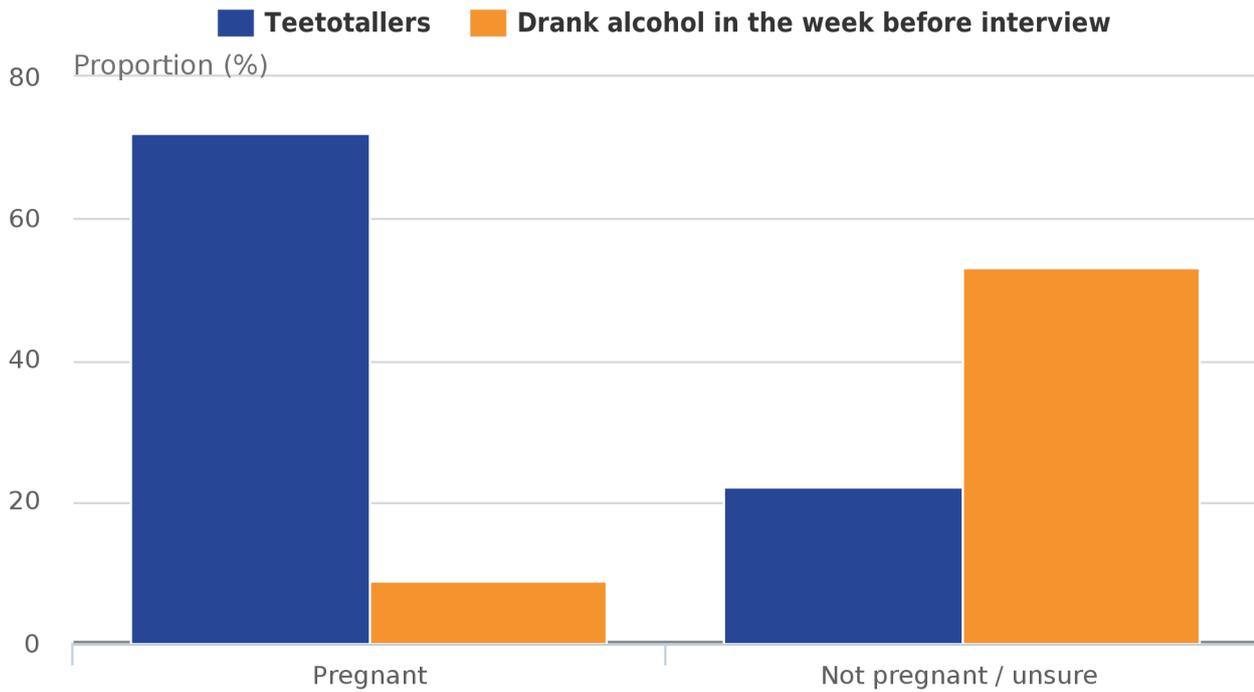
1. Children aged 16 and over have not been classed as dependent children
2. In line with the limits outlined in the Government's Alcohol Strategy, men are considered to have binged if they reported drinking more than eight units of alcohol on their heaviest drinking day in the week before interview, and women if they reported drinking more than six units

6 . Drinking in pregnancy

Drinking alcohol during pregnancy can affect the development of the baby, with drinking later in pregnancy being associated with increased risk of premature birth. Advice from the Department of Health and the NHS is that pregnant women should not drink alcohol at all during their pregnancy. Those who do choose to drink should not exceed one or two units of alcohol once or twice a week.

Pregnant women were more than three times as likely to be teetotallers as other women (72% vs. 22%), as shown in Figure 9. Pregnant women were also less likely to have drunk in the week before interview. Fewer than 1 in 10 pregnant women drank in the week before interview compared with more than 5 in 10 of those who were not pregnant or unsure.

Figure 9: Teetotal women and women who drank in the week before interview, by pregnancy status, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

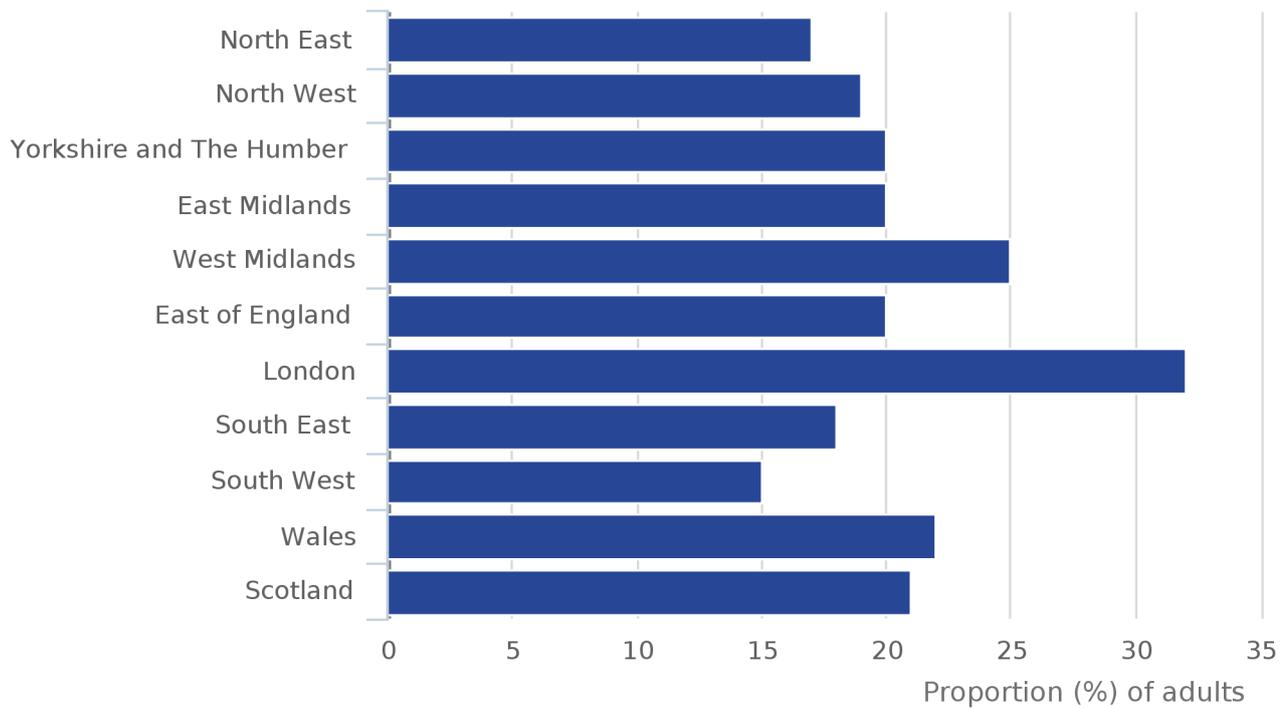
1. Teetotalers are those who said that they do not drink alcohol at all

7 . Regional differences in drinking habits

Adults living in London most likely to be teetotalers

In 2013 almost one in three adults living in London (32%) said they were teetotalers. This was considerably higher than the Great Britain average of 21%, and higher than the proportion in any other single region of Great Britain, Figure 10.

Figure 10: Teetotal adults, by region, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. Adults are those aged 16 and over
2. Teetotalers are those who said that they do not drink alcohol at all

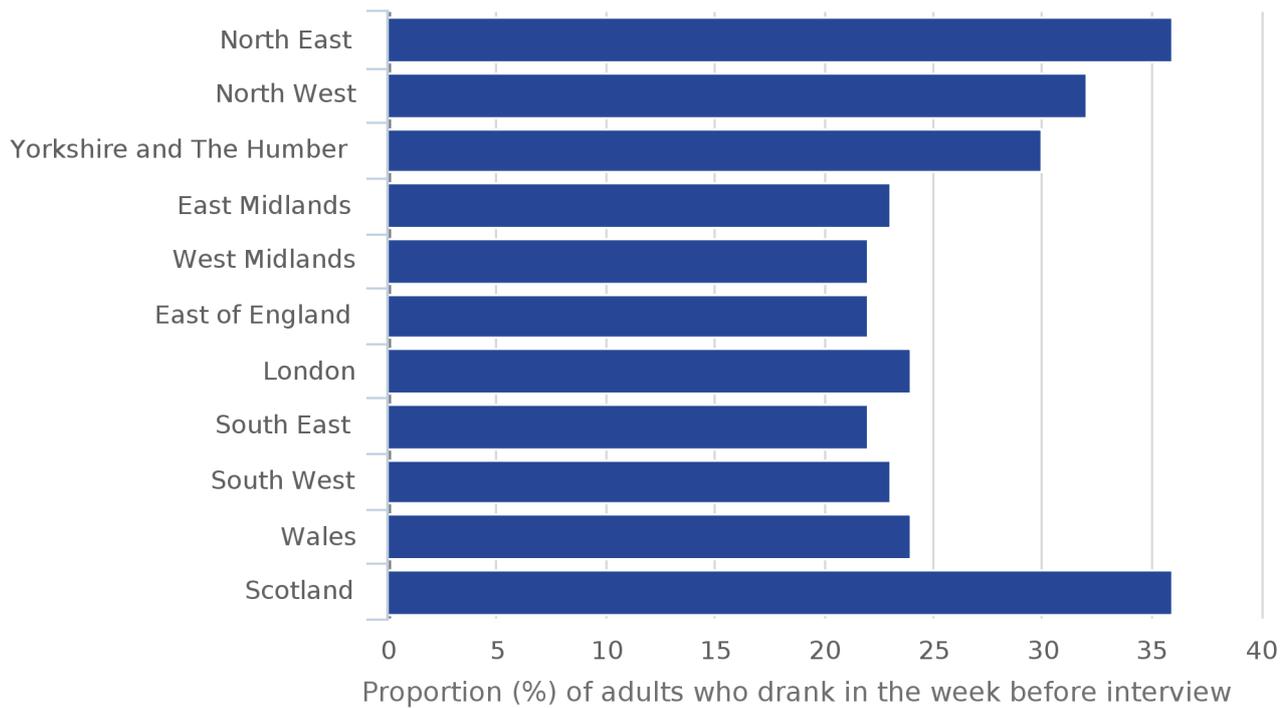
Although it is difficult to attribute regional differences to any single factor, London is the most ethnically diverse region of the UK and has a lower than average population age of just 33. Both of these factors may play a part in London having a higher than average number of teetotalers.

Drinkers living in the north of England and in Scotland were most likely to have binged

Drinkers (those who drank in the week before interview) in the north of England and in Scotland were most likely to have binged. Around a third of drinkers in these regions had binged, compared with less than a quarter of those in other parts of Great Britain.

However it is difficult to explain these regional differences with any particular factor.

Figure 11: Binge drinking among adults who drank in the week before interview, by region, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. In line with the limits outlined in the Government's Alcohol Strategy, men are considered to have binged if they reported drinking more than eight units of alcohol on their heaviest drinking day in the week before interview, and women if they reported drinking more than six units

8. Background notes

1. The Opinions and Lifestyle Survey

The data in this report were collected on the [Opinions and Lifestyle Survey \(OPN\)](#) - an omnibus survey run by the Office for National Statistics. The survey is run monthly and is open for both government and non-government organisations to run questions.

The OPN is currently the only randomised probability sample omnibus survey in Great Britain and provides a fast, reliable and flexible service to customers.

More information on the survey and survey methodology can be found in the [Opinions and Lifestyle Survey Information Guide \(175.5 Kb Pdf\)](#).

2. How to commission a module on the survey

Clients can enquire about purchasing modules of questions by emailing the survey manager at opinions@ons.gsi.gov.uk.

3. Comparability

This report provides information on the alcohol consumption habits of adults in Great Britain, and follows on from the series of releases from the General Household Survey (GHS) and General Lifestyle Survey (GLF).

The OPN and GHS/GLF provide comparable results. However there are some differences in the design and content of the surveys. More information can be found in the [‘Opinions and Lifestyle Survey, Smoking Habits Amongst Adults, 2012’](#) publication.

In 2006, some changes were introduced to the methodology used to estimate alcohol consumption. The assumed number of units for ‘normal strength beer, stout, lager, or cider’, ‘strong beer, stout, lager or cider’ and ‘wine’ categories changed. The 2005 estimates produced in this report have been recalculated and based on the same alcohol content assumptions as later estimates.

The methodology for estimating wine consumption also changed in 2006. From 2006, respondents were asked about wine glass size, from a choice of small (125ml), medium (175ml) or large (250ml). Previously it was assumed that 175ml glasses had been used. The 2005 estimates do not, therefore, account for these potential differences in wine glass size.

4. Coherence

There are a number of other sources of alcohol consumption data. Some of these have been listed below, together with a brief explanation of their comparability with the OPN.

Health Survey for England (Health and Social Care Information Centre), Welsh Health Survey (Welsh Government) and Scottish Health Survey (Scottish Government)

There are some differences in the approach to data collection between these surveys. One difference is in the collection modes used to collect drinking data on these surveys.

The Opinions and Lifestyle Survey collects data using Computer Assisted Personal Interviewing (CAPI). This is the main method used on the Health Survey for England (HSE) and Scottish Health Survey (SHeS). However on HSE and SHeS paper booklets are used to collect alcohol consumption data for 16 and 17 year olds and in certain cases those aged 18 to 24 (18 to 19 for SHeS).

The main collection mode for the Welsh Health Survey (WHS) is paper questionnaire.

Alcohol consumption data collected using CAPI tend to be lower than those using paper questionnaires. More information about these differences can be found in [‘An Analysis of Mode Effects Using Data From the Health Survey for England 2006 and the Boost Survey for London’](#).

More information on each of these surveys, and the data collected, can be found on the [Health and Social Care Information Centre](#), [Welsh Government](#) and [Scottish Government](#) websites.

5. Reliability

It is likely that the estimates underestimate drinking levels to some extent. Social surveys consistently produce estimates of alcohol consumption that are lower than the levels indicated by alcohol sales data. This is likely to be because people either consciously or unconsciously underestimate their alcohol consumption.

6. Approach to statistical significance

Where estimates for different populations have been described as different throughout this commentary, they have been tested and found to be significantly different at 5% significance level ($p < 0.05$).

95% confidence intervals for each table value have been supplied as a [separate table \(204 Kb Excel sheet\)](#). Where historical data have been provided, confidence intervals have been supplied for the last two years (2012 and 2013).

7. Assumed levels of alcohol in beverages

Table 1 shows the assumed number of units for each measure of each drink type collected on the Opinions and Lifestyle Survey.

Table 1: Assumed alcohol content of drinks and measures collected on the Opinions and Lifestyle Survey

Type of drink	Measure	Assumed units of alcohol
Normal strength beer, stout, lager or cider	Half-pint	1.0
Normal strength beer, stout, lager or cider	Pint	2.0
Normal strength beer, stout, lager or cider	Small can	1.5
Normal strength beer, stout, lager or cider	Large can	2.0
Normal strength beer, stout, lager or cider	Bottle	1.5
Normal strength beer, stout, lager or cider	Schooner	1.3 ¹
Strong beer, stout, lager or cider	Half-pint	2.0
Strong beer, stout, lager or cider	Pint	4.0
Strong beer, stout, lager or cider	Small can	2.0
Strong beer, stout, lager or cider	Large can	3.0
Strong beer, stout, lager or cider	Bottle	2.0
Strong beer, stout, lager or cider	Schooner	2.7 ²
Spirits or liqueurs	Standard 25ml measure	1.0
Sherry or martini	Glass	1.0
Wine (including champagne and babycham)	Small glass (125ml)	1.5
Wine (including champagne and babycham)	Medium glass (175ml)	2.0
Wine (including champagne and babycham)	Large glass (250ml)	3.0
Wine (including champagne and babycham)	Bottle	9.0
Wine (including champagne and babycham)	Unknown glass size	2.0
Alcopops	Small can	1.5
Alcopops	Standard bottle	1.5
Alcopops	Large bottle	3.5

Source: Office for National Statistics

Notes:

1. A schooner is 2/3 of a pint. When people said that they drank normal strength beer, stout, lager or cider in schooners, a value of 4/3 (four divided by three) units was used for each schooner that was consumed

2. A schooner is 2/3 of a pint. When people said that they drank normal strength beer, stout, lager or cider in schooners, a value of 8/3 (eight divided by three) units was used for each schooner that was consumed

8. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

Compendium

Adult Smoking Habits in Great Britain, 2013



Contact:
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Next release:
To be announced

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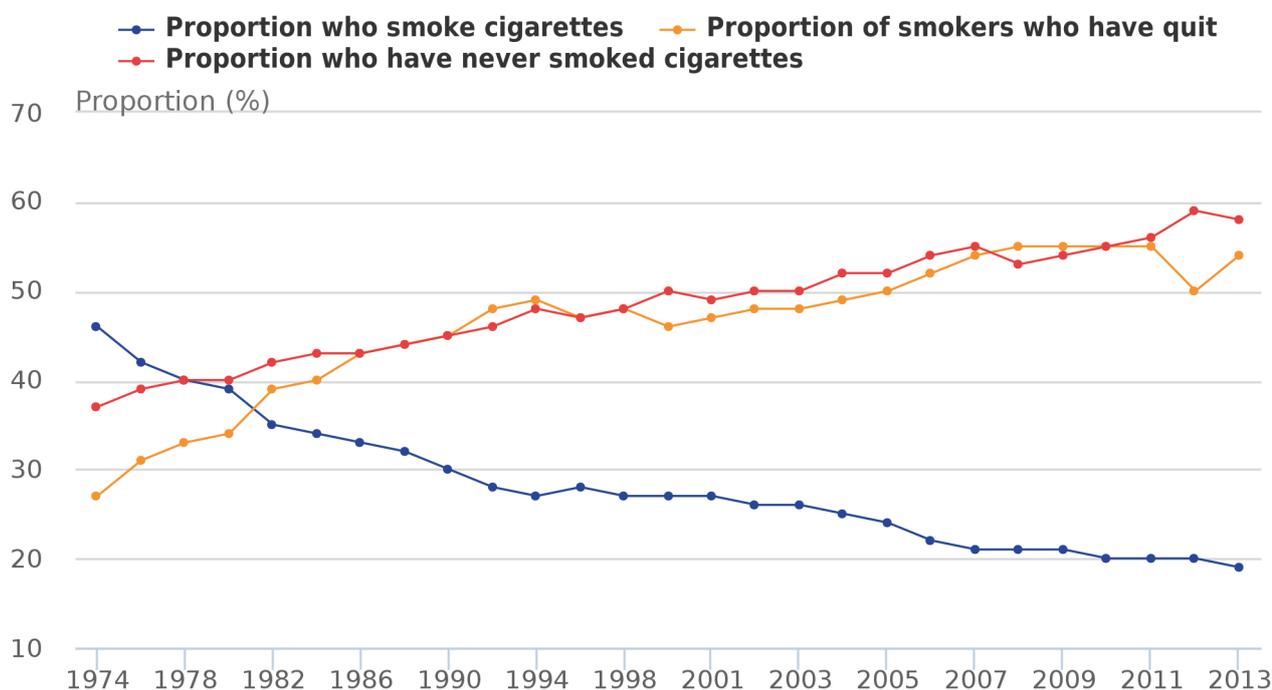
1 . Key points in 2013

- The proportion of the GB adult population who smoke cigarettes has fallen by more than a half in the last 40 years, from 46% in 1974 to 19% in 2013. Not only have fewer people taken up smoking, but more of those who did smoke have quit
- Women accounted for the fall on the previous year - the proportion of women who smoke cigarettes fell from 19% to 17% between 2012 and 2013. There was relatively little change in this proportion for men
- Unmarried people were almost twice as likely to be cigarette smokers as married people
- The proportion who smoke cigarettes was higher amongst unemployed people, people working in routine and manual occupations and those with lower level educational qualifications. These are all factors associated with poverty
- E-cigarettes are almost exclusively used by smokers and ex-smokers. Almost none of those who had never smoked cigarettes were e-cigarette users

2 . Summary of findings

In 2013 the proportion of the GB population who smoke cigarettes was less than half the proportion in 1974, Figure 1. Fewer people had taken up cigarette smoking, and more of those who did smoke had quit.

Figure 1: Proportion who smoke cigarettes, proportion of smokers who have quit, and the proportion who have never smoked cigarettes, Great Britain, 1974-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Notes:

1. Estimates prior to 2000 are unweighted
2. Prior to 2000, data were collected every other year. Estimates for odd years up to 1999 have been interpolated

3. The proportion of smokers who have quit is the proportion of all those who said that they have smoked cigarettes regularly, who no longer smoke
4. The group 'never smoked' contains those who said that they do not smoke cigarettes nowadays, and have never smoked cigarettes regularly

The likelihood of being a cigarette smoker is complex and related to a number of factors. These include employment status, job type, educational achievement, income and marital status. Unemployed people, those with more routine jobs, lower levels of educational achievement and lower incomes were more likely to be cigarette smokers than others. Married people, those with high levels of academic achievement and older people were all less likely to be cigarette smokers than others.

E-cigarette use was almost solely confined to smokers and ex-smokers, and was negligible amongst those who have never smoked cigarettes. E-cigarettes were mainly used to help smokers quit smoking, and because users saw them as being less harmful than cigarettes.

3 . Why do these results matter?

Smoking is the leading cause of preventable death in Great Britain. In 2009, smoking [caused nearly 80,000 deaths in England](#) alone. Estimates from the Scottish and Welsh governments suggest that smoking is responsible for around [13,500 deaths per year in Scotland](#) and [5,500 in Wales](#). Exposure to second-hand smoke (passive smoking) can lead to a range of diseases, many of which are fatal, with children especially vulnerable to the effects of passive smoking.

Smoking also has economic costs, adding significantly to the burden on the NHS. Research from Oxford University suggests that smoking cost the NHS in the UK [£5.2 billion in 2005/06](#). It is estimated that in 2011/12, [approximately 5% of all hospital admissions in England](#) for those aged 35 and over were attributable to smoking.

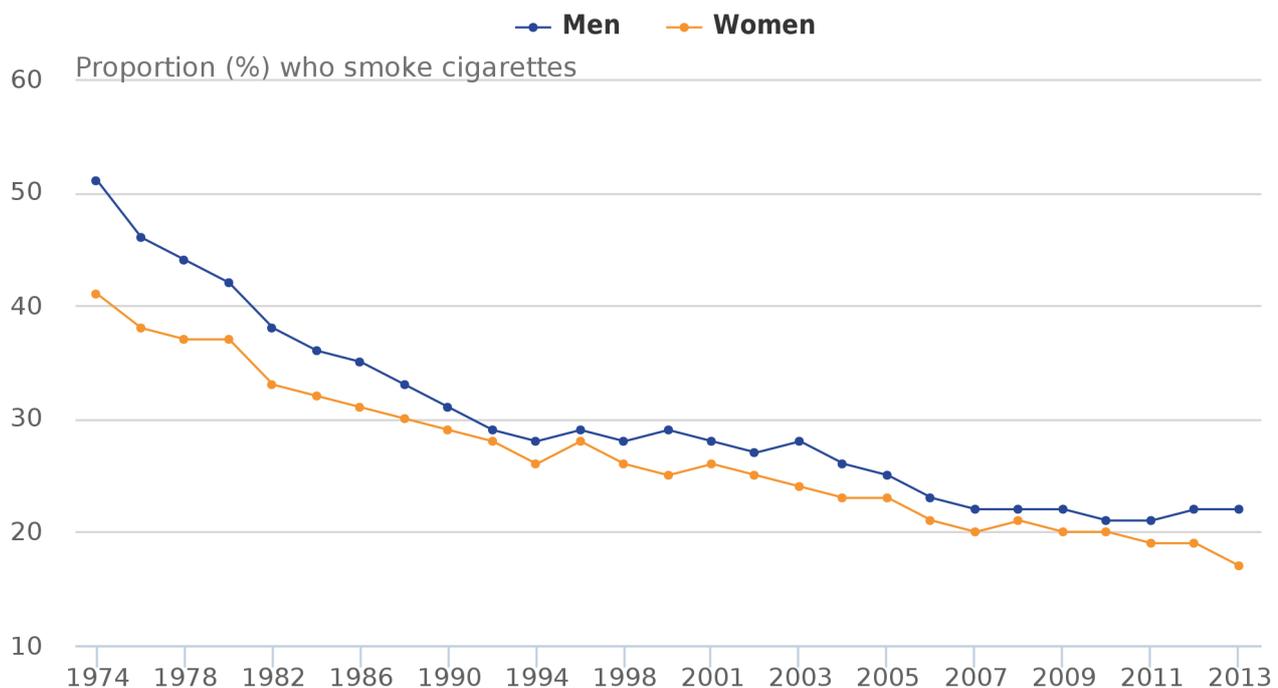
Reducing the prevalence of cigarette smoking is therefore a key objective for the Government and devolved administrations. The Government has set a smoking prevalence target for England of [18.5% by 2015](#). The [Welsh Government has a target](#) of 20% by 2016, and 16% by 2020. The Scottish Government has a target of 17% by 2016, with a longer term target of 5% by 2034.

The UK Government and Welsh and Scottish governments have published the papers '[Healthy Lives, Healthy People – A Tobacco Control Plan for England](#)', '[Tobacco Control Action Plan for Wales](#)' and '[Creating a Tobacco-Free Generation – A Tobacco Control Plan for Scotland](#)'. These set out their respective strategies for reducing the proportion of the population that smokes and the harm caused by tobacco use.

4 . The proportion of the population who smoke cigarettes has fallen over the last 40 years

The proportion of the population who smoke cigarettes has fallen gradually over the past 40 years, from 46% in 1974 to 19% in 2013. This latest figure is similar to the 2013 cigarette smoking levels reported in the [Integrated Household Survey \(IHS\)](#). Over the 40 years this fall was seen amongst both men and women, Figure 2, and in all age groups.

Figure 2: Proportion of population who smoke cigarettes, by sex, Great Britain 1974-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Notes:

1. Estimates prior to 2000 are unweighted
2. Prior to 2000, data were collected every other year. Estimates for odd years up to 1999 have been interpolated

Over this time the proportion of the population who had never smoked cigarettes increased from 37% to 58%. The increase was most notable in men; in particular men aged 50-59 where the proportion who had never smoked more than tripled from 17% to 55%.

The proportion of cigarette smokers who had quit doubled between 1974 and 2013, from 27% to 54%. Although in 1974 the proportion was lower amongst women than men (21% vs. 32%), by 2013 women had closed this gap (55% vs. 53%).

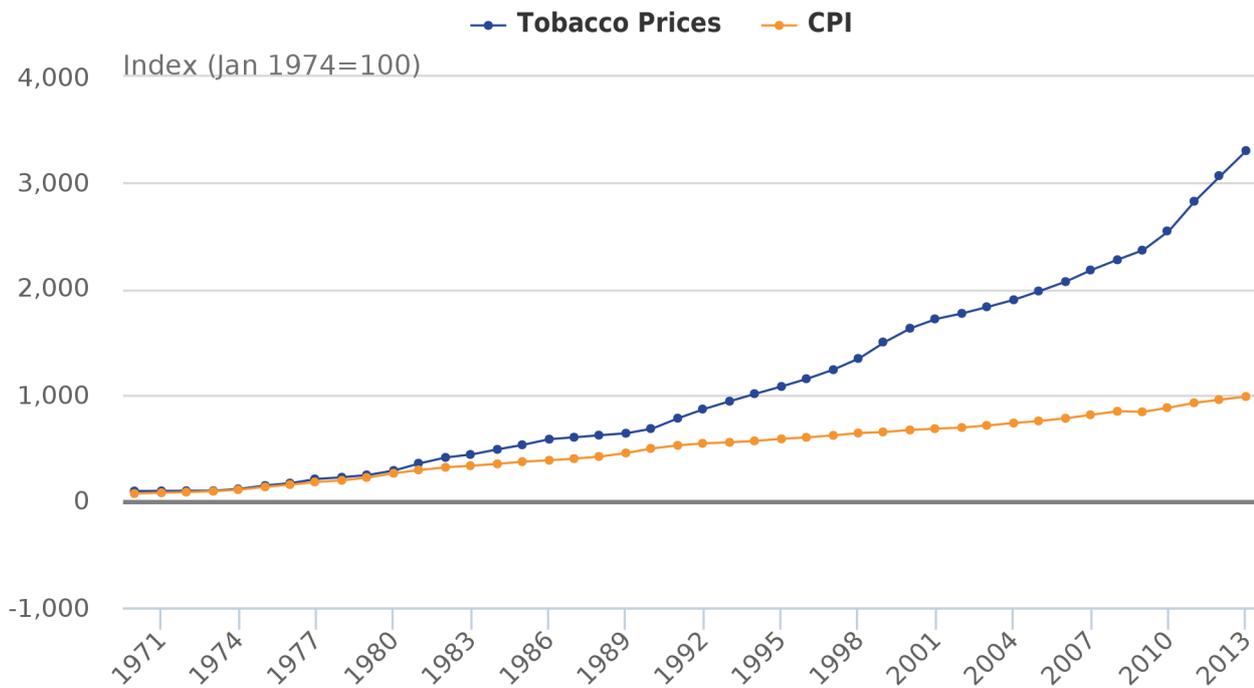
Why are fewer people taking up smoking now than 40 years ago, and why are more smokers quitting?

In 1974 more than 6 in 10 people had at some point smoked cigarettes regularly. By 2013 this had fallen to 4 in 10.

Greater effort is made nowadays to alert the public to the dangers of smoking. Many initiatives and legislative changes have been made over this time (see [background note 8](#) for further details), although it is difficult to say to what extent each initiative has contributed to the fall in the proportion who smoke. There is greater encouragement and pressure to stop smoking, and initiatives such as [No Smoking Day](#) and [Stoptober](#) are well publicised and promoted.

Smoking has become more expensive over this period, with tobacco prices increasing well above the rate of inflation as measured by the Consumer Price Index (CPI), Figure 3. Consequently there has been a gradual increase in the proportion of a smoker's income that has been needed to fund their habit.

Figure 3: Tobacco Price Inflation versus Consumer Price Inflation, United Kingdom, 1970-2013



Source: Office for National Statistics

Notes:

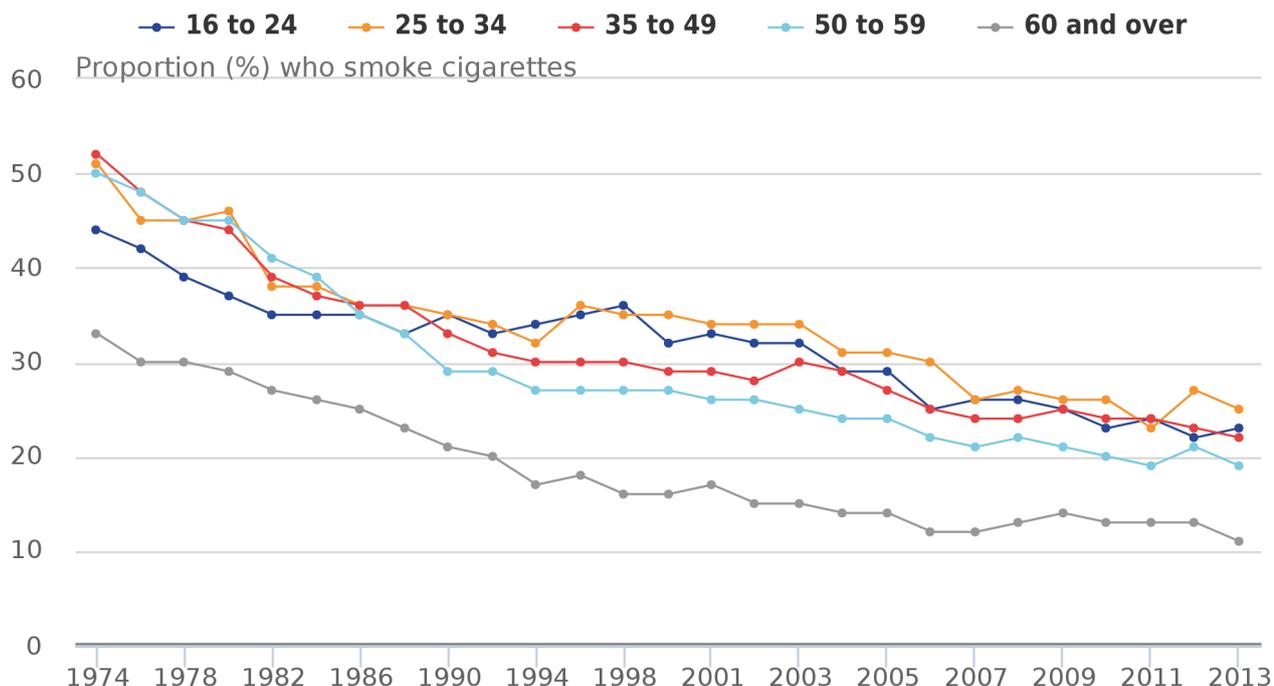
1. As the CPI begins in 1989, the CPI series is modelled up to 1988. For further details please see <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcM%3A77-290190>

Smokers now have access to a range of products and services to help them quit smoking that were not available in the 1970s. Smokers can access smoking cessation support groups, and there are various nicotine replacement therapies (NRTs) available, such as nicotine gum, spray and patches. More recently, e-cigarettes have also been introduced to the marketplace.

5 . Cigarette smoking and age

The fall between 1974 and 2013 in the proportion who smoke cigarettes was seen in all age groups, Figure 4, with the largest falls seen in the 50-59 and 35-49 age groups. Both fell by just over 30 percentage points.

Figure 4: Proportion who smoke cigarettes, by age, Great Britain, 1974-2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey, General Household Survey - Office for National Statistics

Notes:

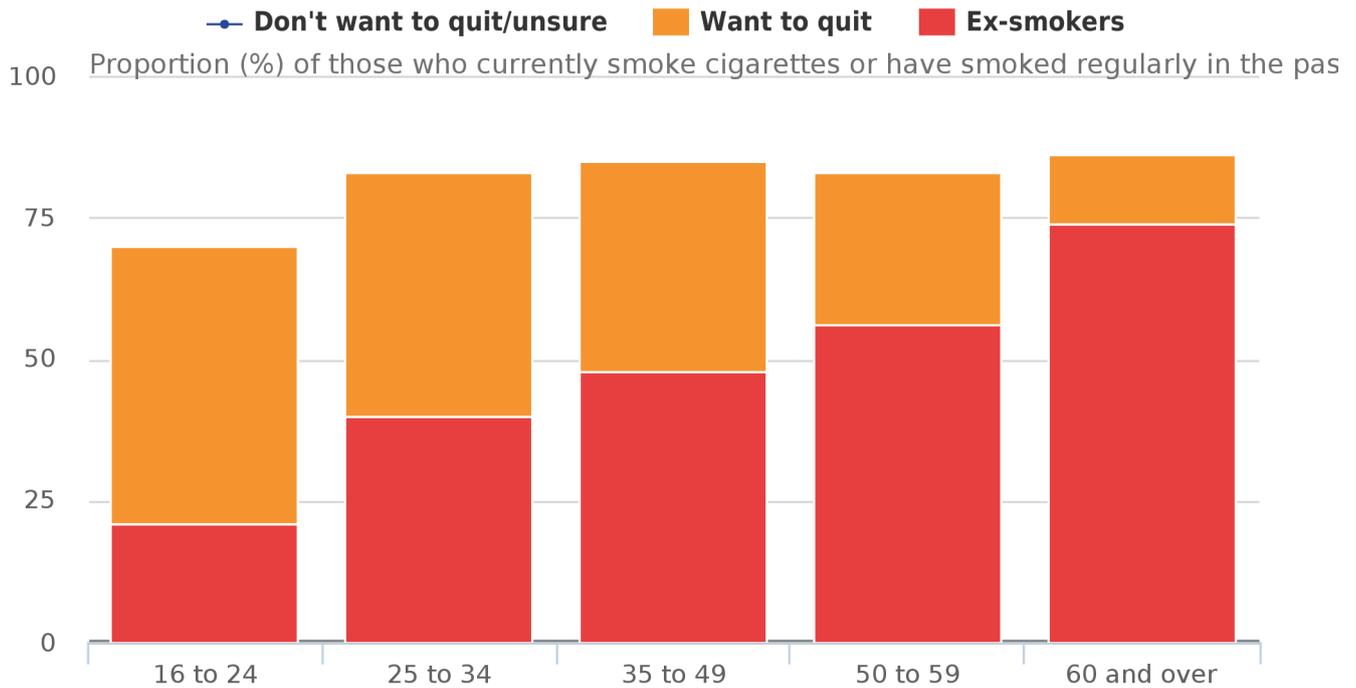
1. Estimates prior to 2000 are unweighted
2. Prior to 2000, smoking data were collected every other year. Estimates for odd years up to 1999 have been interpolated

The proportion of the population who smoke cigarettes has been consistently higher in the 16-24 and 25-34 age groups since the late 1990s. Although the proportion has fallen in these groups, they have remained the highest groups up to 2013.

[General Lifestyle Survey](#) data from 2008-2011, Figure 5, show that among those aged 25 and over the proportion of cigarette smokers who either wanted to or had quit remained constant as age increased. The fact that more had quit smoking was the driver behind the decreasing proportion of cigarette smokers in older age groups. It can take people many attempts to quit smoking, and people who are older may be more likely to have found a method that works for them.

Figure 5: Desire to quit smoking, by age, 2008-2011

All current and ex-smokers aged 16 and over



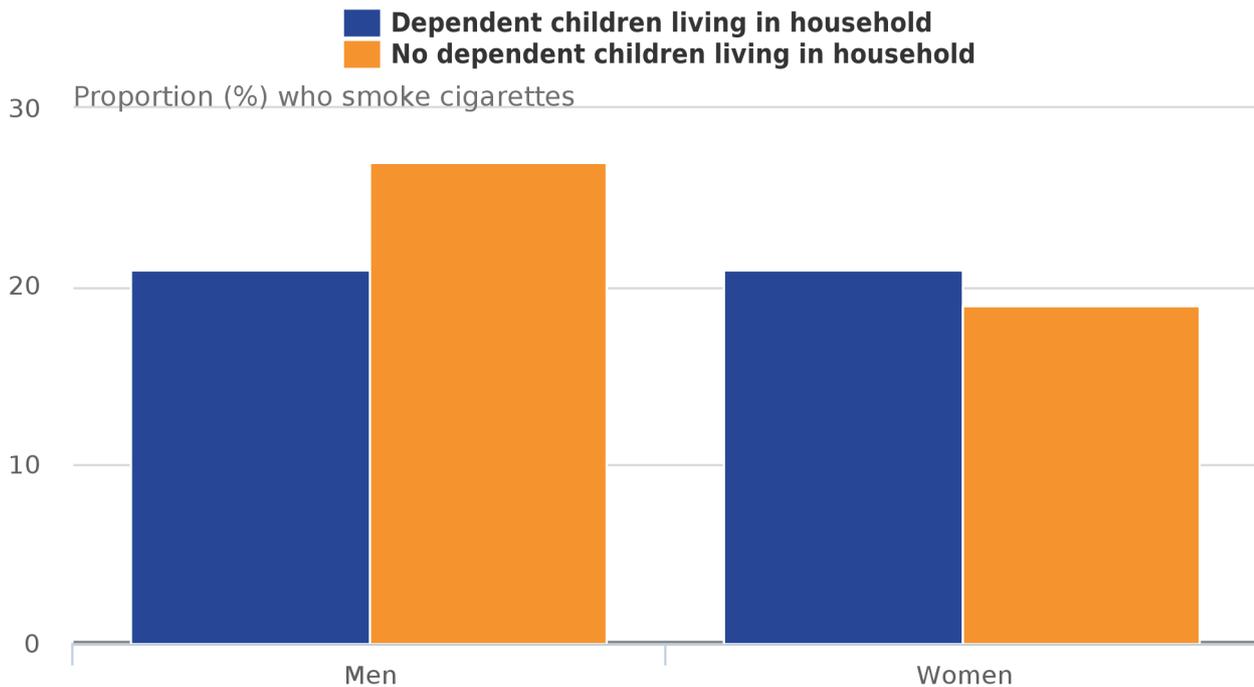
Source: General Lifestyle Survey - Office for National Statistics

6 . Relationships and cigarette smoking

Children's exposure to cigarette smoke

Exposure to second-hand smoke is hazardous to health, in particular to the health of children. The tobacco control plans for [England](#), [Wales](#) and [Scotland](#) each highlight the need to reduce children's exposure to second-hand smoke, and to reduce the proportion of children who smoke. The tobacco control plan for England refers to findings that a 15 year old who lives with a parent who smokes is [almost twice as likely to smoke](#) as one who lives with parents who do not.

Figure 6: Proportion of those aged 16-60 who smoke cigarettes, by sex and whether dependent children live in the household, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. Children aged 16 and over have not been classed as dependent children

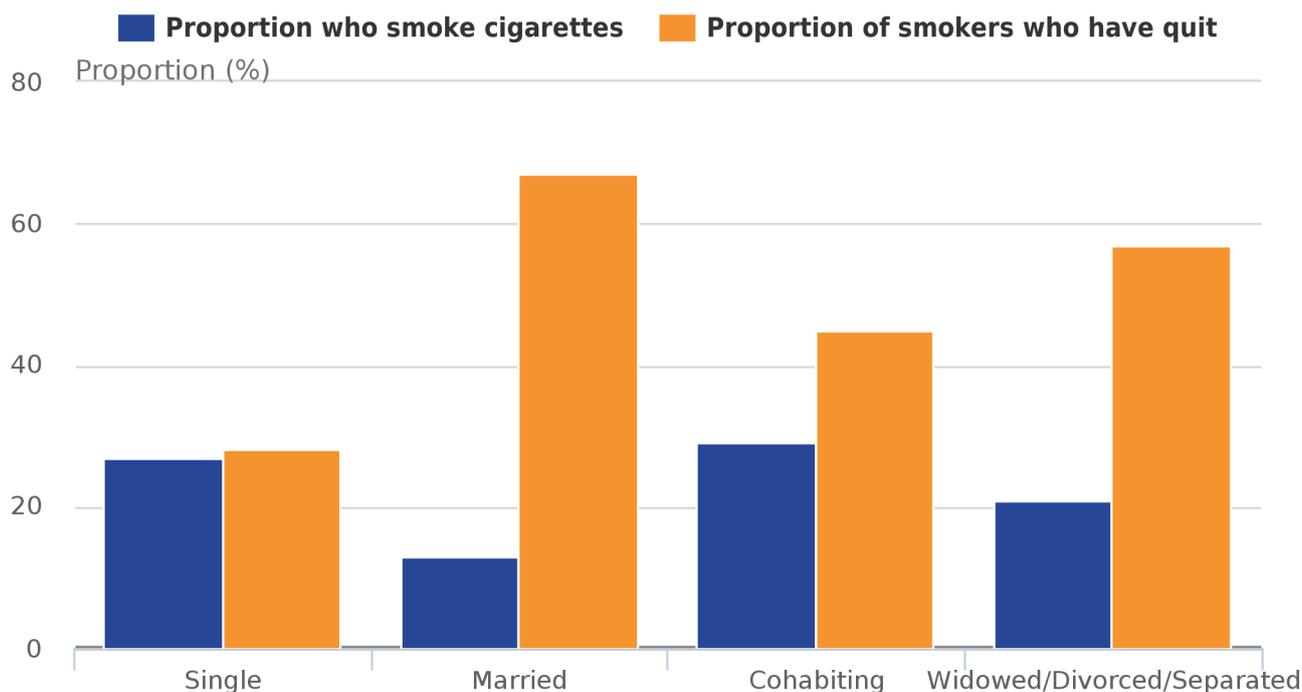
Women who lived with dependent children (under the age of 16) were just as likely to smoke cigarettes as those who did not, Figure 6. This is because women tend to give up smoking at a younger age compared with men. For men the proportion who smoke cigarettes was lower amongst those who lived with dependent children. Men were more likely to stop smoking at an older age than women but it is not clear whether having children is a factor.

Children's exposure to cigarette smoke cannot be defined simply by the proportion of parents who smoke. The tobacco control plans of the UK, Scottish and Welsh governments refer to the need to reduce exposure to second-hand smoke in the home and family car. Questions around children's exposure to second-hand smoke are asked on the Health Surveys for [England](#), [Wales](#) and [Scotland](#).

Differences in the proportion who smoke cigarettes, by marital status

The proportion of the population who smoke cigarettes was lowest amongst those who were married, Figure 7.

Figure 7: Proportion who smoke cigarettes and proportion of smokers who have quit, by marital status, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. The group 'married' includes those in same-sex civil partnerships
2. The proportion of smokers who have quit is the proportion of all those who said that they have smoked cigarettes regularly, who do not currently smoke

This is partly because of age. Single people are more likely to be younger, with married people, cohabiters and those who are widowed, divorced or separated are more likely to be older. However when age was controlled for, unmarried people were almost twice as likely to be cigarette smokers as married people.

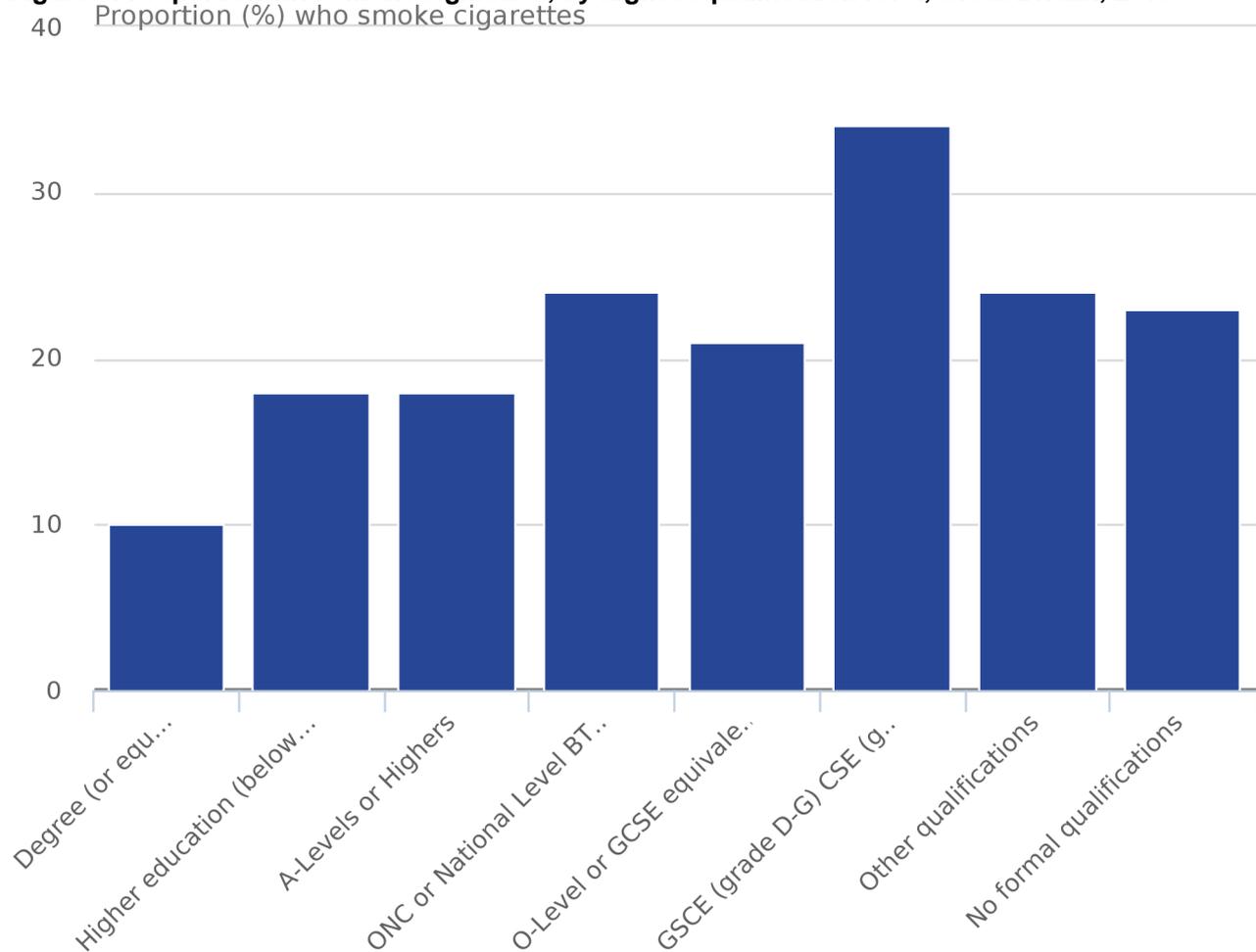
Married smokers were more likely than other smokers to have quit, but it is not clear whether those who had quit had done so before or after marriage.

7 . Cigarette smoking and factors associated with poverty

Cigarette smokers were more likely to have characteristics associated with poverty. This supports findings from an ONS report published in April 2014 which looked at the links between deprivation and smoking.

The proportion who smoked cigarettes was highest amongst those with lower level educational qualifications (Figure 8), unemployed people, those working in routine and manual occupations and those with low incomes. However these factors are themselves related. For example those with lower level educational qualifications are more likely to be unemployed or working in routine and manual occupations, and subsequently they are also more likely to have less income.

Figure 8: Proportion who smoke cigarettes, by highest qualification level, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. All of the specified categories include qualification of an equivalent level. For example 'GCSE (A-C)' also includes O-Levels of equivalent standard

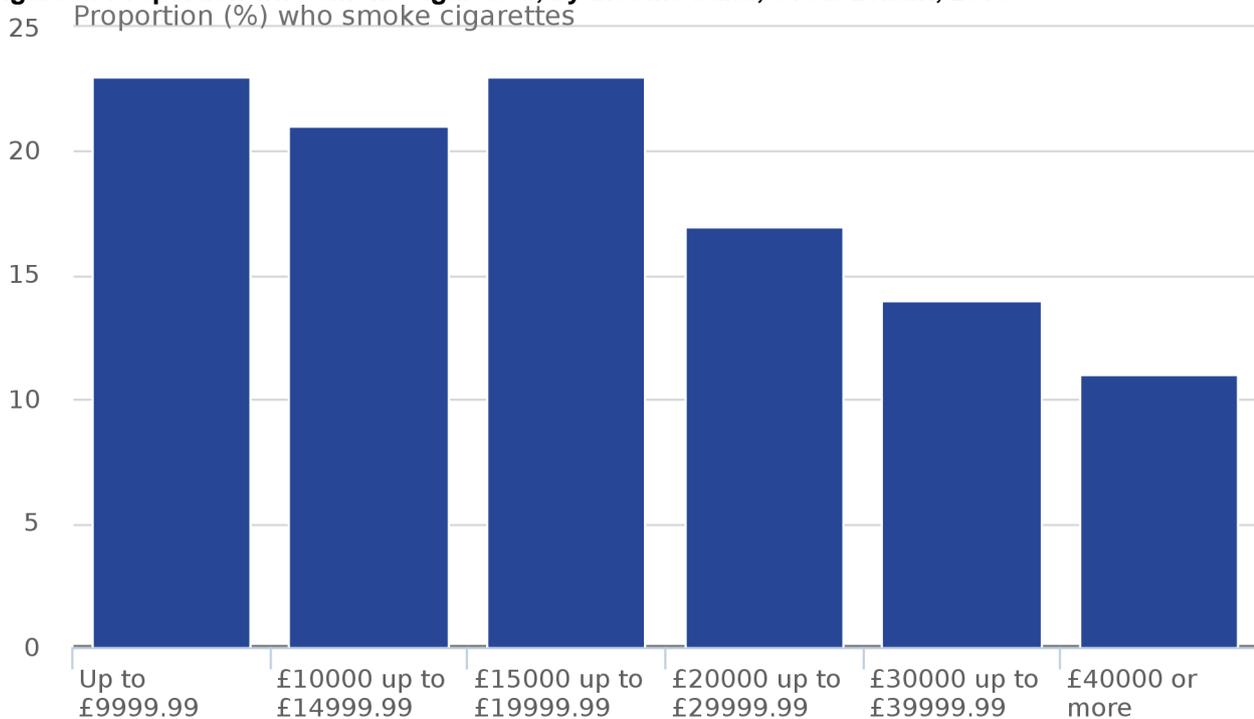
When people who shared the same characteristics were compared, those whose highest qualification was equivalent to an A-Level were almost twice as likely (1.7 times) to be cigarette smokers as those with a degree. Those with lower level qualifications were increasingly likely to be cigarette smokers; those with a qualification equivalent to GCSE (D-G) were more than four times as likely as those with a degree to be cigarette smokers.

Those with no qualifications were less likely than those with lower level qualifications to be cigarette smokers. However once we account for factors such as age, employment status and job type, the likelihood that someone with no qualifications was a smoker was similar to that of someone with a GCSE (D-G).

Unemployed people were twice as likely to be cigarette smokers as employed people who shared similar characteristics.

Those with higher incomes were less likely than others to be cigarette smokers, Figure 9. This can be explained by the fact that those with higher incomes are more likely to be employed, working in managerial and professional occupations and to have high levels of educational achievement.

Figure 9: Proportion who smoke cigarettes, by income band, Great Britain, 2013



Source: Opinions and Lifestyle Survey - Office for National Statistics

Notes:

1. Gross personal income is used as the measure of income. This covers all personal income before deductions for tax, National Insurance etc. It relates to income that is directly received (such as pay, benefits or interest from savings), and does not include income received through a third party (such as a spouse or partner)

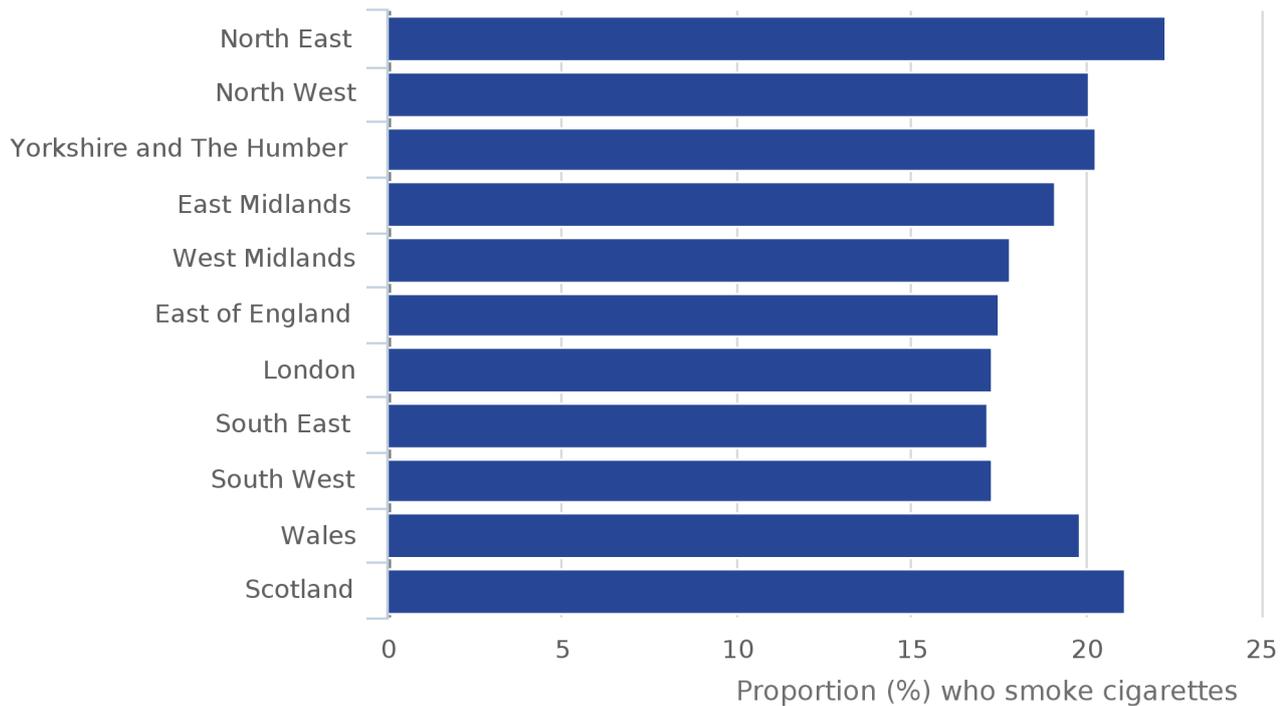
8 . Regional differences in the proportion who smoke cigarettes

The tobacco control plans for [England](#), [Wales](#) and [Scotland](#) provide separate targets for each of the countries of GB. In England the aim is to reduce the proportion of the population that smokes cigarettes to 18.5% by 2015. In Wales the target is 20% by 2016, and 16% by 2020, whereas in Scotland the target is 17% by 2016, with a longer term goal of 5% (or 'smoke-free') by 2034.

The proportion who smoked cigarettes was highest in 2013 in northern regions of England, and in Scotland and Wales, as shown by data from the [Integrated Household Survey \(IHS\)](#), Figure 10. These are generally the areas that have higher unemployment levels, lower average income and lower levels of educational achievement. IHS data have been used as the larger sample size provides more precise comparisons at this level of geography.

Figure 10: Proportion who smoke cigarettes, by region, Great Britain, 2013

All persons aged 18 and over



Source: Integrated Household Survey - Office for National Statistics

9 . Use of e-cigarettes, and the relationship to smoking

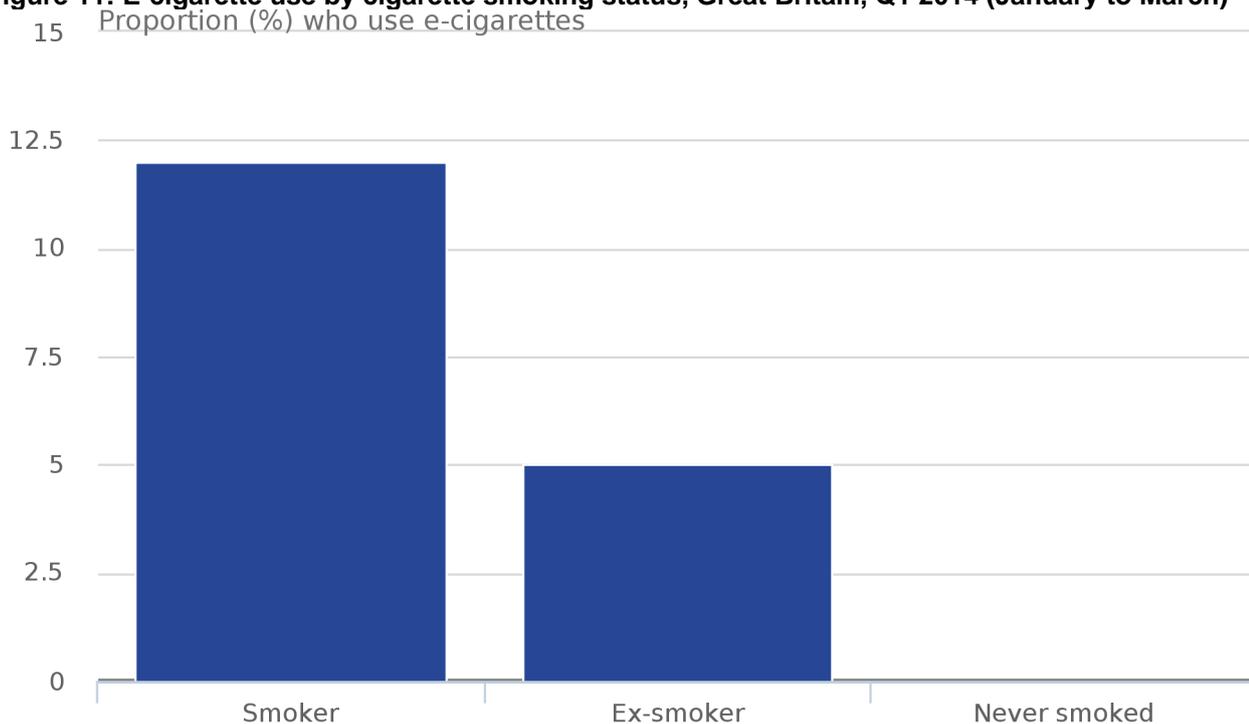
The debate around use of e-cigarettes

E-cigarettes have been sold since 2004, and in Europe since 2006. Their popularity and availability has increased, which has led to debate around their use. Some feel that e-cigarettes could renormalise smoking, or [could be a gateway to smoking](#) by introducing non-smokers to nicotine. Others feel that they could be a useful tool in the effort to reduce tobacco consumption. To date, e-cigarettes have mainly been [marketed as a cheaper and healthier alternative to smoking](#). However, the long-term health effects of using e-cigarettes have yet to be established. This has led to a [World Health Organisation](#) call for tighter controls on e-cigarettes.

ONS has chosen to publish preliminary findings on e-cigarette use in response to the emerging need for more information. These data were collected between January and March 2014. Complete 2014 findings are planned for publication as part of the next Adult Smoking Habits in GB publication in 2015.

Our preliminary findings

Figure 11: E-cigarette use by cigarette smoking status, Great Britain, Q1 2014 (January to March)



Source: Opinions and Lifestyle Survey - Office for National Statistics

E-cigarettes were almost exclusively used by smokers and ex-smokers, Fig 11. More than 1 in 10 (12%) of cigarette smokers also used e-cigarettes, compared with 1 in 20 (5%) ex-smokers and almost none of those who had never smoked. These findings reflect those from a [YouGov survey](#) commissioned by Action on Smoking and Health (ASH). Data on e-cigarette use have also been collected as part of the [Smoking Toolkit Study](#).

E-cigarettes were found to be used mainly as smoking cessation aids and for the perceived health benefits (compared with smoking tobacco). Over half of e-cigarette users said that their main reason for using e-cigarettes was to stop smoking, and about one in five said the main reason for their use was because they thought they were less harmful than cigarettes.

10. Background notes

1. The Opinions and Lifestyle Survey

The data in this report were collected on the Opinions and Lifestyle Survey (OPN) - an omnibus survey run by the Office for National Statistics. The survey is run monthly, and is open for both government and non-government organisations to run questions.

The OPN is the only randomised probability sample omnibus survey in Great Britain, and provides a fast, reliable and flexible service to customers.

More information on the survey and survey methodology can be found in the [Opinions and Lifestyle Survey Information Guide](#).

2. How to commission a module on the survey

Clients can enquire about purchasing modules of questions by e-mailing the Survey Manager at opinions@ons.gsi.gov.uk.

3. Comparability

The report provides information on the cigarette smoking habits of adults, and follows on from the series of releases from the General Household Survey (GHS) and General Lifestyle Survey (GLF). The OPN and GLF/GHS provide comparable results. However there are some differences in the design and content of the two surveys. More information can be found in the [‘Opinions and Lifestyle Survey – Smoking Habits Amongst Adults, 2012’](#) publication.

4. Coherence

There are a number of other sources of smoking data. These have been listed below with a brief explanation of the comparability of each source with the OPN.

Integrated Household Survey (IHS), Office for National Statistics

The [IHS](#) has produced statistics on cigarette smoking prevalence since 2010. These are broadly comparable with the OPN estimates of cigarette smoking prevalence. The IHS sample is far larger than the OPN sample. This leads to more precise estimates, especially at lower level geographies. As such we have used regional IHS estimates in this report, as they allow for comparison between regions.

The IHS asks questions around smoking of those aged 18 and over, whereas the OPN also asks the questions of 16 and 17 year olds. The construction of the proportions of the population who have never smoked cigarettes, and those who are ex-smokers, also differ, as the OPN asks an additional question around this.

More information on the IHS and its methodology can be found in the [most recent IHS report](#).

Health Survey for England (Health and Social Care Information Centre), Scottish Health Survey (Scottish Government) and Welsh Health Survey (Welsh Government)

These surveys ask questions on smoking of those aged 18 and over. They are run independently and as such each asks a different suite of questions about smoking.

More information on each of these surveys can be found on the [Health and Social Care Information Centre](#), [Scottish Government](#) and [Welsh Government](#) websites.

5. Reliability

It is likely that the survey underestimates cigarette consumption and, to a lesser extent, cigarette smoking prevalence. [Evidence suggests](#) that when respondents are asked how many cigarettes they smoke per day, there is a tendency for respondents to round the figure down to the nearest multiple of 10. Underestimates of consumption are likely to occur in all age groups.

Under-reporting of prevalence, however, is more likely to occur among young people, in particular those aged under 18 (as a result of the legal age of purchase for cigarettes in the UK). To protect their privacy, those aged 16 and 17 are given the option to complete the smoking section of the questionnaire themselves, so that neither the questions nor the responses can be heard by any of the other persons present.

6. Approach to statistical significance

Where values have been commented on as different in the commentary, these have been tested for significance and found to be significant at 5% level ($p < 0.05$).

95% confidence intervals for the values in the reference tables have been provided as a [separate table \(91.5 Kb Excel sheet\)](#). Where historical data have been provided, confidence intervals have been provided for the latest two years.

7. E-cigarettes

ONS collected preliminary data on the use of e-cigarettes from January to March 2014, and has continued to collect data during October and November 2014. As such, the full release of the data will be included in the 2014 smoking report.

ONS has chosen to publish preliminary data in this report to better meet user needs for information on the use of e-cigarettes.

ONS are currently working with users including other government departments to further develop questions on e-cigarette use. If you are interested in these statistics then let us know your views by contacting us at opinions@ons.gsi.gov.uk.

8. Changes in legislation and government policy, 1970-2013

Since 1970, successive governments have made numerous changes to policy and legislation with regards to tobacco and smoking.

Table 1: Changes in tobacco policy, 1970-201

Year	Change(s)
1971	Following an agreement between the government and the tobacco industry, government health warnings begin being carried on all cigarette packaging in the UK.
1973	First tar/nicotine tables published.
1984 (March)	First No Smoking Day.
1984 (July)	Smoking banned on London Underground trains.
1985	Smoking ban extended to include all stations that are wholly or partially underground.
1986 (February)	Advertising guidelines agreed. These include a ban on tobacco advertising in cinemas, and new health warnings.
1986 (April)	Protection of Children (Tobacco Act) passed. This banned the sale of all tobacco products to those aged under 16 - previously the law only applied to smoking tobacco.
1991	Health warnings now legally required on cigarette packets. A series of new health warnings are introduced, covering 6% of the pack.
1992	Sale of single cigarettes becomes illegal, following implementation of the Children and Young Person's (Protection from Tobacco) Act 1991.
2003	Following an EU products directive, descriptions such as 'light' and 'mild' are removed. Maximum tar yields are reduced and larger health warnings begin appearing on packaging.
2003	End to tobacco advertising on billboards, print media, direct mail and then internet (Tobacco Advertising and Promotion Act).
2007 (July)	Ban on smoking in enclosed public places in force across the whole of the UK. Scotland had been the first country of the UK to do this (March 2006) followed by Wales and Northern Ireland (April 2007) and finally England.
2007 (October)	Age of purchase for tobacco products increases from 16 to 18.
2008	EU directive comes into force, introducing printed warnings on the back of all tobacco packaging.
2011 (October)	Sale of tobacco from vending machines banned in England (and later Wales and Scotland).
2012 (April)	Tobacco displays banned in large stores.
2012 (October)	First Stobtober event launched. Tobacco displays banned in large stores in Wales.

Source: Action on Smoking and Health (ASH)

9. Details of the policy governing the release of new data are available by visiting <http://www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html> or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.