Office for National Statistics

Compendium

# General health (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey)

Includes chapters on health, smoking, drinking, households, families and access to vehicles.

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# 1 . General health

The General Lifestyle Survey (GLF) and its predecessor the General Household Survey (GHS) have included a series of questions on health since 1971. Although periodic changes have been made to the content of the health section, it is possible to monitor changes in health over a 40 year period. This chapter presents information on recent trends over time in self-reported health and data for the 2011 survey year.

## How the data are used and their importance

GLF health data are used by government departments, health organisations and charities to make informed decisions on policies and related programmes and projects. ONS and academic institutes also use the data to conduct research on different aspects of health including: health expectancy; health related risk factors and inequalities in health. The Economic and Social Data Service (ESDS) publish information on the various research projects that have used GLF data. This information can be downloaded from the ESDS website.

This report includes statistics produced directly from the GLF. However, GLF data are combined with other sources in the computation of key health indictors. For example, self-assessed general health and limiting long-standing illness statistics from the GLF are used in the calculation of official healthy life expectancies, and experimental health expectancy statistics.

Healthy life expectancies have been calculated since 1981 and are updated annually; these data are freely accessible via the ONS website. Experimental health expectancy statistics using GLF survey data are produced on an ad-hoc basis and focus on issues such as health inequalities across areas experiencing differing levels of deprivation. These experimental statistics have featured as published peer-reviewed articles in Health Statistics Quarterly (HSQ). The final edition of HSQ was published in February 2012 but these peer-reviewed experimental statistics will continue to be published directly on the ONS website.

Trends and comparisons of national health expectancies feature routinely in ONS publications such as Social Trends, Pension Trends, and Focus on Older People. Health expectancies are used by the Department of Health (DH), Department for Work and Pensions (DWP) and the Department for Environment Food and Rural Affairs (DEFRA). DH uses the statistics in monitoring health inequalities and in targeting health resources. DEFRA uses the health expectancy indicators for monitoring progress in Sustainable Development (SD 50) in the UK. DWP uses the statistics as indicators for healthy active living beyond retirement; the data are an important source for understanding life expectancy in the context of healthy aging and inform options for pension reform.

## The results

The analysis in this chapter shows results for self-assessed general health, long-standing illness or disability, acute sickness and details of long-standing health conditions. The results are based on responses from adults aged 16 and over living in private households in Great Britain (excluding institutions, such as nursing homes). Health information is also collected from a responsible adult about all children in the household.

# 2 . Self-assessed general health

Self-assessed general health is used as a measure for estimating future health outcomes and is therefore an important source for planning health services.

In 2008 the former self-assessed general health question relating to health over the previous 12 months, which had three possible responses; 'Good', 'Fairly good' or 'Not good', was replaced with a new question. The new question asks respondents how their health is in general and has five possible responses; 'Very good', 'Good', 'Fair', 'Bad' or 'Very bad'. The new question was first added to the survey in 2005 and is harmonised with national surveys across the European Union. This section reports on the responses to this question.

It should be noted that to allow comparisons between the two general health questions, both were included on the GHS (and asked of all adults) between 2005 and 2007 with the three-category question asked first. This means that responses during this period may be subject to bias caused by question exposure/order effects, for example adults who might have otherwise responded 'Very good' to the five-category question could have responded 'Good' in line with the highest category of the three-category question. This might explain the notable change in the percentages between the 'Very good' and 'Good' categories between 2007 and 2008. Therefore, care should be taken if drawing conclusions concerning this change.

Between 2005 and 2008, the proportion of adults aged 16 and over reporting 'Very good' or 'Good' general health increased from 75 % to 79 % and remained at this level until 2010 before falling back to 77 % in 2011. The proportion of adults reporting 'Bad' or 'Very bad' general health ranged from 5 % to 7 % between 2005 and 2011. In 2011, 34 % of adults said their health was 'Very good', 43% reported 'Good' health, 18 % reported they had 'Fair' health, 5 % reported they had 'Bad' health and 1 % said their health was 'Very bad'.

Table 7.1 (351 Kb Excel sheet)

# 3 . Long-standing and limiting long-standing illness or disability

Respondents to the GLF are asked whether they have a long-standing illness, disability or infirmity. Those who report a long-standing illness (which includes any disability or infirmity) are then asked if this limits their activities in any way. Data on long-standing illness and limiting long-standing illness include both adults and children. It should be noted that the estimates are based on the respondents own assessment of their health or the health of children in their care. Therefore changes over time may reflect changes in people's expectations of their health as well as changes in incidence or duration of sickness. In addition, different sub-groups of the population may have varying expectations, activities and capacities for adaptation.

Overall the proportion of people reporting a long-standing illness or disability has increased over time, from 21% in 1972 to 32% in 2011. This increase occurred between 1972 and 1991 and the proportion reporting a long-standing illness or disability has remained similar since then. A reason for this could be the increase in life expectancy and decrease in family size which has resulted in a much higher proportion of individuals in older age groups where long-standing illness or disability is likely to be more common.

The proportion of people reporting a limiting long-standing illness or disability has changed very little since it was first asked on the survey in 1975: the proportion of people reporting a limiting long-standing illness or disability in 1975 was 15% and in 2011 this proportion was 19%.

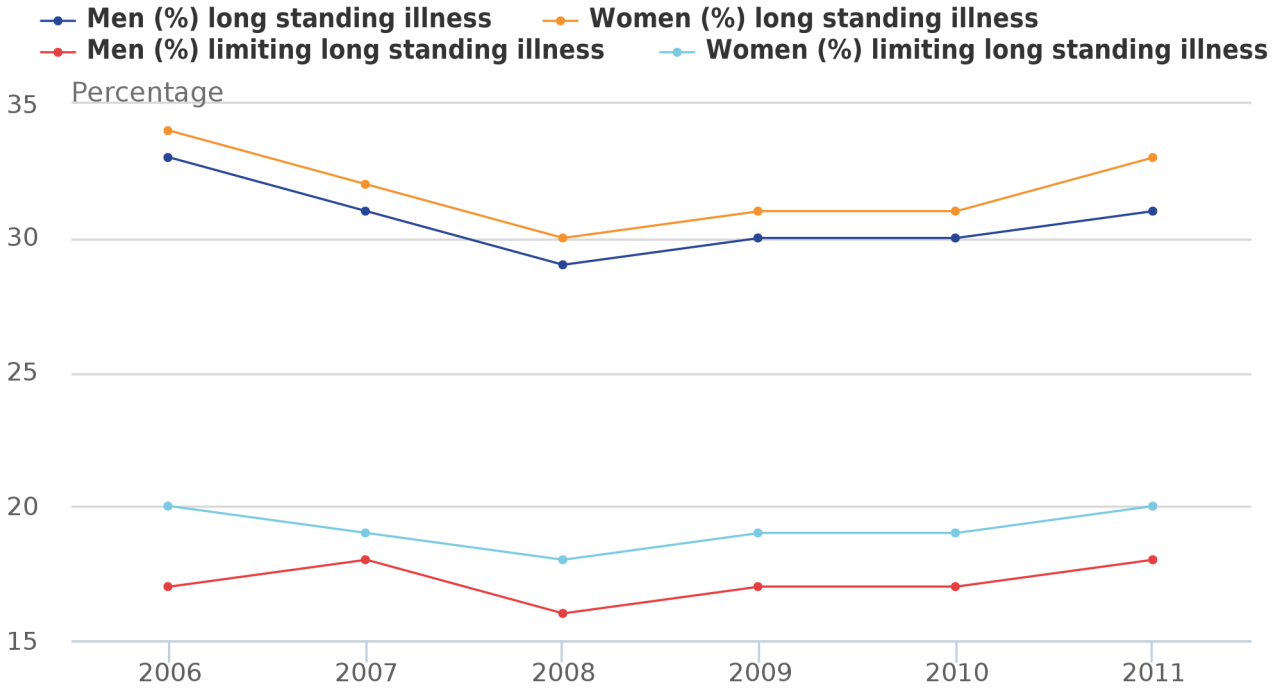
The commentary in this section focuses on results since 2006, reflecting the first year of the longitudinal component of the survey. Discussion of trends prior to 2006 can be found in earlier editions of the GLF/GHS reports (available on the ONS website).

Over the six year period from 2006 to 2011 the proportion of males and females reporting a long-standing illness or disability has remained fairly consistent. The proportion of males reporting a long-standing illness has fallen two percentage points over this period (from 33% in 2006 to 31% in 2011) and among females the proportion has fallen by one percentage point (from 34% in 2006 to 33% in 2011).

In 2011, as in all previous years, the prevalence of both long-standing and limiting long-standing illness increased with age. The increase was particularly marked among those aged 45 and over. The 45 to 64 age group were almost twice as likely (42%) to report a long-standing illness than those aged 16 to 44 (22%). Among those aged 65 to 74, 58% reported a long-standing illness compared with 68 % of those aged 75 and over. The proportions reporting a limiting long-standing illness similarly rose with age: 12% (aged 16 to 44); 25% (aged 45 to 64); 36% (aged 65 to 74); and 47% (aged 75 and over).

Table 7.2 (351 Kb Excel sheet)

**Figure 7.1: Percentage of males and females reporting (a) long-standing illness (b) limiting long-standing illness 2006 to 2011, Great Britian**




**Source: General Lifestyle Survey - Office for National Statistics**

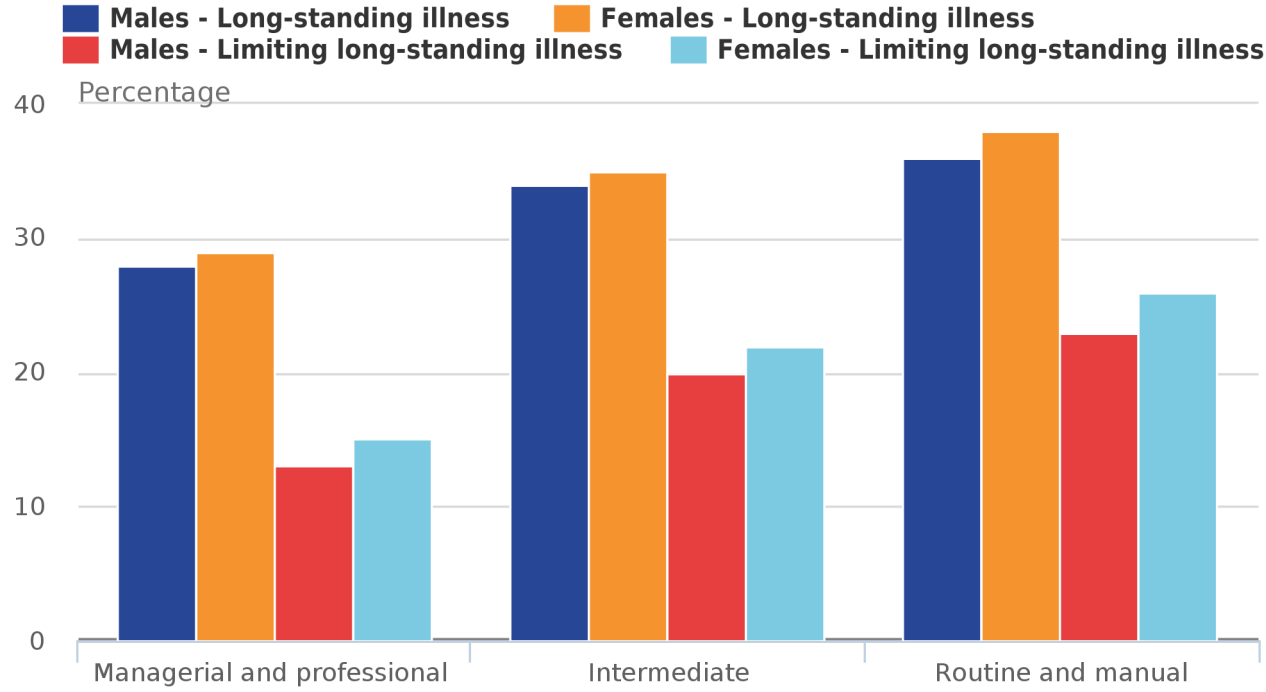
The socio-economic classification (NS-SEC) used in this report is based on information about occupation and employment status (see Appendix A, Definitions and terms for further information). Tables 7.4 to 7.6 (351 Kb Excel sheet) present data using NS-SEC shown in three main groupings: managerial and professional, intermediate, and routine and manual occupations.

Prevalence of both long-standing and limiting long-standing illness varies by the socio-economic status of the Household Reference Person (HRP). In 2011 people living in households where the HRP was in a routine or manual occupation group had the highest prevalence of long-standing illness (36% of males and 38% of females). They were followed by the intermediate group (34% of males and 35% of females) and the managerial and professional group (28% of males and 29% of females).

A similar trend was evident among people who reported a limiting long-standing illness. Males and females living in households where the HRP was in a routine and manual occupation group were most likely to report a limiting long-standing illness (23% of males and 26% of females); followed by the intermediate group (20% of males and 22% of females); and the managerial and professional group (13% of males and 15% of females).

Tables 7.4 and 7.5 (351 Kb Excel sheet)

**Figure 7.2: Prevalence of long-standing and limiting long-standing illness by sex and socio-economic classification of household reference person, 2011, Great Britain**




**Source: General Lifestyle Survey - Office for National Statistics**

**Notes:**

1. Results for 2006 to 2011 include longitudinal data

# 4 . Acute sickness

Acute sickness is defined as any illness or injury that has caused a person to cut down on their normal activities in the last two weeks. Data on acute sickness were collected for both adults and children.

Over the most recent five year period, the proportion of all people reporting acute sickness remained similar at 12%. As in previous years, the prevalence of acute sickness in 2011 was greater for females (13%) than for males (10%). Those in households where the HRP was in a routine or manual occupation group were more likely to report acute sickness (11% of males and 14% females) than those in households where the HRP was in the managerial and professional group (9% of males and 12% of females).

Tables 7.2 and 7.6 (351 Kb Excel sheet)

Respondents who reported an acute sickness were also asked how many days their activities were restricted for. The average number of restricted activity days per person per year due to illness or injury generally increased with age. In 2011 people aged 65 to 74 had (on average) more than twice as many restricted activity days per year (41 days) than those aged 16 to 44 (18 days). Working men and women had (on average) fewer days restricted activity per year (14 days for men and 21 days for women) than men and women who were economically inactive (47 days for men and 47 days for women).

Tables 7.3 and 7.9 (351 Kb Excel sheet)

# 5 . Details of long-standing conditions

Respondents aged 16 and over who reported a long-standing illness or condition were asked to provide further details in order that their illness and/or condition could be classified according to chapter headings of the International Classification of Diseases (ICD-10). This classification is based on the symptoms of the illness or condition, rather than the cause.

Similar to previous years of the survey, the most common conditions reported in 2011 were musculoskeletal problems (139 per 1,000 people) and conditions of the heart and circulatory system (101 per 1,000 people). Women were more likely than men to report musculoskeletal problems (164 per 1,000 women compared with 112 per 1,000 men). This was largely due to differences in rates of arthritis and rheumatism (85 per 1,000 for women and 46 per 1,000 for men).

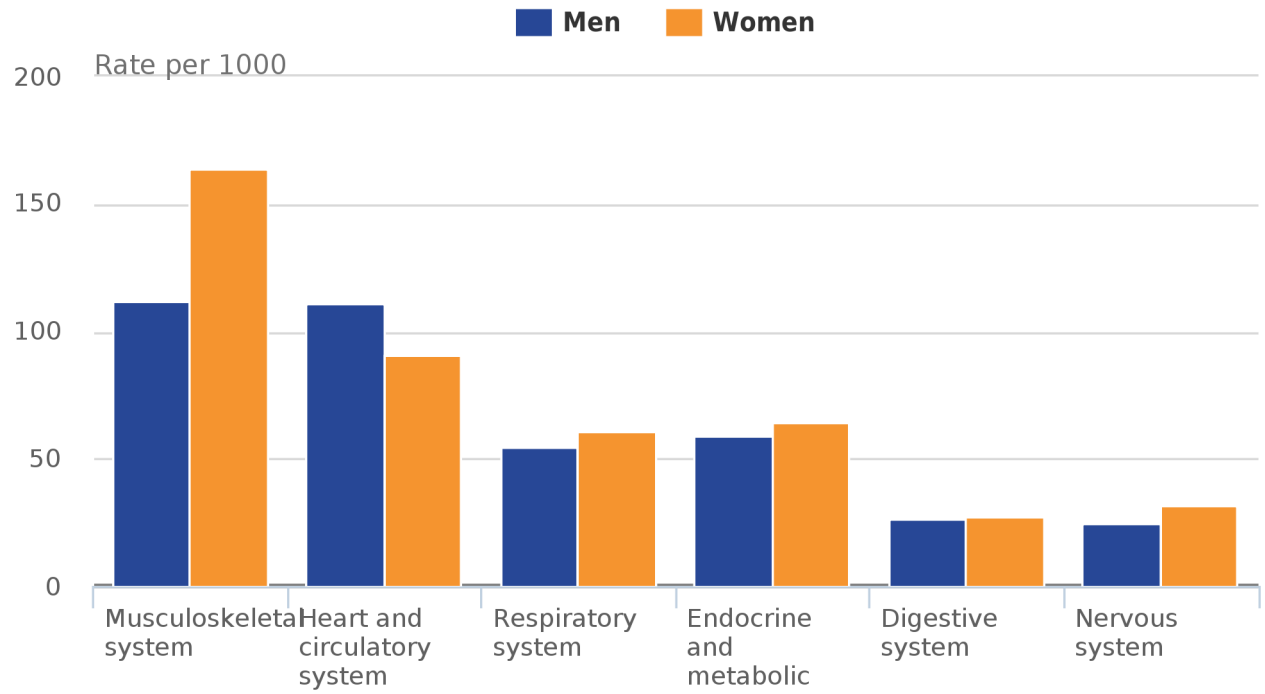
For the majority of long-standing conditions there was a higher prevalence amongst older people compared to younger people. A condition of the musculoskeletal system was reported at a rate of 51 per 1,000 people aged 16 to 44, compared with a rate of 304 per 1,000 people aged 75 and over. While 17 per 1,000 people aged 16 to 44 reported a heart and circulatory system condition, the corresponding rate among those aged 75 and over was 316 per 1,000 people. The notable exceptions were mental disorders – a rate of 47 and 42 per 1,000 people aged 16 to 44 and 45 to 64 compared with a rate of 17 and 26 per 1,000 people aged 65 to 74 and 75 and over respectively. Other conditions which showed no relation with age include skin complaints and infectious diseases.

Tables 7.11 ,7.12, and 7.14 (351 Kb Excel sheet)

The prevalence of long-standing conditions varied by the socio-economic status of the Household Reference Person (HRP). Adults in households where the HRP was in the managerial and professional occupational grouping had the lowest rates for all health conditions and those in households where the HRP was in the semi-routine and routine occupational grouping had the highest rating. For example, adults in households where the HRP was in the managerial and professional occupational group had a rate of 111 per 1,000 people for musculoskeletal conditions and 81 per 1,000 people for heart and circulatory problems, whereas the corresponding rates for adults in households where the HRP was in semi-routine and routine occupational groupings were 187 per 1,000 people and 138 per 1,000 people respectively. Consequently, of all those reporting a long-standing illness, adults in households where the HRP was in the managerial and professional group reported the lowest average number of conditions (1.12 conditions), and those adults in households where the HRP was in the semi-routine and routine group reported the highest average number of conditions (1.72 conditions).

Tables 7.13 and 7.15 (351 Kb Excel sheet)

**Figure 7.3: Rate per 1000 reporting long-standing condition groups, by sex, 2011, Great Britain**




**Source: General Lifestyle Survey - Office for National Statistics**

# 6. Background notes

1. 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