



Health Survey for England 2017

Children's health

Published 4th December 2018

[This report presents key statistics about children's health and health-related behaviours, showing 2017 prevalence and trends.](#)

Key findings

- The proportion of children aged 8 to 15 who had ever smoked has decreased from 19% in 1997 to 5% in 2017.
- 11% of children aged 13 to 15 had ever tried smoking, compared to 1% of those aged 11 to 12 and 0.4% of those aged 8 to 10.
- The proportion of children aged 8 to 15 reporting ever having had a proper alcoholic drink – a whole drink, not just a sip - fell from 45% in 2003 to 14% in 2017.
- The proportion ever having had a proper alcoholic drink increased from younger to older children. Only small proportions of younger children had tried drinking: 2% aged 8 to 10 and 6% aged 11 to 12, compared with 32% aged 13 to 15 in 2017.
- 18% of children aged between 5 and 15 ate the recommended five or more portions of fruit and vegetables a day.
- 94% of boys and 95% of girls reported very good or good health.

Contents



Contents

Key findings	1
This is a National Statistics publication	3
Introduction	4
List of tables	7
Children's height and weight	8
Children's cigarette smoking	9
Children's experience of alcohol	12
Children's fruit and vegetable consumption	14
Children's general health	16

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This report may be of interest to members of the public, policy officials, people working in public health and to commissioners of health and care services to see key statistics about children's health and health related behaviours in England.

Introduction

Contents

This child focused report presents key statistics about children's health and health-related behaviours showing 2017 prevalence and trends. It covers content previously published in the child section of the trends commentary for HSE2016 and earlier years. It also includes content previously published in the children's smoking section of HSE2015 and earlier years.

The Health Survey for England series

The Health Survey for England is a series of annual surveys designed to measure health and health-related behaviours in adults and children living in private households in England. The survey is currently commissioned by NHS Digital (formerly the Health and Social Care Information Centre (HSCIC)), and before April 2005 was commissioned by the Department of Health. Since 1994, the survey has been carried out by NatCen Social Research and the Research Department of Epidemiology and Public Health at UCL (University College London).

Each annual survey has covered the adult population aged 16 and over living in private households in England. Since 1995, the surveys have also covered children aged 2 to 15, and since 2001, infants aged under 2 have been included. In some years a boost sample is used to increase the proportion of participants from certain population groups. There was no sample boost in 2017.

In 2017, interviews were completed with 7,997 adults and 1,985 children.

The survey consists of an interview and nurse visit. It has a series of core elements that are included every year or alternate years, and special topics that are included in selected years. For children, these topics are currently included every year:

- General health
- Experience of smoking
- Experience of drinking alcohol
- Height measurements
- Weight measurements
- Child saliva samples

Other topics are covered regularly, including well-being, fruit and vegetable consumption and physical activity.

Trend tables

The trend tables focus on core topics and measurements. Trend tables present the results within the general population sample, although in some years boost sample data have been included. For example, some trends for 2002, 2005 to 2010 and 2015 are based on data from children in both boost and general population samples to increase the precision of the results.

Because the current sample size for children (unless there is a child boost) is relatively small compared with previous years, the child trend tables were changed to present results for age groups rather than for individual age years. Trend tables up to 2012 showed individual age years for most tables, and these are available at <http://content.digital.nhs.uk/catalogue/PUB13219>.

About the survey estimates

The commentary in this report focuses on key trends in the health of children aged between 0 and 15 since 1995, or the earliest year for which comparable data are available.

The Health Survey for England, in common with other surveys, collects information from a sample of the population. The sample is designed to represent the whole population as accurately as possible within practical constraints, such as time and cost. Consequently, statistics based on the survey are estimates, rather than precise figures, and are subject to a margin of error, also known as a 95% confidence interval. For example, the survey estimate might be 24% with a 95% confidence interval of (22% to 26%). A different sample might have given a different estimate, but we expect that the true value of the statistic in the population would be within the range given by the 95% confidence interval in 95 cases out of 100.

Where differences are commented on in this report, these reflect the same degree of certainty that these differences are real, and not just within the margins of sampling error. These differences can be described as statistically significant.¹

Confidence intervals are quoted for key statistics within this report and are also shown in more detail in the Excel tables accompanying the Methods report. Confidence intervals are affected by the size of the sample on which the estimate is based. Generally, the larger the sample, the smaller the confidence interval, and hence the more precise the estimate.

To limit the burden on households, the number of children selected to take part in the survey has been limited. Between 1995 and 2014, no more than two children in each household were selected. From 2015, this was revised so that up to four children could be selected to take part, but no more than two from each age group, 0 to 12 and 13 to 15.

Since 1995, children's data have been weighted to account for the probabilities of selection. In 2003, non-response weighting was introduced for the first time in the HSE series.²

Since 2013, standard errors (shown in some tables) have been calculated for all survey years using a complex samples module of the statistical package. When the children's trend tables were recalculated to present results in age groups from 2013, standard errors (shown in some tables) were calculated for all survey years using a

¹ Statistical significance does not imply substantive importance; differences that are statistically significant are not necessarily meaningful or relevant.

² In 2003, key survey variables using weighted and unweighted estimates were compared. This comparison showed that there are small differences between weighted and unweighted results, which are generally larger for men than women. See Blake, M. *Weighting the data*. Section 7.4.2, in Sproston K, Primatesta P (eds). *Health Survey for England 2003. Volume 3: Methodology and documentation*. The Stationery Office, London, 2004.

complex samples module of the statistical package. This complex samples module takes account of the complex survey design and weighting used in the HSE rather than assuming a simple random sample.³ In the earlier trend tables, standard errors for years up to 2002 did not use a complex samples module, and therefore indicated narrower margins of error than those shown in the tables from 2013 onwards.

In the tables, '-' represents zero, and '0' represents a percentage less than 0.5 but not zero. Where estimates are based on fewer than 50 cases these are not shown.

Population number estimates

Separate tables have been produced for key variables showing estimates of the numbers of people in the population, using prevalence data. These number estimate tables are available for fruit and vegetable consumption. The tables are accompanied by a user guide which includes a technical note explaining how they are produced.⁴

³ Full details of the HSE sample can be found in the 2017 Methods report at <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2017>.

⁴ Health Survey for England - 2017 Trend Tables: Population number estimates tables at <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2017>.

List of tables

1	Children's mean height, by survey year, age and sex	1995-2017
2	Children's mean weight, by survey year, age and sex	1995-2017
3	Children's self-reported cigarette smoking status, by survey year, age and sex	1997-2017
4	Children's Saliva cotinine levels of cotinine-validated non-smokers aged 4 to 15, by parental smoking	2016-2017
5	Children's self-reported experience of alcohol, by survey year, age and sex	1999-2017
6	Children's daily fruit and vegetable consumption, by survey year, age and sex	2001-2011, 2013-2017
7	Children's general health, by survey year, age and sex	1995-2017
8	Children's longstanding illness, by survey year, age and sex	1995-2009, 2011-2017
9	Children's acute sickness, by survey year, age and sex	1995-2017

Children's height and weight

Introduction

Infants (aged 0 to 1) were first included in the survey in 2001. The weight of infants over six weeks has been measured every year since 2001. Trends in children's weight are shown for the periods 1995 to 2017, based on children aged 2 to 15, and from 2001 to 2017, based on children aged 0 to 15.

Infant length was measured between 2001 and 2008, although for some years during this period the samples of infants were too small for analysis.⁵

Children's mean height, by survey year, age and sex

Tables showing mean heights for age groups of children between 2 to 15 are provided for information. The mean heights for age groups were 99.2cm for ages 2-4, 119.2cm for ages 5-7, 137.6cm for ages 8-10, 151.8 for ages 11-12 and 164.3cm for ages 13-15.

Table 1

Children's mean weight, by survey year, age and sex

Tables showing mean weights for age groups of children between 0 to 15 are provided for information. The mean weights for age groups were 9.7kg for ages 0-1, 15.8kg for ages 2-4, 23.4kg for ages 5-7, 34.5kg for ages 8-10, 45.7kg for ages 11-12 and 59.5kg for ages 13-15.

Table 2

⁵ Estimates of infant length based on the measurements of children aged under 2 between 2001 and 2008 can be found in the trend tables published in 2015, as can data on BMI for this age group. <http://www.content.digital.nhs.uk/catalogue/PUB22616>.

Children's cigarette smoking

Introduction

People who start smoking at a young age have higher prevalence rates for all types of tobacco-related cancers than others in their age group, linked primarily to their earlier exposure to the harmful toxins from cigarettes. Young smokers also experience more short and long-term respiratory symptoms than their non-smoking peers.⁶ Those who start smoking during childhood are more likely to continue smoking as adults, and less likely to give up than those who start smoking in later life. They are also likely to consume more cigarettes and suffer from a greater addiction to tobacco.⁷

The 1998 White Paper *Smoking Kills*⁸ set out the government's tobacco policy, and included a target to reduce smoking prevalence among 11 to 15 year olds to 9% by 2010. The Health Act 2006,⁹ as well as introducing smokefree legislation, introduced a further change in the law aimed at reducing the prevalence of smoking among young people. As a result, from October 2007 it became illegal to sell cigarettes to anyone under the age of 18.¹⁰ The 2009 Health Act¹¹ included measures to prohibit the display of tobacco products at the point of sale and create powers to control the sale of tobacco from vending machines. In 2011, the government's Tobacco Control Plan¹² set out further measures to reduce smoking, including ending tobacco displays in all shops, which was enacted in 2015. In 2015, the government passed legislation making it illegal to smoke in private vehicles that are carrying someone under 18, and also making it illegal for adults to buy (or try to buy) tobacco products or e-cigarettes for someone under 18¹³.

A revised Tobacco Control Plan, published in 2017, *Towards a smokefree generation*¹⁴ aims, by the end of 2022, 'to reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less'.

⁶ Action on Smoking and Health. *Asthma and Smoking*. ASH, London, 2015

<http://ash.org.uk/information-and-resources/reports-submissions/reports/ash-research-report-asthma-and-smoking/>

⁷ Chen J, Millar WJ. *Age of smoking initiation: implications for quitting*. Health Reports 1998; **9**: 39-46.

⁸ Department of Health. *Smoking kills: a White Paper on tobacco*. DH, London, 1998.

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/PublicationsandStatistics/Publications/PublicationsPolicyAndGuidance/DH_4006684

⁹ Office of Public Sector Information. *The Health Act 2006*.

www.opsi.gov.uk/ACTS/acts2006/ukpga_20060028_en_1

¹⁰ Office of Public Sector Information. *The Children and Young Persons (Sale of Tobacco etc.) Order 2007*. Statutory Instruments 2007 No. 767. www.opsi.gov.uk/si/si2007/uksi_20070767_en_1

¹¹ Department of Health. *Health Act 2009*. Gateway Reference 11194, 12676.

www.legislation.gov.uk/ukpga/2009/21/contents

¹² Department of Health, *Healthy Lives, Healthy People: A Tobacco Control Plan for England*, 2011

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf

¹³ Department of Health & Social Care, *Rules about tobacco, e-cigarettes and smoking: 1 October 2015*

<https://www.gov.uk/government/publications/new-rules-about-tobacco-e-cigarettes-and-smoking-1-october-2015/new-rules-about-tobacco-e-cigarettes-and-smoking-1-october-2015>

¹⁴ Department of Health, *Towards a Smokefree Generation: a tobacco control plan for England*, 2017.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022_2_.pdf

Children aged 8 to 15 are asked about cigarette smoking in the HSE interview. The questions are presented in a self-completion booklet, to allow the child to answer without revealing their answers to their parents. They are asked 'Have you ever tried smoking a cigarette, even if it was only a puff or two?'¹⁵ This is followed by a question that confirms their smoking status; regardless of the answer to the first question, children are counted as smokers only if they answer 'yes' to the first question and something other than 'I have never smoked' to the second question

Trends are examined between 1997 and 2017; data from previous years are not comparable.

Children's self-reported cigarette smoking status, by survey year, age and sex

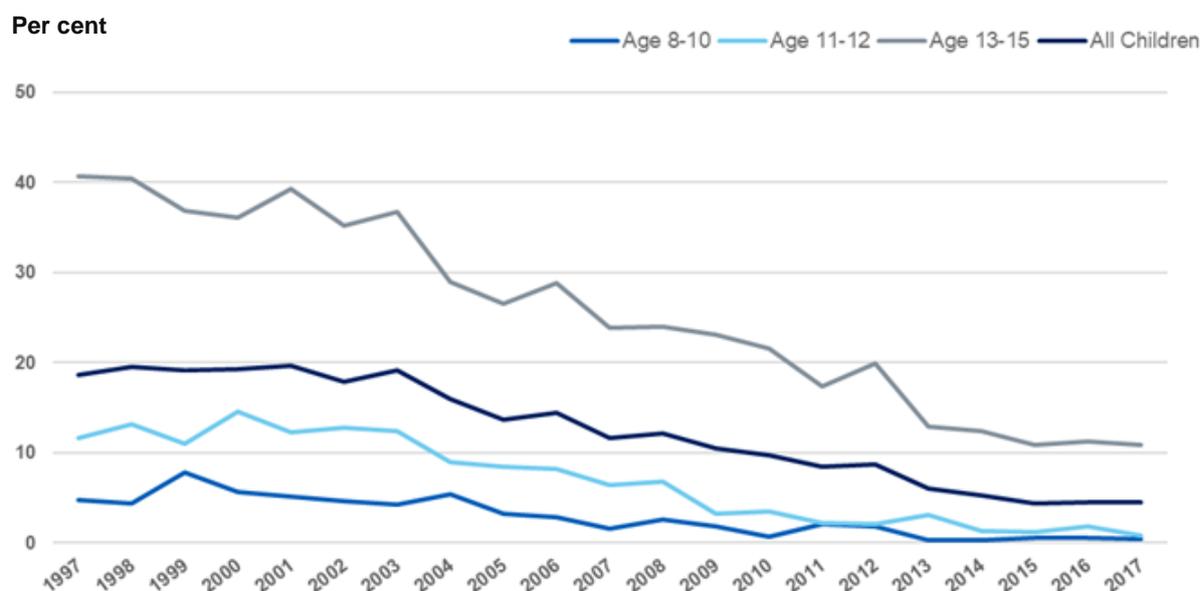
The proportion of children aged 8 to 15 who had ever smoked has decreased from 19% in 1997 to 5% in 2017¹⁶. The downward trend was apparent in all the age groups. Levels have been similar since 2013.

In all survey years, the proportion of children who had ever tried smoking generally increased with age, being much higher among those aged 13 to 15 than among younger children, as shown in Figure 3.

In 2017, 11% of children aged 13 to 15 had ever tried smoking, compared to 1% of those aged 11 to 12 and 0.4% of those aged 8 to 10.

Figure 1, Table 3

Figure 1: Proportion of children aged 8 to 15 who had ever smoked cigarettes, 1997 - 2017



Base: Aged 8 to 15

¹⁵ In 2017, the questionnaire made clear that this excludes electronic cigarettes.

¹⁶ As explained in the Introduction to this report, survey estimates are subject to a margin of error. It is likely that the proportion of children aged 8 to 15 in the population who had ever smoked was between 3% and 7% in 2017

Cotinine measurements

Cotinine, a metabolite of nicotine, provides an indicator of recent exposure to tobacco or its smoke. Cotinine is generally considered the most useful of the various biological markers that are indicators of smoking. Saliva samples were taken from children aged 4 to 15 during the nurse visit and were analysed for cotinine. The measurement of cotinine in the HSE provides an objective check on self-reported smoking behaviour. When analysed in a specialist laboratory, as is done for HSE, low levels are also a sensitive marker of exposure to other people's smoke. Cotinine has a half-life in the body of between 16-20 hours, so it will detect regular smoking but may not detect occasional smoking if the last occasion was several days ago. Sources of cotinine other than tobacco can for practical purposes be ignored.

Cotinine levels for this survey were measured using a very sensitive method.¹ The limit of detection is 0.1ng/ml. Levels below this indicate no or minimal exposure to tobacco smoke. In this report, as in the HSE 2015 report when this subject was last discussed, cotinine levels of 12ng/ml or above have been used to indicate personal smoking, while levels between 0.1ng/ml to below 12ng/ml are used to indicate exposure to second-hand smoke among non-smokers. The upper limit of 12ng/ml was revised from the threshold of 15ng/ml used in HSE reports before HSE 2013. The change was in response to research using HSE data which suggested a lower optimal cotinine cut-off to be indicative of personal smoking in populations with lower smoking prevalence.

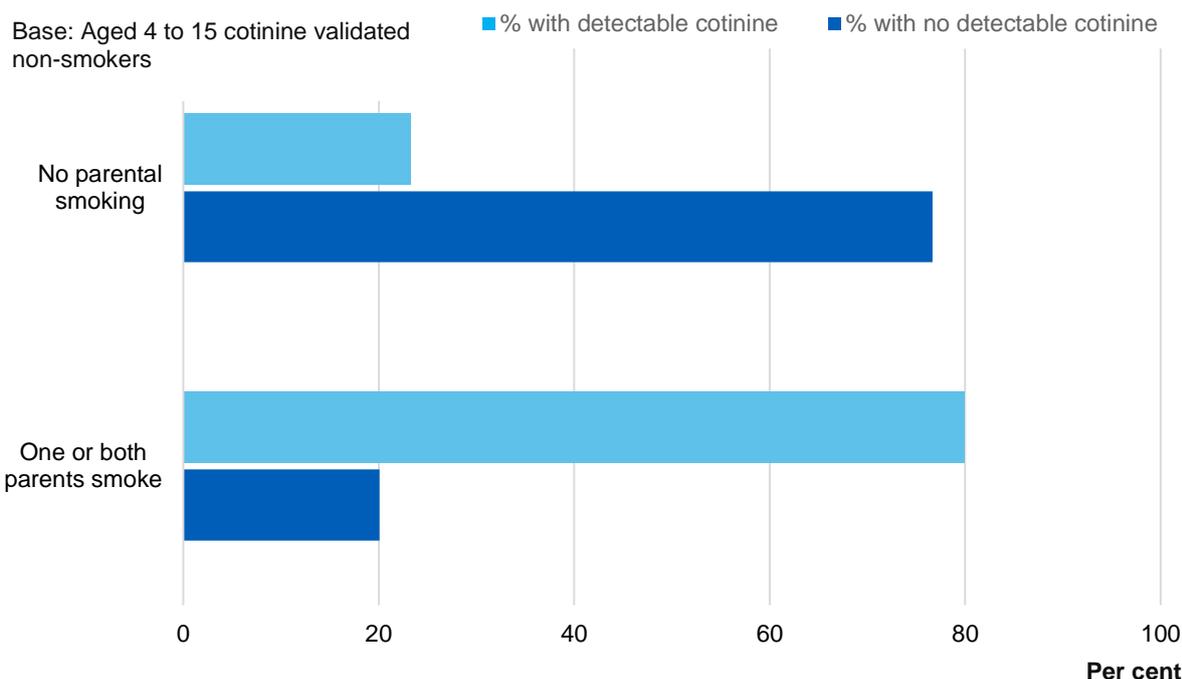
Children's cotinine levels among non-smokers, by parental smoking

23% of non-smoking children aged 4 to 15 whose parent(s) did not report being current smokers had detectable cotinine compared with 80% of non-smoking children aged 4 to 15 living in a household where one or both parents currently smoked

The geometric mean cotinine levels showed a similar pattern by parental smoking status, with higher levels among non-smoking children where one or both parents currently smoked cigarettes than among children whose parents did not smoke.

Figure 2, Table 4

Figure 2 Detectable cotinine status, by parental smoking status



Children's experience of alcohol

Introduction

The 2007 Home Office report *Safe. Sensible. Social. The next steps in the Alcohol Harm Reduction Strategy* reviewed progress since the government's alcohol harm reduction strategy was launched in 2004, and outlined renewed proposals to tackle the problems associated with alcohol misuse.¹⁷ The report identified underage drinkers as one of three problem groups to be specifically targeted. The objectives for young people focused on educating them about making responsible choices about alcohol and restricting the supply of alcohol to underage drinkers. Proposed measures included tougher law enforcement to prevent underage sales and clearer guidelines to young people and parents about the effects of youth alcohol use.

England has been identified as having one of the highest rates of regular drinking and drunkenness among young people in Europe.^{18,19} Concern has been raised about

¹⁷ Department of Health, Home Office et al. *Safe. Sensible. Social. The next steps in the national alcohol strategy*. London, 2007. http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_085386

¹⁸ Hibell B et al. *The ESPAD Report 2003: alcohol and other drug use among students in 35 European countries*. Swedish Council for Information on Alcohol and Other Drugs, Stockholm, 2004. www.drugsandalcohol.ie/5923/7/ESPAD_2003_report_part_one.pdf

¹⁹ Currie C et al (eds.). *Young People's Health in Context: international report from the HBSC 2001/02 survey*. WHO Policy Series: Health policy for children and adolescents, Issue 4. WHO Regional Office for Europe, Copenhagen, 2004. www.euro.who.int/__data/assets/pdf_file/0008/110231/e82923.pdf

increasing levels of consumption within the 11 to 13 age group and among adolescent girls.²⁰

The government published the *Youth Alcohol Action Plan*²¹ in 2008, and in 2009, the Department of Health published guidance from the Chief Medical Officer of England on alcohol consumption by children and young people.²² This included a recommendation that children under the age of 15 do not drink any alcohol at all and that alcohol consumption for 15 to 17 year olds should be under the supervision of a parent or carer. In 2012, the government published its alcohol strategy. One of the key outcomes identified was 'a sustained reduction in both the numbers of 11 to 15 year olds drinking alcohol and the amounts consumed'.²³ In 2014, the government introduced a ban on the sale of alcohol below the cost of duty plus VAT, aiming 'to reduce excessive alcohol consumption and its associated impact on alcohol related crime'²³

Children aged 8 to 15 are asked about their experience of alcohol in the HSE interview. The questions are presented in a self-completion booklet, to allow the child to answer without revealing their answers to their parents. They are asked 'Have you ever had a proper alcoholic drink – a whole drink, not just a sip?' This is followed by a second question, added in 1999: 'Have you ever drunk alcopops (such as Bacardi Breezer, Smirnoff Ice, WKD etc)?' Children are counted as having drunk alcohol if they answer 'yes' to either question.

Trends are examined between 1999 and 2017; data from previous years are not comparable.

Children's self-reported experience of alcohol, by survey year, age and sex

The proportion of children aged 8 to 15 reporting ever having had a proper alcoholic drink – a whole drink, not just a sip - fell from 45% in 2003 to 14% in 2017.²⁴

The prevalence of boys aged 8 to 15 ever having had a proper alcoholic drink varied between 42% and 47% between 1999 and 2003, but has fallen since then. From 2014 to 2017, the proportion has remained the same, at 16%.

²⁰ Alcohol Concern. *Young People's Drinking*. Acquire: Alcohol Concern's Quarterly Information and Research Bulletin. Alcohol Concern, London, 2006.

²¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/238735/7387.pdf

²² Department of Health. *Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical Office*. DH, London, 2009.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110256.pdf

²³ HM Government. *The Government's alcohol strategy*. London, 2012.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

²³ The Home Office, *Guidance on banning the sale of alcohol below the cost of duty plus VAT*, London, 2016

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/619234/2017-03-13_HO_Guidance_on_BBCS__1_.pdf

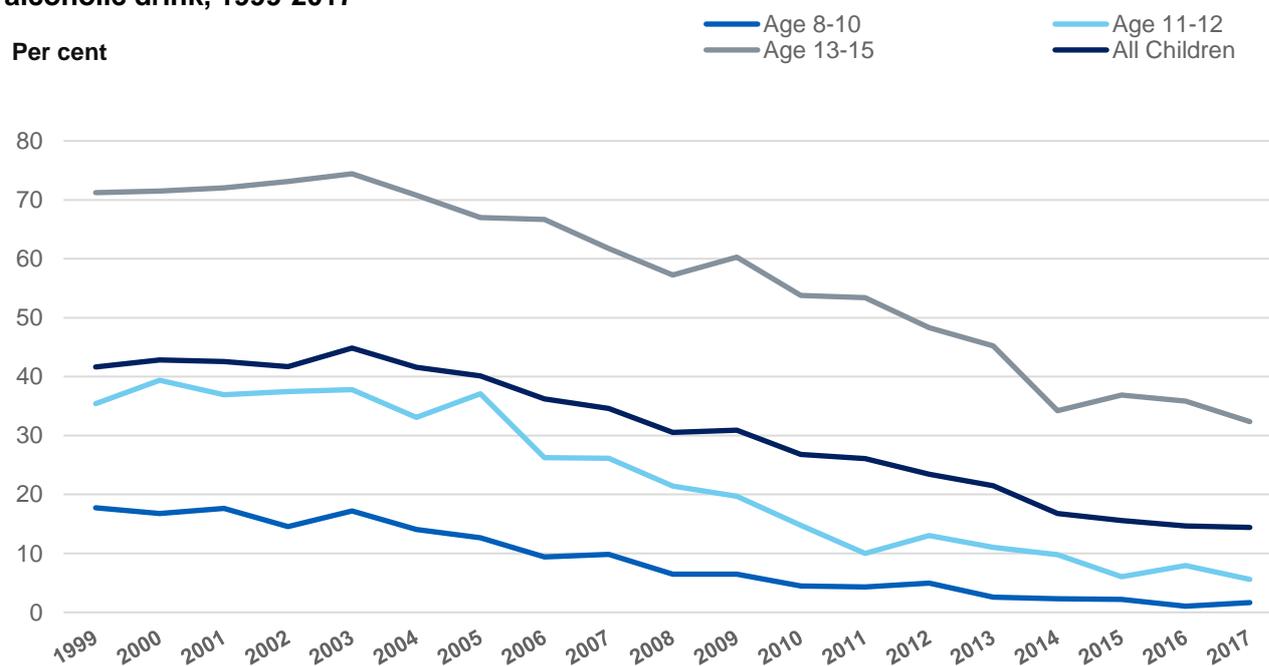
²⁴ As explained in the Introduction to this report, survey estimates are subject to a margin of error. It is likely that proportion of children aged 8 to 15 in the population who had ever had a proper alcoholic drink was between 12% and 18%.

The proportion of girls aged 8 to 15 who had ever had a proper alcoholic drink varied between 39% and 43% from 1999 to 2004, and has dropped since then. The decline has been particularly marked since 2013, declining 10 percentage points from 23% to 13% in 2017.

As with smoking, the proportion ever having had a proper alcoholic drink increased from younger to older children. Only small proportions of younger children had tried drinking: 2% aged 8 to 10 and 6% aged 11 to 12, compared with 32% aged 13 to 15 in 2017.

Figure 3, Table 5

Figure 3: Proportion of children ages 8 to 15 who have ever had a proper alcoholic drink, 1999-2017



Children's fruit and vegetable consumption

Introduction

The protective health benefits of a diet rich in fruit and vegetables have been long recognised for both adults and children. Diet plays a key role in shaping children's health both now and later in life. A childhood diet abundant in fruit and vegetables can ensure an adequate intake of many essential nutrients and can help displace foods high in saturated fats, sugar and salt.²⁵

Many government papers raised concerns about children's diet and a number of initiatives were launched to educate children about healthier food options. For example, the National Healthy Schools Standard, part of the National Healthy Schools

²⁵ *Diet, nutrition and the prevention of chronic diseases: report of a Joint FAO/WHO Expert Consultation*. WHO Technical Report Series, No. 916. World Health Organization, Geneva, 2003. www.who.int/dietphysicalactivity/publications/trs916/en/

Programme, was implemented in 1998 and was designed to encourage schools to consider diet and nutrition in a variety of aspects of school life.²⁶

Following the 1997 white paper *Excellence in Schools*,²⁷ and 2003 Green Paper *Every Child Matters*,²⁸ in which the government pledged to help all schools to become healthy, there was a focus on implementing initiatives in schools which aim to educate and provide children with healthy food options, in particular wider access to fruit and vegetables. These included the School Fruit and Vegetable Scheme,²⁹ breakfast clubs and fruit tuck shops. The School Fruit and Vegetable Scheme was introduced in 2004 as part of the 5 A DAY programme to reinforce messages about improving children's diets and to minimise the health inequalities experienced by some groups of the population.

In an attempt to remove the inequalities that exist in accessing a healthy nutritious diet, the government's 2005 *Food and Health Action Plan*³⁰ set out a strategy to promote a healthy balanced diet. This framework focused on improving access to, and increasing the average consumption of a variety of fruit and vegetables to at least five portions per day. The 5 A DAY programme, introduced in 2000, is aimed at encouraging the population to increase their consumption of fruit and vegetables.

Fruit and vegetable consumption is measured among children aged 5 to 15 in the HSE interview, using the same questions as for adults. There are no figures available for fruit and vegetable consumption in 2012 because it was not collected in the survey that year.

Children's fruit and vegetable consumption, by survey year, age and sex

In 2017, 18% of children aged between 5 and 15 ate the recommended³¹ five or more portions of fruit and vegetables a day.

The proportion of children eating five or more portions per day was 11% in 2003 and then increased to 21% in 2006. Since 2007, the prevalence of eating five or more portions has varied between 16% and 23% with no clear trend.

Between 2001 and 2004, the mean number of portions of fruit and vegetables consumed among children aged 5 to 15 was stable between 2.5 and 2.7 portions.

²⁶ NHS and Department for Children, Schools and Families. *Introduction to the National Healthy Schools Programme*.

²⁷ Department for Education and Skills White Paper. *Excellence in Schools*. Cm 3681. The Stationery Office, London, 1997. www.educationengland.org.uk/documents/wp1997/excellence-in-schools.html

²⁸ Department for Education and Skills Green Paper. *Every Child Matters*. Cm 5860. The Stationery Office, London, 2003. <https://www.gov.uk/government/publications/every-child-matters>

²⁹ Department of Health. *School Fruit and Vegetable Scheme*. http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/PublicHealth/Healthimprovement/FiveADay/FiveADaygeneralinformation/DH_4002149

³⁰ Department of Health. *Choosing a Better Diet: a food and health action plan*. DH, London, 2005. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105709.pdf

³¹ The 5 A DAY programme advice is that children should eat at least five portions of a variety of fruit and vegetables a day, but that the child portion size varies with age, body size and levels of physical activity. See <https://www.nhs.uk/Livewell/5ADAY/Pages/Portionsizes.aspx>. HSE questions are based on an 80g portion size for all age groups.

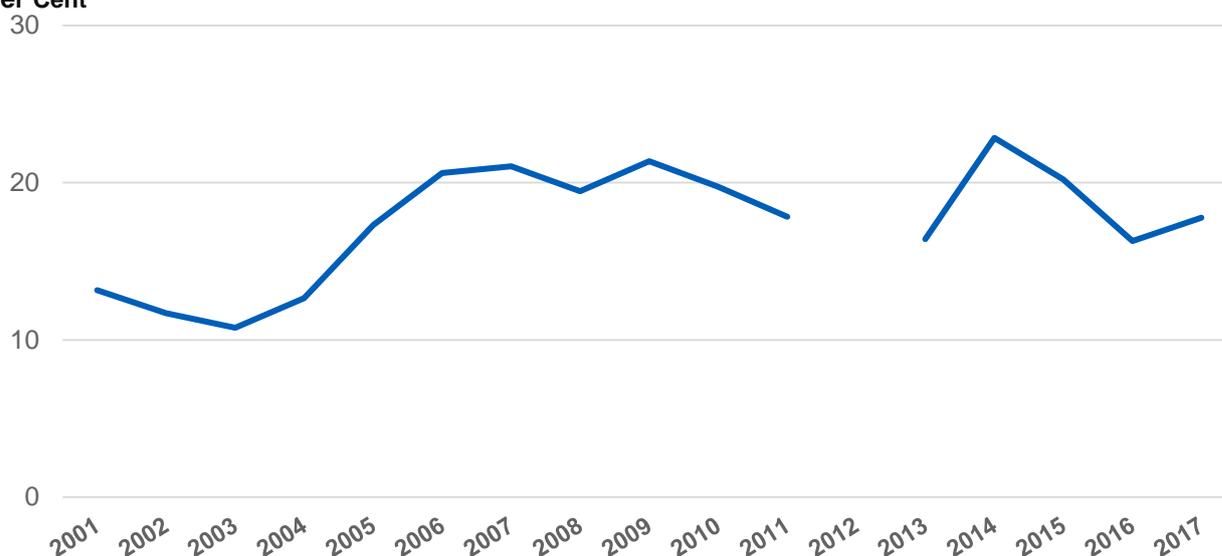
There was an increase to 3.3 portions in 2006 and 2007 and it has fluctuated between 3.0 and 3.5 since then. In 2017 it was 3.2.

Figure 4, Table 6

Figure 4: Proportion of children ages 5 to 15 who ate five or more portions of fruit and vegetables per day, 2001-2017

Base: Aged 5 to 15

Per Cent



Population estimates for fruit and vegetable consumption by children aged 5 to 15 between 2003 and 2017 are available in the population number estimate tables.

Children's general health

Introduction

Information was collected for children about self-reported general health, longstanding illness and acute sickness.

Self-assessed general health is an important indicator of the general health of the population. It is a valid measure for predicting future health outcomes and can be used to project use of health services and provide information useful for policy development. Like self-reported general health, longstanding illness is a valuable indicator of the health of the population, and is also an indicator of inequalities, with links between poverty, social class and self-assessed longstanding illness.

In 2012, the questions on longstanding illness were changed to be consistent with the harmonised disability questions designed for use in social surveys, as recommended by the Disability, Health and Carers Primary Standards in 2011.³² The new questions

³² Office for National Statistics. Harmonised Concepts and Questions for Social Data Sources: Primary Standards. Long-lasting Health Conditions and Illnesses; Impairments and Disability. ONS, Newport, 2011. <http://webarchive.nationalarchives.gov.uk/20160106185646/http://www.ons.gov.uk/ons/guide-method/harmonisation/primary-set-of-harmonised-concepts-and-questions/index.html>

meet government requirements for the classification of disability for the core population with rights under the Equality Act. These questions explicitly ask about physical and mental health, separate the concept of disability from illnesses or health conditions, and refer to illnesses or conditions 'lasting or expected to last 12 months or more' rather than 'over a period of time'.³³

Acute sickness is defined as any illness or injury (including any longstanding condition) that has caused the participant to cut down in the last two weeks on things they usually did.

Parents answered on behalf of children aged 0 to 12, and children aged 13 to 15 answered their own questions, with a parent or guardian present.

Children's general health, by survey year, age and sex

Over the period from 1995 to 2017, at least 90% of boys and girls reported very good or good general health. The proportion of children reporting very good or good health has varied across the period, between 90% and 96% among boys and girls. In 2017, 94% of boys and 95% of girls reported very good or good health.³⁴

Table 7

Children's longstanding illness, by survey year, age and sex

Boys were more likely than girls to report having a longstanding illness (in 2017, 18% and 14% respectively).³⁵

Longstanding illness declined between 1995 and 2003 from 23% to 20% among boys, and from 20% to 16% among girls. Levels remained generally similar between 2003 and 2009, and stood at 21% among boys and 16% among girls in 2009.³⁶ Since 2012 when the questions were changed as explained previously, the proportions with

³³ Until 2011 the question was 'Do you have any long-standing illness, disability or infirmity? By long-standing I mean anything that has troubled you over a period of time, or that is likely to affect you over a period of time?' Since 2012 the question has been 'Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?' Further details about the change to the longstanding illness questions are provided in the 2012 report, Volume 2, Chapter 3, Section 3.4 and in Appendix D to Volume 2. <http://content.digital.nhs.uk/catalogue/PUB13218/HSE2012-Methods-and-docs.pdf>

³⁴ As explained in the Introduction to this report, survey estimates are subject to a margin of error. It is likely that the proportion of boys in the population with very good or good health was between 92% and 95%, and the proportion of girls in the population with very good or good health was between 93% and 96%.

³⁵ Taking account of the margin of error, it is likely that the proportion of boys in the population with a longstanding illness was between 15% and 21%, and the proportion of girls in the population with a longstanding illness was between 11% and 16%.

³⁶ Questions on longstanding illness were not asked of children in the survey in 2010 due to a routing error in the questionnaire. The error was corrected from October 2011. Consequently, there are no figures available for longstanding illness among children in 2010. Results for 2011 are based only on three months' data, so bases are small, margins of error are relatively wide, and the data should be interpreted with caution. No age breakdown is available for 2011.

longstanding illness have been similar (18% for boys, 14% for girls in 2017, compared to 17% and 10% respectively in 2012), slightly below the 2009 level.³⁷

Limiting longstanding illness among boys were at the same level in 1996 and 2017 (both 10%), while the proportion among girls declined over the period from 9% to 6%.

Table 8

Children's acute sickness, by survey year, age and sex

Prevalence of acute sickness generally varied between 9% and 13% between 1995 and 2010. It has been between 8% and 10% since then and was 8% in 2017.³⁸

Table 9

³⁷ The apparent difference between 2009 and 2012 may be because of the change in the questions, rather than a genuine change in prevalence.

³⁸ Taking account of the margin of error, it is likely that the prevalence of acute sickness among children in the population was between 7% and 10%.

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