



Health Survey for England 2018 Quick Guide

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This report provides a brief introduction to the content and methodology of the Health Survey for England 2018. Full details are in the report Health Survey for England 2018: Methods.

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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 who wish to understand the content of the Health Survey for England, how the survey data have been collected and the statistical methods used.

Introduction

About this guide

This Quick Guide to the Health Survey for England 2018 is designed as a reference tool to introduce the survey and indicate where further information can be found.

The Health Survey for England (HSE)

The HSE is a series of annual surveys, of which the 2018 survey is the twenty eighth. The surveys provide regular information that cannot be obtained from other sources about the public's health and health-related behaviour.

Each survey in the series includes core questions, covering general health; hypertension and diabetes; social care; health-related behaviours, including smoking and drinking alcohol; and measurements such as blood pressure, height and weight measurements and analysis of blood and saliva samples. In addition there are modules of questions on specific issues that vary from year to year.

In some years, the core sample has also been augmented by an additional boosted sample from a specific population subgroup, such as minority ethnic groups, older people or children; there was no such boost in 2018.

The HSE has been designed and carried out since 1994 by the Joint Health Surveys Unit of NatCen Social Research and the Research Department of Epidemiology and Public Health at University College London (UCL).

For a more detailed introduction to the HSE 2018, see Section 1 of the report Health Survey for England 2018: Methods.

Publications

The HSE 2018 is published online at <https://digital.nhs.uk/pubs/hse2018>. The published documents comprise the following:

- a summary of key findings
- four topic reports, each in PDF format, with supporting Excel tables
 - Overweight and obesity in adults and children
 - Asthma
 - Longstanding conditions
 - Social care

There are two reports focusing on broader measures of adult health. The report on Adults' health covers:

- general health;
- diabetes (diagnosed and undiagnosed);

- raised total cholesterol;
- hypertension (raised blood pressure);
- health-related quality of life (EQ5D).

The report on Adults' health-related behaviours covers:

- cigarette smoking, including the use of e-cigarettes and other nicotine delivery products;
- exposure to other people's smoke;
- alcohol consumption;
- fruit and vegetable consumption;
- physical activity;
- gambling behaviours.

Children's health is covered in a further report, including trend data.

These reports are supported by a Methods report, giving a full account of the technical aspects of the survey, and the survey documentation, including questionnaires, field materials and protocols for conducting survey measures.

Population estimates are available for some of the trend estimates for adults and children covering 2018 and past years. For adults, these comprise body mass index categories, cigarette smoking, average weekly alcohol consumption and fruit and vegetable consumption. For children, population estimates are shown for the prevalence of overweight and obesity and fruit and vegetable consumption.

Availability of data sets

The HSE is a long survey and only some of the results are included in the reports and data tables. Copies of the anonymised and disclosure-controlled datasets can be made available for specific research projects and teaching requirements. For the latest information about dissemination of the 2018 data please see the HSE website: <https://digital.nhs.uk/data-and-information/areas-of-interest/public-health/health-survey-for-england-health-social-care-and-lifestyles>.

Past HSE datasets are available via the UK Data Service at: <http://discover.ukdataservice.ac.uk/series/?sn=2000021>

Ethical approval

Ethical approval for the 2018 survey was obtained from the East Midlands Nottingham 2 Research Ethics Committee (Reference no. 15/EM/0254).

Sample design

Sample design

As with all previous surveys, the HSE 2018 involved a multi-stage, stratified, random probability sample designed to be representative of the population living in private households in England. Those living in institutions (such as care homes) were outside the scope of the survey.

The sampling frame was the small user Postcode Address File (PAF). The very small proportion of households living in addresses not on PAF (less than 1%) was not covered. The sample consisted of 9,612 addresses selected at random in 534 postcode sectors.

All HSE surveys cover the adult population aged 16 and over living in private households in England (up to a maximum of ten adults per household). From 1995, the survey has included children aged 2 to 15, and from 2001, infants aged under 2 have also been included. Up to four children per household were interviewed (up to two aged between 0 and 12, up to two aged between 13 and 15). Where there were three or more children in an age band, two of the children were selected at random to limit the respondent burden for parents.

For more detailed information about the sample design see Section 2 of the report Health Survey for England 2018: Methods.

The complex survey design and the method of weighting the data (see Sections 7 and 8 of the Methods report) mean that analysis and statistical tests for significance should be done in a package which takes the complex survey design into account, e.g. Stata or SPSS 15 or later versions.

Sample size

The achieved sample size for 2018 at the interview stage was 8,178 adults aged 16 and over and 2,072 children aged 0 to 15. 4,825 adults and 1,103 children had a nurse visit.

Data collection and response

Data collection

Data collection involved both interviews and self-completion. The household interview included questions on household size, composition and relationships; type of dwelling, tenure, and the number of bedrooms; car ownership; smoking within the home; the economic status and occupation of the household reference person; and household income.

Adults were asked to participate in a face-to-face interview which included a self-completion questionnaire. The content of the self-completion booklets varied with age: young adults aged 16 to 17 were asked about smoking and drinking behaviour as well as other questions. Interviewers also had the option of using this booklet for those aged 18 to 24 if they felt that it would be difficult for anyone in this age group to give honest answers to the questions face-to-face with other household members present.

Children aged 0 to 15 were also interviewed and were eligible for a nurse visit. During the interview, those aged 13 to 15 answered on their own behalf while parents answered on behalf of children aged 0 to 12. In addition, children aged 8 and over answered questions on some sensitive topics within a self-completion questionnaire.

On the following pages of this guide, Table 1 summarises the interview topic coverage, and Table 2 summarises the questions included in the self-completion booklets.

Interviewers also measured the weight of all participants and the height of everyone aged 2 and over.

In 2018, for the first time, only a proportion (89%) of addresses were eligible for nurse visits. In these households, nurse visits were offered to all participants who were interviewed (both adults and children).

The nurse visit included questions about prescribed medicines and, for adults, folic acid and nicotine replacement products. Nurses took waist and hip measurements for those aged 11 and over and measured the blood pressure of those aged 5 and over.

Adults were also asked to provide non-fasting blood samples¹ for the analysis of total cholesterol and HDL cholesterol, and glycated haemoglobin. Samples of saliva were taken from children aged between 4 and 15 for the analysis of cotinine (a derivative of nicotine that shows recent exposure to tobacco or tobacco smoke). Written consent was obtained for these samples. Details of the analysis of these samples are provided in Section 9 of the report Health Survey for England 2018: Methods.

Further information about topic coverage can be found in Section 3 of the report Health Survey for England 2018: Methods.

¹ For some blood sample analyses it is necessary for participants to fast for a period before the sample is taken as the composition of the blood sample is affected by recent intake of food or drink. However, for the analytes in the HSE, 'non-fasting' blood samples can be used and participants do not have to fast before the nurse visit.

Table 1: Content of interview by age group

Age in years	0-1	2-4	5-15	16-64	65+
General health, longstanding illness, limiting longstanding illness	•	•	•	•	•
Doctor diagnosed hypertension and diabetes				•	•
Breathing problems	•	•	•	•	•
Receipt of social care					•
Fruit and vegetable consumption			•	•	•
Smoking, e-cigarettes and other nicotine delivery products ^a				• ^a	•
Exposure to second-hand smoke	•	•	•	•	•
Drinking alcohol ^a				• ^a	•
Economic status, occupation				•	•
Educational attainment				•	•
National identity				•	•
Ethnic origin	•	•	•	•	•
Height and weight measurements		•	•	•	•
Consent to link data to health records				•	•

^a Questions about smoking, e-cigarette use and drinking alcohol were included in the self-completion questionnaires for young adults aged 16 to 17. Interviewers also had the option of using this booklet for those aged 18 to 24 if they felt that they would be inhibited from giving honest answers to the questions face-to-face with other household members present.

Table 2: Content of self-completion booklets by age group

Age in years	8-12	13-15	16-17	18+
Smoking ^a	•	•	•	
E-cigarettes ^a	•	•	•	
Other nicotine delivery products ^a		•	•	
Exposure to second-hand smoke	•	•	•	
Drinking alcohol ^a	•	•	•	
EQ-5D (general health)			•	•
General Health Questionnaire (GHQ-12)		•	•	•
Gambling behaviour			•	•
Physical activity (IPAQ) ²			•	•
Sexual orientation			•	•
National identity	•	•		
Religion	•	•	•	•

^a Interviewers had the option of using the booklet for those aged 18 to 24 if they felt that they would be inhibited from giving honest answers to the questions about smoking, e-cigarette use and drinking alcohol face-to-face with other household members present.

Fieldwork procedures, documents and protocols

Full details of the fieldwork procedures can be found in Sections 4 and 5 of the report Health Survey for England 2018: Methods.

Copies of the fieldwork documents and the protocols used for measurements and sample collection are available via <https://digital.nhs.uk/pubs/hse2018>.

Interview length

Interviews could be conducted with between one and four persons per session; the most common session types were with one or two individuals. The median (average) interview length for a single adult was 40 minutes, and for two people (including at least one adult) median interview length was 57 minutes. Nurse visits were conducted

² Physical activity was asked about in less detail than in 2016 and 2012.

with a single individual at a time, and the nurse visit for adults who took part in all the measurements averaged 32 minutes.³

Interviews with children were shorter than with adults, and the interview length varied with age as some modules were only asked of older children. When children were interviewed without adults, for a single child aged 8 to 15 the median interview length was 14 minutes and the median length of the nurse interview was 16 minutes.

Consents

It is important to ensure that participants aged 16 and over give informed consent for all stages of the interview and nurse visit process. For some elements of the survey, verbal consent was sought: for taking part in the survey at all, for answering modules of questions (and any individual question), for completing the self-completion booklet, and for measurements such as height, weight, blood pressure and waist and hip circumference. Verbal consent was not recorded; it is assumed that those who took part in the survey, and answered individual questions or provided physical measurements had consented to do so.

Written consent was obtained for the following during the interview or nurse visit.

- taking biological measurements (blood samples)
- passing on information to others, for instance sending biological sample results to the participant's GP
- storing blood samples for future use
- using personal details for matching to administrative data.

Adults aged 16 and over gave informed consent for all stages of the interview and nurse visit. Parents gave written or verbal consent on behalf of their children aged 0 to 15, and children gave verbal assent for the interview, nurse visit and measurements.⁴ Where written consent had been obtained from parents, children indicated their assent by initialling a box on their consent form, if they were able to do so; if not, parents initialled to indicate that the child had given their assent.

Fieldwork period

Addresses were issued in 12 monthly batches from January to December 2018. Fieldwork was completed in March 2019.

³ The median is the value of a distribution which divides it into two equal parts such that half the cases have values below the median and half the cases have values above the median. It may be a better indicator of interview length than the mean, which can be disproportionately influenced by a relatively small number of cases with very high values (i.e. very long interviews). This can happen because of interruptions, because the respondent has a great deal of information to impart or because the pace of the interviewer is slower than usual, for example because the respondent has difficulties in comprehending questions or instructions.

⁴ Children who were asked for assent were given a clear, age-appropriate explanation that was comprehensible rather than comprehensive.

Response rate

A household response rate of 59% was achieved. A total of 8,178 adults aged 16 and over and 2,072 children aged 0 to 15 were interviewed. This is equivalent to an individual response rate of 54% of adults and 60% of children in all eligible households, whether they co-operated with the survey or not.⁵ Within co-operating households, 86% of adults and 91% of children were interviewed. 4,825 adults and 1,103 children had a nurse visit. Tables 3 and 4 show the response rates to the different survey elements for adults and children.

Table 3: Response among all adults

	Men	Women	All adults
	%	%	%
Interviewed	52	57	54
Height measured	44	50	47
Weight measured	43	48	46
Saw a nurse	30	34	32
Waist and hip measured	29	33	31
Blood pressure measured	29	33	31
Gave blood sample	23	26	24

Table 4: Response among all children

	Boys	Girls	All children
	%	%	%
Interviewed	60	61	60
Height measured	42	43	42
Weight measured	46	48	47
Saw a nurse	33	31	32

The response rate varied by age and sex as well as by region and type of dwelling.

For a more detailed description of the 2018 survey response, see Section 6 of the report Health Survey for England 2018: Methods.

⁵ For information on how the numbers of adults in non co-operating households were estimated, see Section 6 of the HSE 2018 Methods report.

Analysis

Weighting the data

Weighting is applied to HSE 2018 data to correct for probabilities of selection and to minimise bias from non-response.

Selection weights have been applied to HSE samples to correct for the probability of selection in two situations:

- If there were multiple dwelling units or households at a selected address, in which case only one was selected at random
- If there were more than two children aged between 0 and 12 and/or between 13 and 15 at the selected address, in which case two in each age band were selected at random.

From 2003 a non-response adjustment was also incorporated into the weighting strategy. Both selection and non-response weights were applied to HSE 2018 data, and an interview weight was calculated. To account for sample attrition, further separate weights have been calculated for data from different stages of the survey (see below).

Further detail about how the weights were calculated and combined can be found in Section 7 of the report Health Survey for England 2018: Methods.

Note that the complex survey design and the method of weighting the data mean that analysis and statistical tests for significance should be done in a package which takes the complex survey design into account, e.g. Stata or SPSS version 15 or later.

Selecting the appropriate weight

Different weights have been provided to be used as appropriate.

- Interview
- Nurse visit
- Blood sample (adults)
- Cotinine (saliva) sample (children)
- Gambling module.

If questions from different stages of the survey are combined in analysis, the weights for the latest stage of the survey should be used (that is, the latest in the list above). For instance, if blood sample results are being cross-tabulated with questions from the interview stage, the blood sample weight should be used; or if waist circumference results (from the nurse visit) are cross-tabulated with BMI data from the interview, the nurse visit weight should be used.

Weighted data

All 2018 data in the topic reports and trend tables are weighted. Both weighted and unweighted bases are given in each table. The weighted numbers show the relative size of each group in the population, so that data from different columns can be combined in their correct proportions. The unweighted bases show the actual number of participants in each group.

Accuracy and reliability of survey estimates

HSE, 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 the topic reports and trend commentary, 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.⁶

Confidence intervals are quoted for key statistics within individual reports and are also shown in more detail in the Excel tables accompanying each 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.

Design effects and true standard errors

The HSE 2018 used a complex survey and weighting design. One of the effects of this is that standard errors and confidence intervals for survey estimates are generally larger than those that would be derived from an unweighted simple random sample of the same size.

The ratio of the standard error of the complex sample to that of a simple random sample of the same size is known as the design factor. It is the factor by which the standard error of an estimate from a simple random sample has to be multiplied to give the true standard error of the complex design.

True standard errors and design factors are shown for key survey estimates within the HSE 2018 reports.

⁶ Statistical significance does not imply substantive importance; differences that are statistically significant are not necessarily meaningful or relevant.

Survey limitations

The HSE is a cross-sectional survey of the population. It examines associations between health states, personal characteristics and behaviour. However, such associations do not necessarily imply causality. In particular, associations between current health states and current behaviour need careful interpretation, as current health may reflect past, rather than present, behaviour (for instance, current liver disease may reflect previous heavy drinking, although no alcohol is currently consumed). Similarly, current behaviour may be influenced by advice or treatment for particular health conditions (for instance, not smoking currently because of advice relating to lung disease caused by previous smoking).

Standard breakdowns

For most data analysis in the topic reports, three or four standard analysis breakdowns have been used. See Section 8 of the report Health Survey for England 2018: Methods.

Age

For adults, 10-year age groups have been used in the trend tables and topic reports, from 25 to 34 upwards (with 16 to 24 as the youngest age group). Where numbers allow, the oldest age group reported is 85 and over.

The age groups shown for children vary, as pragmatic decisions have been taken to make the results as meaningful as possible. The age groups used are a compromise between providing detailed age-specific data while ensuring sufficient bases for each analysis.

Region

Analysis by region is provided throughout the topic reports. The former nine Government Office Regions have been used.

Both observed and age-standardised data are provided by region in the tables. Observed data can be used to examine actual prevalence or mean values within a region. Age-standardised data are required for comparisons between regions to exclude age-related effects.

Base sizes for regions can be relatively small, and caution should be exercised in examining regional differences.

Equivalent household income

The HSE uses the measure of equivalent household income, which takes into account the number of adults and dependent children in the household as well as overall household income. Households are divided into quintiles (fifths) based on this measure. The age profile of the income quintiles have been age-standardised to account for differences in age profiles between households.

For information about how equivalent income is calculated, see Section 8 and Appendix B: Glossary in the HSE 2018 Methods report.

Index of Multiple Deprivation (IMD)

The English Index of Multiple Deprivation (IMD) is a measure of area deprivation, based on 37 indicators, across seven domains of deprivation.⁷ IMD is a measure of the overall deprivation experienced by people living in a neighbourhood, although not everyone who lives in a deprived neighbourhood will be deprived themselves. To enable comparisons, areas are classified into quintiles (fifths). The age profile of the IMD quintiles have been age-standardised to account for different area age profiles.

For further information about the IMD, see Section 8 and Appendix B: Glossary in the HSE 2018 Methods report.

Age-standardisation

Adult data within this report have been age-standardised to allow comparisons between groups after adjusting for the effects of any differences in their age distributions. When different sub-groups are compared in respect of a variable on which age has an important influence, any differences in age distributions between these sub-groups are likely to affect the observed differences in the proportions of interest. For information about the method used, see Section 8.6 of the HSE 2018 Methods report.

Table conventions

For further information about the table conventions see the notes at the beginning of the Excel tables for each report, available via <https://digital.nhs.uk/pubs/hse2018>.

For further information about the data analysis and reporting of HSE 2018, see Section 8 of the report Health Survey for England 2018: Methods.

Biological samples

Sample analytes

Blood samples were tested for total and HDL cholesterol and glycated haemoglobin (HbA_{1c}). Saliva samples were tested for cotinine, a derivative of nicotine.

Quality control of blood and saliva analytes

The overall conclusion for the 2018 data is that methods and equipment used for the measurement of blood and saliva analytes produced internal quality control (IQC) and external quality assessment (EQA) results within expected limits. The results of the analyses for each of the main blood analytes and saliva cotinine levels were acceptable for the HSE 2018.

⁷ The seven domains used to calculate IMD are: income deprivation; employment deprivation; health deprivation and disability; education; skills and training deprivation; crime; barriers to housing and services; and living environment deprivation.

For details of procedures used in the collection, processing and transportation of the biological specimens see Section 9 of the report Health Survey for England 2018: Methods, and the accompanying documentation.

Internal Quality Control (IQC)

ICQs help identify and prevent the release of any errors in an analytical run, as well as being used to monitor trends over time.

For each analyte or group of analytes, the laboratory obtains a supply of quality control materials. The results obtained by the laboratory are evaluated from replicate measurements (over several runs) in conjunction with target values provided by manufacturers of IQC materials, if available. IQC values are assessed against an acceptable range and samples are re-analysed if they are not within the acceptable range.

For further information on IQC see Section 9 of the report Health Survey for England 2018: Methods, and the accompanying Excel tables.

External Quality Assessment (EQA)

EQAs allow the comparison of results between laboratories measuring the same analyte. An EQA scheme for an analyte or group of analytes distributes aliquots (sub-samples) of the same samples to participating laboratories, which are blind to the concentration of the sample received. This process is repeated with multiple samples over the course of a year. Results are returned to the scheme organisers, who provide a laboratory-specific report including the mean values, measures of between-laboratory precision and the bias of the results obtained by that laboratory.

EQA is a retrospective process of assessment of performance, especially of inaccuracy or bias related to mean values. Unlike IQC it does not provide control of release of results at the time of analysis.

There was no external quality control scheme available in 2018 for cotinine analysis but ABS Laboratories participates in inter-laboratory split analyses to ensure comparable results.

For further information on EQA see Section 9 of the report Health Survey for England 2018: Methods and the accompanying Excel tables.

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