Health Survey for England

2009

Health and lifestyles

Summary of key findings

A survey carried out on behalf of The NHS Information Centre

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Introduction

The Health Survey for England (HSE) is part of a programme of surveys commissioned by The NHS Information Centre for health and social care (NHS IC), and carried out since 1994 by the Joint Health Surveys Unit of the National Centre for Social Research (NatCen) and the Department of Epidemiology and Public Health at the UCL Medical School. The study provides regular information that cannot be obtained from other sources on a range of aspects concerning the public’s health and many of the factors that affect health. The series of Health Surveys for England was designed to monitor trends in the nation’s health, to estimate the proportion of people in England who have specified health conditions, and to estimate the prevalence of certain risk factors and combinations of risk factors associated with these conditions. The survey is also used to monitor progress towards selected health targets.

Each survey in the series includes core questions and measurements (such as blood pressure, anthropometric measurements and analysis of blood, saliva and urine samples), as well as modules of questions on specific issues that vary from year to year. In recent 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, as in this year’s survey, children.

This is the nineteenth annual Health Survey for England. All surveys have covered the adult population aged 16 and over living in private households in England. Since 1995, the surveys have included children who live in households selected for the survey; children aged 2-15 were included from 1995, and infants under two years old were added in 2001. Those living in institutions were outside the scope of the survey. This should be borne in mind when considering survey findings since the institutional population is likely to be older and, on average, less healthy than those living in private households.

The HSE in 2009 included a general population sample of adults and children, representative of the whole population at both national and regional level, and a boost sample of children aged 2-15. For the general population sample, 4,680 addresses were randomly selected in 360 postcode sectors, issued over twelve months from January to December 2009. Where an address was found to have multiple dwelling units, one was selected at random. Where there were multiple households at a dwelling unit, a random selection was made and a single household was included.

All adults and children in selected households were eligible for inclusion in the survey. Where there were three or more children aged 0-15 in a household, two of the children were selected at random to limit the respondent burden for parents. A nurse visit was arranged for all participants who consented.

In addition to the core general population sample, a boost sample of children aged 2-15 was selected using 12,600 addresses. These were drawn from the 360 core sampling points and an additional 180 boost only sampling points. As for the core sample, where there were three or more children in a household, two of the children were selected at random. There was no nurse follow up for this child boost sample.

A total of 4,645 adults and 3,957 children were interviewed in 2009, with 1,147 children from the core sample and 2,810 from the boost. A household response rate of 68% was achieved for the core sample, and 74% for the boost sample. Among the general population sample, 3,261 adults and 807 children had a nurse visit.
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* This module was administered by self-completion.
* This module was administered by self-completion for those aged 16-17 and some aged 18-24.
The HSE in 2009 was a short survey with a relatively small sample size, providing an update on core topics such as general health, fruit and vegetable consumption, alcohol consumption and smoking. Small additional modules of questions were also included, covering kidney disease, and personal care plans for those with longstanding illnesses or conditions. Participants were interviewed, and for those in the core sample this was followed by a visit from a specially trained nurse.

Height was measured for participants aged two and over, and weight was measured for all participants. Nurses measured waist and hip circumference among those aged 11 and over and blood pressure among those aged 16 and over. Non-fasting blood samples and urine samples were collected from adults aged 16 and over, and saliva samples for cotinine analysis from adults aged 16 and over and children aged 4-15. Nurses obtained written consent before taking samples from adults, and parents gave written consent for their children’s samples. Consent was also obtained from adults to send results to their GPs.

This booklet presents findings for adults and children from the 2009 Health Survey for England. All 2009 data in this report are weighted. Data for adults in the general population have been weighted to allow for non-response, and data for children (combining core and boost samples) have been weighted for selection differences and non-response. Both weighted and unweighted bases are given in each table in the main report. The unweighted bases show the number of participants involved. The weighted bases show the relative sizes of the various sample elements after weighting, reflecting their proportions in the population in England.

The full report consists of two volumes, published as a set as ‘The Health Survey for England 2009’:
1. Health and lifestyles
2. Methods and documentation.

The second volume, Methods and documentation, provides details of the survey design, methods and response.
Longstanding illness and personal care plans

Longstanding illness is an important indicator of the health of the general population, and is also an important indicator of inequalities, with strong links between poverty, social class and self-assessed longstanding illness. As the population ages, the number of people with a longstanding illness or condition is expected to rise.

Personal care plans were introduced in 2006 as part of a strategy to support and empower people with long term conditions. The aim was to offer them to everybody with a longstanding illness by the end of 2010, and the strategy sought to place the patient at the centre of their care. The intention was that those with longstanding conditions should be able to make informed decisions about the treatment that they receive and be supported to live as independently as possible for as long as they can.

A personal care plan is a written agreement between a patient and their health professional about the care and support required to manage a long term condition. The plans enable people to manage the treatment of their illness and the services they receive by creating a personalised package of care.

Men and women reported a similar prevalence of longstanding illness (41% of men, 43% of women). Almost a quarter reported an illness that limited their activity in some way (22% of men and 23% of women). Overall fewer men than women reported having two or more longstanding illnesses (16% of men and 19% of women). The prevalence of longstanding illness and limiting longstanding illness increased with age in both sexes. A similar increase with age was also found among those with two or more illnesses.

Overall, 15% of men and 17% of women with a longstanding illness reported having agreed a personal care plan, with the majority having agreed this in the last 12 months (12% of men and 13% of women). Most of those with a longstanding illness who had not agreed a personal care plan said that they did not want one; however around one in five reported that they would have liked one.

The initial findings in the 2009 HSE suggest that personal care plans have so far made a favourable impact on the care of those with longstanding illness, and may act as a catalyst for investigating options and taking self care initiatives. Overall 67% of men and 70% of women with a personal care plan said that it had improved the health and social care services they received. There was a clear association between active participation in self-care and whether or not a personal care plan had been agreed. 65% of men and 59% of women with a longstanding illness who did not have a personal care plan did not actively participate in self care options examined, compared with just 32% of men and 28% of women with a personal care plan.

The two most commonly reported options for self care, both offered by health professionals and taken up by adults with a longstanding illness, were ‘help to find information about a condition’ and ‘help to find information about choices for care’.

Health and lifestyle factors among adults
Chronic kidney disease (CKD) is recognised as a global public health problem. Studies in Australia, USA, and Europe have found an overall prevalence of 10-16% in adults. One study from the USA has shown an increase in prevalence over the last few decades. Some key factors associated with moderate CKD are increasing age, female sex, lower socio-economic status, hypertension (both cause and consequence), and diabetes. Key factors associated with progression include proteinuria (protein in the urine including albumin) and higher blood pressure levels.

The main absolute risk associated with CKD is cardiovascular morbidity and mortality. Obesity and metabolic syndrome are also associated with CKD by a variety of mechanisms and not just through Type 2 diabetes and hypertension. Some patients have progressive loss of kidney function and may develop symptoms due to complications such as anaemia; those who develop severe CKD may require renal replacement therapy (RRT) by dialysis or transplantation. In England in 2009, the rate of people starting RRT was 109 per million population (pmp) and the prevalence of RRT was 767 pmp. Such treatments are costly, with the annual cost of haemodialysis being over £20,000 per person.

In the HSE, renal (kidney) function was assessed in two ways. Serum creatinine levels were used to estimate glomerular filtration rate (eGFR), and albuminuria, the presence of albumin in the urine, was measured using the albumin:creatinine ratio.

7.6% of men and 7.9% of women reported having been tested for kidney disease, and 1.5% of men and 1.3% of women reported having doctor-diagnosed CKD. The prevalence of self-reported kidney disease increased with age until 65-74 and then declined slightly for both men and women. Prevalence of the disease peaked at age 65-74 for both men (3.7%) and women (3.0%).

47% of men and 49% of women had abnormal kidney function, i.e. eGFR levels less than 90 ml/min/1.73m²; this included 5% of men and 7% of women who had levels less than 60 ml/min/1.73m². The proportion of both men and women with abnormal eGFR levels increased with age.
A slightly higher proportion of men than women had abnormal urinary albumin excretion (10% and 8% respectively). The proportion increased steadily with age for men (from 6% in men aged 16-54 to 26% in those aged 75 and over). For women, there was little variation up to the age of 74 (6-9%) but a significant increase to 18% in the oldest age group.

Overall, 5% of men and 7% of women had stage 3-5 chronic kidney disease, although most of these participants did not report a doctor diagnosis. Again there was strong variation by age, with only 1% of men and 2% of women aged 16-54 at stage 3-5, but this rose to 32% of men and 36% of women aged 75 and over.

Diabetes is characterised by high blood glucose levels (hyperglycaemia). Untreated, hyperglycaemia is associated with damage and possible failure of many organs, especially the eyes, kidneys, nerves, heart, and blood vessels. Type 1 and Type 2 diabetes differ; Type 1 diabetes is the result of an autoimmune destruction of the cells of the pancreas which produce insulin, and is treated with insulin injections. Type 2 diabetes is characterised by the inability of the body to respond to insulin and/or insufficient insulin secretion, and is controlled with diet and then drugs, and sometimes with insulin therapy. Type 2 diabetes is more common, accounting for about 90% of all diabetes in England. Diabetes substantially increases the risk of cardiovascular disease (CVD), and tends to worsen the effect of other risk factors for CVD such as dyslipidaemia (abnormal levels of blood fats), hypertension, smoking and obesity. Being overweight or having a raised waist measurement are risk factors for diabetes. Diabetes mellitus (including Types 1 and 2 and, among women, gestational diabetes) is a leading cause of avoidable mortality; it is estimated that 11.6% of all deaths among those aged 20–79 in England in 2005 were as a result of diabetes.

Overall, the prevalence of doctor-diagnosed diabetes was significantly higher in men than in women (6.5% and 4.5% respectively). Diabetes prevalence was below 5% in men and 4% in women aged up to 54, after which it increased substantially with age in both sexes.

Glycated haemoglobin reflects medium-term blood glucose levels and is used for assessing diabetic control. In this report, a raised glycated haemoglobin level is taken to be 6.5% or more in the general population, while levels below 6.5% in people with doctor-diagnosed diabetes is indicative of good control of diabetes. More men than women had a raised glycated haemoglobin level of 6.5% or above (6.8% and 4.9% respectively). This proportion increased with age in both sexes.

Among those aged 35 and over, the prevalence of both age-standardised doctor-diagnosed diabetes and raised glycated haemoglobin varied across income groups. Prevalence of doctor-diagnosed diabetes was lowest among those in the highest equivalised household
income tertile (6.9% of men and 1.7% of women), and highest in the middle and lowest tertiles (11.3% and 8.4% respectively for men, and 7.0% and 8.4% respectively for women). Prevalence of raised glycated haemoglobin was lower among those in the highest income quintile (6.2% in men and 1.3% in women) compared with those in the lowest income quintile (10.9% in men and 10.2% in women).

There has been a substantial rise in the proportion of men who reported doctor-diagnosed diabetes since 1994, from 2.9% to 6.5%; similarly there has been an increase in women, with the proportion rising by more than two percentage points from 1.9% to 4.5%.

**Hypertension**

High blood pressure, or hypertension, is an important public health challenge worldwide because of its high prevalence and the concomitant increase in risk of disease. It is the most important modifiable risk factor for cardiovascular, cerebrovascular and renal disease, and one of the most preventable and treatable causes of premature deaths worldwide.

The prevalence of survey-defined hypertension (at least 140mmHg systolic and/or 90mmHg diastolic blood pressure or on treatment for hypertension) was 32% in men and 27% in women. The prevalence significantly increased with age in both sexes.

Prevalence of survey-defined hypertension was generally higher than prevalence of self-reported doctor diagnosed hypertension in all adults. 23% of men and 22% of women reported a doctor diagnosis of hypertension. Among participants with survey-defined hypertension, 45% of men and 53% of women were on treatment for hypertension, and the treatment rate increased with age across both sexes. Among those on treatment, 58% of men and 50% of women had their blood pressure controlled.

**General and psychosocial health**

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. In older people, self-assessment of poor overall health has been associated with increased risk of mortality, and has also been reported to be predictive of functional decline.

The 12-item General Health Questionnaire (GHQ12) is a widely used and validated measure of psychosocial wellbeing, and was included in the 2009 HSE. A GHQ12 score of 4 or more is referred to as a ‘high GHQ12 score’, indicating probable psychological disturbance or mental ill health.

Men and women held similar views of their own health: overall 77% of men and 76% of women reported their health as good or very good, and 7% of both men and women...
reported their health as bad or very bad. There was a strong association between self-reported health and age; 17% of men and 18% of women aged over 75 reported their health as bad or very bad, compared with 3% of both men and women aged 16 to 24. Adults living in the lowest income quintile were the most likely to consider their health as bad or very bad (18% of men and 15% of women) compared with 3% of men and 2% of women in the highest income quintile.
Women were more likely to score highly on the GHQ12 than men (18% and 15% respectively). In contrast to self-reported general ill health, there was no obvious pattern across age groups for mental ill health. There was variation according to income; men and women in the lowest income group were most likely to have a high score on the GHQ12 (23% of men and 26% of women, compared with 10% of men and 11% of women in the highest income group).

![Prevalence of high GHQ12 score, by equivalised household income and sex](image)

High GHQ12 scores were associated with physical health. Participants who reported that their health was bad or very bad were more likely to have a high GHQ12 score (52% of men, 54% of women) than participants who reported their health as good or very good (10% and 13% respectively). Similarly, participants with more than one longstanding illness were more likely to have a high GHQ12 score than participants with one longstanding illness or no illnesses; 27% of men and 32% of women with two or more illnesses had a high score compared with 17% of men and 22% of women with one illness.

**Anthropometric measures, overweight and obesity**

Obesity or overweight is a significant public health problem because it is a major risk factor for disease and mortality. A number of studies have established that overweight and obesity are associated with cardiovascular risk and cardiovascular-related mortality. Obesity is also associated with cancer, disability during older age and decreased life expectancy, as well as serious chronic conditions such as Type 2 diabetes, hypertension, and hyperlipidaemia (high levels of fat in the blood that can lead to narrowing and blockages of blood vessels).

The prevalence of overweight and obesity is indicated by body mass index (BMI) as a measure of general obesity, and/or waist circumference as a measure of abdominal obesity. BMI, defined as weight in kilograms divided by the square of the height in metres (kg/m²) was calculated in order to group people into the following categories:

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<th>Description</th>
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<td>Less than 18.5</td>
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<tr>
<td>18.5 to less than 25</td>
<td>Normal</td>
</tr>
<tr>
<td>25 to less than 30</td>
<td>Overweight</td>
</tr>
<tr>
<td>30 or more</td>
<td>obese</td>
</tr>
</tbody>
</table>

Overall, men and women had the same mean BMI (27.0kg/m²), and mean BMI generally increased with age in both sexes up to the age of 74, but dropped back slightly among those aged 75 and over.

Almost a quarter of adults (22% of men and 24% of women) were obese. 66% of men and 57% of women were overweight or obese. Among both men and women, prevalence of overweight and obesity was lowest in the 16-24 age group, and generally increased in the older groups up to the age of 74.
Levels of obesity have increased over the period measured by the HSE. In men the prevalence of obesity increased from 13% in 1993 to 22% in 2009; the 2009 level is not significantly different from the 2008 level of 24%. In women, 16% were obese in 1993 and 24% were obese in 2009, again with no significant change since 2008. There are indications that the trend may be flattening out, at least temporarily. However, it is too soon to tell whether this is the case.
A raised waist circumference is defined as greater than 102cm in men, and greater than 88cm in women. Mean waist circumference was 96.4cm in men and 87.4cm in women. A higher proportion of women than men had a raised waist circumference (44% and 32% respectively). The prevalence of raised waist circumference increased with age in both sexes up to the age group 65-74.

National Institute for Health and Clinical Excellence (NICE) guidelines define low, high and very high waist measurements for men and women. A high or very high waist circumference is associated with increased health risks for those with a BMI below 35kg/m²; health risks are very high for those with a BMI of 35 kg/m² or more with any waist circumference.

Using the NICE categories, most men and women who were overweight or obese tended also to have a high or very high waist circumference, and were therefore at increased health risk. Using combined categories of BMI and waist circumference to assess risk, 19% of men were estimated to be at increased risk, 14% at high risk and 20% at very high risk. The equivalent proportions for women were 14% at increased risk, 18% at high risk and 23% at very high risk.

The ‘5 A DAY’ programme is part of a preventative strategy aimed at improving diet and nutrition in the general population. Current guidelines recommend that adults and children should aim to eat five or more portions of fruit and vegetables each day.

Fruit and vegetable consumption is measured in portions per day, based on consumption in the day before the interview. Portions are expressed in everyday units such as whole or half fruit and tablespoons or bowls, to make it easier for survey participants to recall their consumption accurately.

More women than men consumed the recommended five or more portions of fruit and vegetables daily (25% of men, 28% of women). These proportions are similar to those reported in 2008, and are slightly lower than in 2006, when 28% of men and 32% of women consumed at least five portions daily.

Consumption varied with age among both sexes; it was lowest among those aged 16-24 (17% of men and 18% of women this age ate five or more portions), and generally increased with age until the oldest age group, where consumption was slightly lower than among those aged 55-74. As in previous years, higher consumption was also associated with higher income, and vice versa: 32% of men and 37% of women in the highest income quintile had consumed five or more portions, but only 18% of men and 19% of women in the lowest quintile had done so.
Smoking is the single greatest cause of preventable illness and premature death in the UK. Figures from the report Statistics on Smoking: England 2010 showed that in England in 2009, smoking contributed to over 81,400 deaths per year, accounting for 23% of deaths in men and 14% of deaths in women aged 35 and over. It is also estimated that around 5% (462,900) of all hospital admissions in England among adults aged 35 and over in 2008/2009 were attributable to smoking. The cost to the NHS of treating smoking-related illness is estimated to be £2.7 billion per year.

In the 2009 HSE, self-reported cigarette smoking prevalence was 24% for men and 20% for women. As in previous years, cigarette smoking prevalence varied by age, being higher among younger adults (32% for men and 26% for women aged 25-34) and lower among older adults (11% for men and 8% for women aged 75 and over).

Mean daily cigarette consumption was higher among male smokers than female smokers (13.6 for men and 12.6 for women). For both male and female smokers, mean cigarette consumption was higher among those aged 35 and over.

Cigarette smoking prevalence varied by equivalised household income. Smoking prevalence was highest among those living in the lowest income households (40% for men and 34% for women) and lowest among those living in the highest income households (14% for men and 11% for women).

Cotinine is a derivative of nicotine and a level of 15 nanograms per millilitre (ng/ml) is indicative of personal tobacco use in the past 24 hours. Among self-reported non-smokers, detectable cotinine levels of less than 15ng/ml are indicative of exposure to other people’s smoke. 26% of men and 21% of women had a cotinine value consistent with having smoked a cigarette in the previous 24 hours. This is slightly higher than self-reported smoking prevalence, and particularly among women there appears to be a low but persistent level of under-reporting of cigarette smoking behaviour.

Mean cotinine levels varied by age, being lowest among male and female smokers aged 16-34 (223.8ng/ml among men, 196.3ng/ml among women) and higher among older smokers (345.0ng/ml among men aged 55 and over and 300.8ng/ml among women aged 35-54).

Geometric mean cotinine levels among non-smokers were 0.10ng/ml for men and 0.09ng/ml for women. The 2008 HSE reported that geometric mean cotinine levels fell significantly after the introduction of smokefree legislation. The geometric mean cotinine levels observed in 2009 remained at the lower, post legislation, level, as did self-reported mean hours of exposure to other people’s smoke (on average 3.4 hours for men and 3.3 hours for women).
Drinking alcohol is generally recognised as an established part of British culture and most British adults drink alcohol, at least occasionally. Yet concern has increased in recent years among policy makers, health professionals and the general public about the damage caused by excessive drinking to individuals, communities and society as a whole. Alcohol has been identified as a causal factor in more than 60 medical conditions, including mouth, throat, stomach, liver and breast cancers; hypertensive disease (high blood pressure), cirrhosis and depression. The wider impact of alcohol has been highlighted, including damage to unborn children, parenting problems, domestic violence, road accidents, antisocial behaviour and crime. The concept of ‘passive drinking’ has been suggested, analogous to ‘passive smoking’, to raise awareness of the extent of the harms alcohol can cause.

The majority of adults had drunk alcohol in the last week; 72% of men, 56% of women. This includes 22% of men and 12% of women who had drunk alcohol on five or more days in the last week. Drinking at this frequency increased with age, from 11% of men and 4% of women aged 16-24 to 33% of men aged 55-64 and 17% of women aged 55-74.

Prevalence of drinking in the last week increased strongly in line with equivalised household income, from 54% of men and 47% of women in the lowest quintile to 86% of men and 72% of women in the highest quintile.

The current recommendations for daily alcohol intake are that it should not regularly exceed three to four units for men and two to three units for women. In the last week, 43% of men and 31% of women had drunk more than the recommended maximum on at least one day. This includes 25% of men and 15% of women who had drunk more than twice the recommended maximum.

Among those who drank in the last week, on average men consumed 8.3 units on the day they drank most in the last week, and women consumed 5.4 units. Average consumption decreased with age among both sexes.

Among those adults who drank in the last week, the majority exceeded recommendations on at least one day; 60% of men and 55% of women had done so. 35% of men and 27% of women had drunk more than twice the recommended levels on at least one day in the last week. The proportions drinking at these potentially harmful levels declined with age, from 59% of men and 49% of women aged 16-24 to just 6% of men and 1% of women aged 75 and over.

Younger age groups and those with higher incomes were most likely to have drunk more than twice the recommended limits on at least one day in the last week.
There is considerable evidence that childhood overweight and obesity can be linked with numerous long-term and immediate health risks. Childhood and adolescent obesity can persist into adulthood, where the direct health risks of obesity are severe and well established, and childhood and adolescent overweight/obesity have been linked directly to middle-age mortality and morbidity.

In addition to the increased risk for health problems in later life, children face immediate health consequences of obesity including increased risks for an abnormal lipids profile and elevated blood pressure. Associations between childhood obesity and increased asthma prevalence and the incidence of Type 2 diabetes mellitus have been reported. Overweight and obesity can also have psychological effects.

16% of boys and 15% of girls aged 2-15 were classed as obese, and 31% of boys and 28% of girls were classed as either overweight or obese. Boys aged 11-15 were more likely than those aged 2-10 to be obese (20% of boys aged 11-15, compared with 14% aged 2-10);
However there was no equivalent difference between the age groups among girls (15% were obese in each age group).

Among children aged 2-15, there was variation both in mean BMI and in the proportion of children who were obese according to equivalised household income. Girls in the highest two income quintiles were the least likely to be obese (6% in the highest quintile and 8% in the second highest), and those in the lowest two quintiles were the most likely (19% and 21%). The pattern was slightly different among boys, with similar proportions obese in the highest four quintiles, and a higher proportion in the lowest quintile (20%).

Overall, 61% of boys and 54% of girls aged 8-15 felt that they were about the right weight, while 9% of boys and 13% of girls felt that they were too heavy, and 9% of boys and 6% of girls thought they were too light (21% of boys and 28% of girls were not sure). The majority of children who thought themselves too heavy were obese (83% of boys and 59% of girls). Of those children who thought of themselves as about the right weight, 28% of boys and 17% of girls were overweight or obese.

The majority of children aged 8-15 said that they were not trying to change their weight (70% of boys and 65% of girls), while 20% of boys and 29% of girls said they were trying to lose weight. Among those who said they were trying to lose weight, 16% of boys and 24% of girls were overweight and 54% and 39% respectively were obese. Boys who were not trying to change their weight were more likely than girls to be overweight or obese (27% of boys and 18% of girls who were not trying to change their weight were overweight or obese).

The lack of significant change in the last three to four years in the proportion that were obese suggests that the trend in obesity now appears to be flattening out. It will be important to continue to monitor the trends in future HSE data to confirm that this is a continuing pattern, rather than a plateau within a longer term trend which is still gradually increasing.
This booklet is a summary of the findings from the 2009 Health Survey for England: Craig R, Hirani V (eds). Health Survey for England 2009.

Volume 1: Health and lifestyles.

Volume 2: Methods and documentation.


Full results are available in the survey report at www.ic.nhs.uk/pubs/hse09report, and also in an anonymised data file lodged with the Data Archive at the University of Essex. Reports and data files from earlier surveys are similarly available.

For the general population, tables showing selected trends from 1993 to 2009 will be found on The NHS Information Centre website at www.ic.nhs.uk/pubs/hse09trends or at the address below.

**Contact points**

**The Information Centre**
1 Trevelyan Square
Boar Lane
Leeds LS1 6AE
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**National Centre for Social Research**
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**ESRC Data Archive**
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Website: www.data-archive.ac.uk
National Centre for Social Research
www.natcen.ac.uk

The National Centre for Social Research is the largest independent social research institute in Britain, specialising in social survey and qualitative research for the development and evaluation of policy. NatCen specialises in research in public policy fields such as health, housing, employment, crime, education and political and social attitudes. Projects include ad hoc and continuous surveys, using face-to-face, telephone, online and postal methods; many use advanced applications of computer assisted interviewing. NatCen has approximately 300 staff, a national panel of over 1,000 interviewers, and 150 nurses who work on health-related surveys.

Research Department of Epidemiology and Public Health, UCL Medical School
www.ucl.ac.uk/epidemiology

The Research Department of Epidemiology and Public Health, chaired by Professor Sir Michael Marmot, is a leading centre for research into the social determinants of health. The department has a strong interdisciplinary structure. The Department houses over 170 staff in 11 main research groups, including the Joint Health Surveys Unit, part of the Health and Social Surveys Research Group. Collaborative research is conducted through the International Institute for Society and Health and across the Division.

The Department’s research programme is concerned particularly with social factors in health and illness and inequalities in these, including national cross-sectional surveys of health and behaviour (such as diet), longitudinal studies of cardiovascular disease (Whitehall studies) and the English Longitudinal Study of Ageing (ELSA); international studies of cardiovascular disease and diabetes; sociodental indicators of need; and the socio-economic and policy implications of an ageing population.