

Measuring National Well-being, Health, 2012

Author Name(s): **Jen Beaumont, Jennifer Thomas, ONS**

Abstract

During the national debate about Measuring National Well-being, when asked what affected their well-being, health was the most common response from individuals. Following the national debate one of the proposed domains for Measuring National Well-being is health. In the most recent consultation there was strong support for the domain and for most of the proposed experimental headline measures within it. These currently include healthy life expectancy, self-reported health and a measure of mental illness. This article explores the headline measures in more detail and puts them into the context of other objective and subjective measures of health and well-being. It starts with self-reported health and its relationship to the Office for National Statistics measures of subjective well-being, which indicate how people think and feel about their lives. The subsequent sections will examine life expectancy, mortality, disease and physical ill health, mental health and some lifestyles which can affect health. There is also a short section on social care which covers those with specific needs.

Key points

Self-reported health and subjective well-being

- In 2011/12, adults aged 16 and over in the UK who report that they have health problems do not always report low levels of life satisfaction: about two in five of those who report bad or very bad health report a medium or high level of life satisfaction.
- In 2011/12, adults aged 16 and over in the UK who report good health do not always report high levels of satisfaction with their lives: about one in five of those who report good or very good health report a low or very low level of life satisfaction.

Life expectancy, mortality, illness and disease

- Between 1930 and 2010 life expectancy at birth in the UK (that is the length of time that an individual born in a specific year can expect to live) increased by around a third for both sexes from 58.7 to 78.2 years for men and from 63.0 to 82.3 for women.
- Death rates in the UK have decreased over time but the prevalence of negative lifestyle behaviours such as obesity, heavy drinking and binge drinking has increased.

- Cancer was still the most common cause of death in the UK in 2011, followed by heart disease, diseases of the respiratory system and cerebrovascular diseases, which includes stroke.
- While cancer rates increased considerably between 1971 and 2010 in the UK, survival rates have improved: half of people with cancer now survive their disease for five years after diagnosis.
- About half of adults in the UK who stated they have both a Disability Discrimination Act (DDA) disability and a work limiting disability, report low or very low levels of life satisfaction compared to less than one in five of those with neither a DDA disability and a work limiting disability.

Mental ill health and mental well-being

- The GHQ-12 measure of psychosocial illness shows little change between 2002/03 and 2008/09: about 20 per cent of adults in the UK showed some evidence of psychological distress in each year (scoring 4 or more on a scale from 0 to 12).
- In England in 2007, around one in six adults had a common mental disorder such as anxiety or depression.

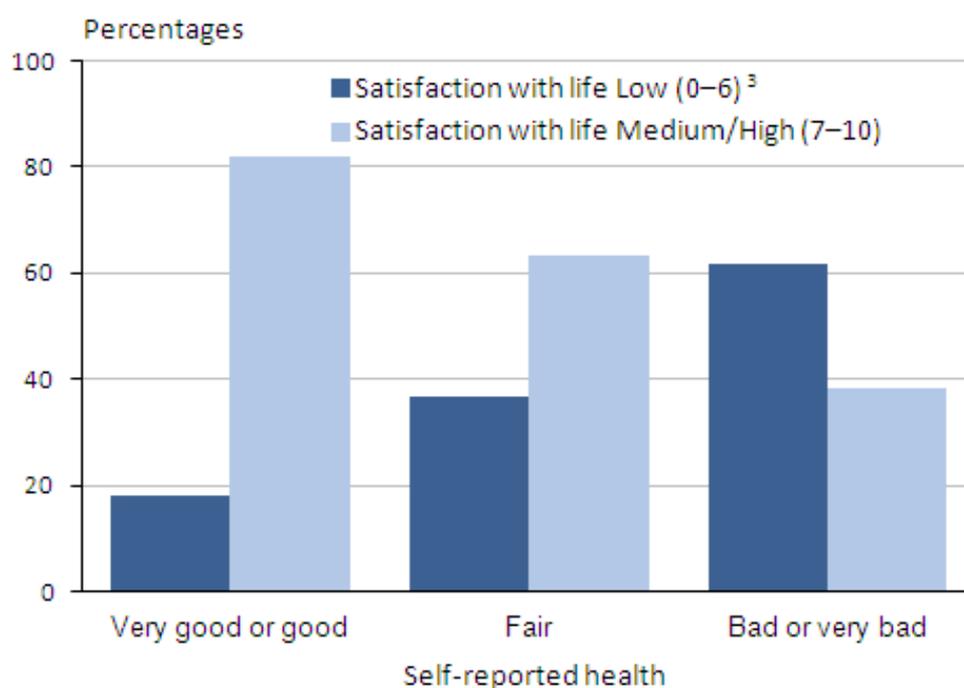
Health and life satisfaction

This section explores the relationship between individuals' views of their own health and their feelings about their well-being.

People's own assessment of their health is associated with their assessment of their overall life satisfaction. However, it should be remembered that health is only one determinant of life satisfaction. When asked about their satisfaction with their lives, not everyone who reported that their health was good or very good reported high levels of life satisfaction, nor did all those who reported bad or very bad health report that their life satisfaction was low. Analysis of ONS data shows that nearly 1 in 5 (18 per cent) of those who reported good or very good health reported low satisfaction with life overall. Nearly 2 in 5 (38 per cent) of those who reported bad or very bad health reported high or medium levels of satisfaction with life overall (**Figure 1**). Similar patterns emerge when the questions about how worthwhile the things they do are, and how happy and anxious they felt yesterday are analysed for these two self reported health categories.

Figure 1. Self-reported health (1) and satisfaction with life overall (2), 2011/12

United Kingdom



Source: SWB experimental APS dataset, ONS (April 2011–March 2012)

Notes:

1. Individuals are asked to say whether their general health is very good, good, fair, bad or very bad.
2. Individuals were asked to rate how satisfied they were with their lives overall on a scale of 0 to 10 where 0 was 'not at all satisfied' and 10 was 'completely satisfied'.
3. For more detail on grouping please refer to ONS 2012b.

Download chart
[XLS](#) [XLS format](#)

(28 Kb)

While this analysis shows that those who feel that they have good health are much more likely to report higher levels of subjective well-being and, conversely, that those who report poor health are much more likely to report lower subjective well-being; it also supports the view that individuals' well-being depends on additional aspects of their lives. For example, different levels of well-being are shown when data are analysed by age, marital status, tenure of dwelling, level of volunteering, continued learning and employment status¹. More information about these relationships can be found in other Measuring National Well-being domain publications².

Notes

1. [ART First ONS Annual Experimental Subjective Well-being Results](#)
2. [Measuring National Well-being index](#)

Life expectancy

This section discusses various life expectancy measures. Between 1930 and 2010, there have been considerable improvements in life expectancy in the UK. During this period, life expectancy at birth (that is the length of time that an individual born in the specific year can expect to live) in the UK increased by around 20 years (or a third) for both sexes. In 1930 life expectancy at birth was 58.7 years for males and 63.0 years for females, increasing to 78.2 years for males and 82.3 years for females in 2010 (ONS, 2011b). Such increases in life expectancy are a clear indication of improvements in the health of individuals as a result of better lifestyles, enhanced health care, increases in prosperity and public health regulation (for example, the Clean Air Act 1956). The more recent improvements are shown in Table 1: in the years between 2000-2002 and 2008-2010, life expectancy at birth has increased by 2.5 years for males and 1.9 years for females.

As those who report good health are more likely to also report higher levels of well-being, it is important to measure not only the total life expectancy but also how many years of life can be expected to be lived in good general health. This can be examined by looking at Disability Free Life Expectancy (DFLE) and Healthy Life Expectancy (HLE), both of which measure the length of time an individual can expect to live free of activity restricting long-lasting illness and in very good or good health respectively¹. Their calculation uses mortality data combined with measures of health quality. Over the period 2000–02² to 2007–09 HLE for males at birth in the UK increased from 60.7 years to 63.0 years and from 62.4 years to 65.0 years for females. Disability-free life expectancy has also risen for both males and females at birth in the UK over this time period. So at birth about four-fifths of life is expected to be spent in good health or disability-free and this proportion remains similar for data analysed for the years 2000–02 to 2006–07 ([Table 1: Life expectancy, healthy life expectancy and disability-free life expectancy at birth \(30 Kb Excel sheet\)](#)).

Life expectancy and disability-free life expectancy are also available at age 65: for example, based on data for 2007-09, a male at age 65 can expect to live another 17.8 years with just under 10 of those years in good health and a female at age 65 can expect to live another 20.4 more years with 11.5 of those years in good health³. However, sub-national breakdowns in the form of Local Authorities (LAs), small areas and by socioeconomic position reveal sizeable variation in the levels of health expectancy and in the proportion of life spent in favourable health states. Sub UK geographical variation in life expectancy over time is available and can be seen on the ONS website in the ONS Interactive Content⁴.

The World Bank⁵ published data about life expectancy at birth for all residents as well as for males and females for a large number of countries. Of the 193 countries for which they provide figures for 2010, the UK was ranked 20th with a life expectancy at birth of 80.4 years. Of these countries; San Marino, Japan, Hong Kong SAR, and Switzerland had the highest life expectancies (between 82.2

years and 83.2 years) in 2010. Lesotho and Sierra Leone had the lowest with life expectancies at birth of 47 years.

Notes

1. Healthy life expectancy (HLE) and disability-free life expectancy (DFLE) are summary measures of population health that combine mortality and self-reports of health status. In contrast to life expectancy, these two indicators measure both the quality and quantity of life. Essentially they partition life expectancy into the following two components:
 - years lived free from activity restricting ill health or disability (DFLE) or in a good state of general health (HLE),
 - years lived with activity restricting ill health or disability and years lived in a not good state or poor state of general health.

Period life expectancy for the UK is the average number of additional years a person would live if he or she experienced the age-specific mortality rates of the given UK population during the observed time period for the rest of their life. Therefore, it is not the number of years someone in the UK population in that time-period would actually be likely to live, because the death rates in the population are likely to change.

HLE at birth is defined as the number of years that a newly born baby can expect to live in good or fairly good health if he or she experienced current mortality rates and 'good' or 'very good' health rates, based on self-assessed general health for different age-groups during their lifespan.

Disability-free life expectancy, defined as expected years lived without a limiting long-standing illness, is calculated in the same way as HLE, except that it uses age-sex specific rates of 'without limiting long-standing illness' instead of rates of 'good/very good' health.

2. 2000–02 estimate is based on synthetic extrapolation because of a change in data definition from 2005.
3. [Health Expectancies at birth and age 65 in the United Kingdom, 2007-09](#), Office for National Statistics.
4. [Neighbourhood Statistics - Find statistics for an area](#)
5. [World bank, \(2010\): life expectancy figures](#)

Mortality and cause of death

Increases in life expectancy are linked to changes in lifestyles and improvements in both access to and quality of health care which have contributed to a reduction in early deaths for adults and to increases in the proportion of children who survive beyond infancy. Improvements in preventative measures such as immunisation and screening have also had a positive effect on life expectancy

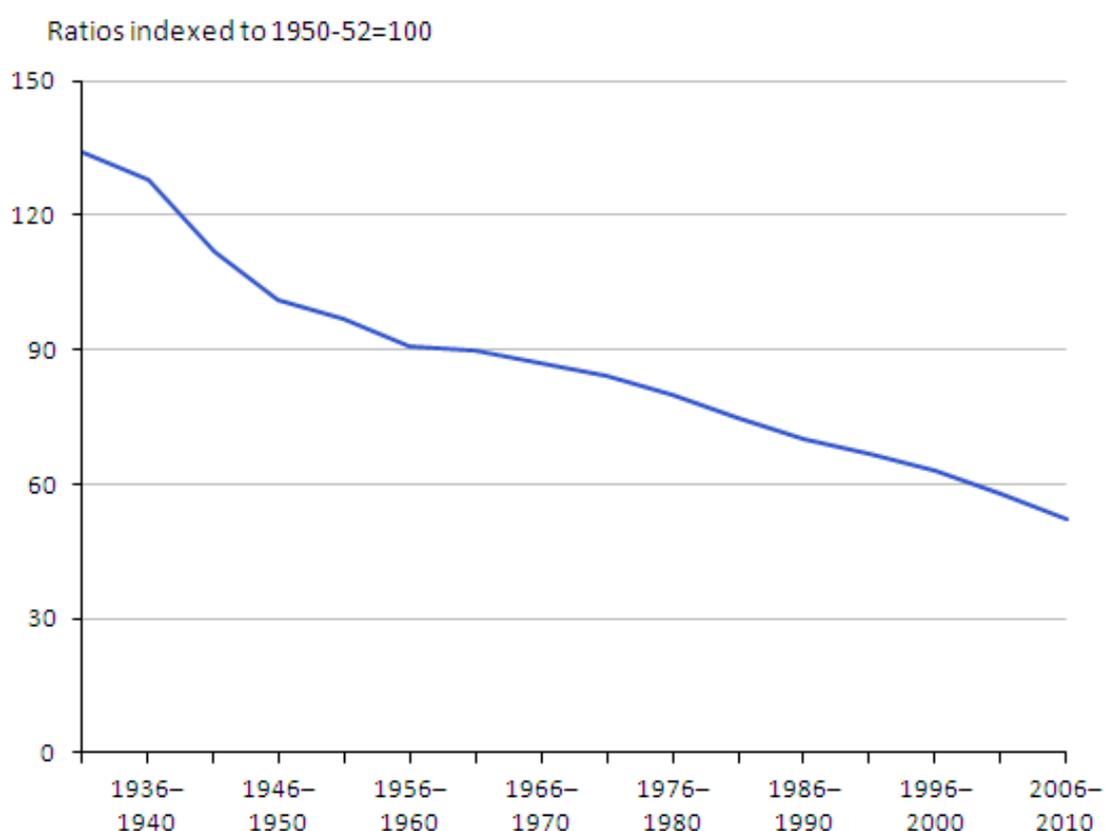
and will be discussed later in this article. This section will investigate mortality over time and causes of death.

Mortality over time

In order to compare mortality over time, death rates have to be standardised by age to take into consideration the changes in the age structure of the population. These adjusted data are described as age standardised. Those shown for England and Wales in **Figure 2** illustrate change in mortality by setting the rate in 1950–52 to 100, and comparing other years with this, so that index numbers higher than 100 will indicate a higher rate than that in 1950–52 and those lower than 100 will show a rate lower than that in 1950–52. Age-standardised death rates have shown a steady decrease over the time period shown in Figure 2: in the period 1931–35 rates were more than one and a half times as high as those in 2012.

Figure 2. Age-standardised mortality ratios (1), 1931–2010

England and Wales



Source: Office for National Statistics

Notes:

1. Figures include deaths of non-residents. Figures are for deaths registered in each calendar year. Age-standardised mortality ratios are standardised to the European Standard Population. Age-standardised rates are used to allow comparison between populations which may contain different proportions of people of different ages, and so also allow comparisons over time.

Download chart

XLS [XLS format](#)

(28.5 Kb)

Information about mortality rates at local authority level in England and Wales is provided as an interactive map of age standardised mortality rates by gender¹.

Infant mortality has also reduced in recent years and has contributed to the reduction in overall mortality rates and the increases in life expectancy discussed above. Infant mortality is calculated as the rate of death in those aged less than one year old per 1,000 live births so that the change in the number of births does not affect the rate². Between 1980 and 2010 infant death rates in England and Wales decreased from 12.0 per 1,000 live births to 4.3 per 1,000 live births and the number of infant deaths decreased from nearly 7,900 to nearly 3,100. For England and Wales there have also been considerable decreases in all the age-specific mortality rates over the last 10 years. For example, in 2000 the age specific mortality rates for those aged 70-74 were 38.4 per 1,000 population for males and 23.2 for females per 1,000 population. By 2010 these rates had reduced by almost a third to 26.0 per 1,000 population for males and 16.8 per 1,000 population for females (ONS, 2010a).

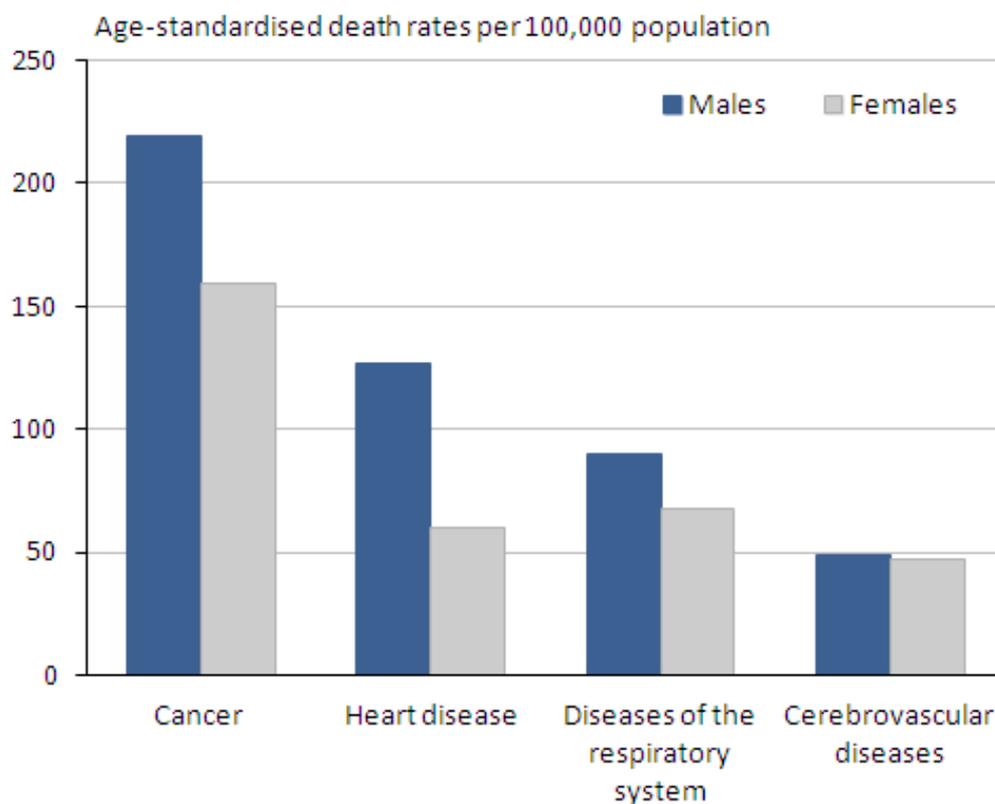
Causes of death

In 2001 there were just over 604,000 deaths in the UK, the number of deaths decreased to just over 561,000 in 2010. Of these, 493,242 deaths were in England and Wales, a rise of 0.4 per cent compared with 2009 (491,348) (ONS, 2010b).

Figure 3 shows the most common causes of death which were cancer, heart disease, diseases of the respiratory system and cerebrovascular disease (which includes strokes) respectively. Men are more likely than women to die of the more common causes of death in all instances. Each of these causes can be linked, in part, to the lifestyles which are discussed later in this article.

Figure 3. Age-standardised death rates (1) per 100,000 population for selected underlying causes: by sex, 2008

United Kingdom



Source: Office for National Statistics, Scottish Government, Northern Ireland Statistics and Research Agency

Notes:

1. Rates are based on the European Standard Population and include those aged under one.

Download chart

[XLS](#) [XLS format](#)

(28 Kb)

Notes

1. [Neighbourhood Statistics - Find statistics for an area](#)
2. For more information about births see Measuring National Well-being - Population, [Social Trends 42 - Population](#) and for more information about childhood mortality see [Gestation-specific infant mortality in England and Wales](#).

Disability, disease and ill health

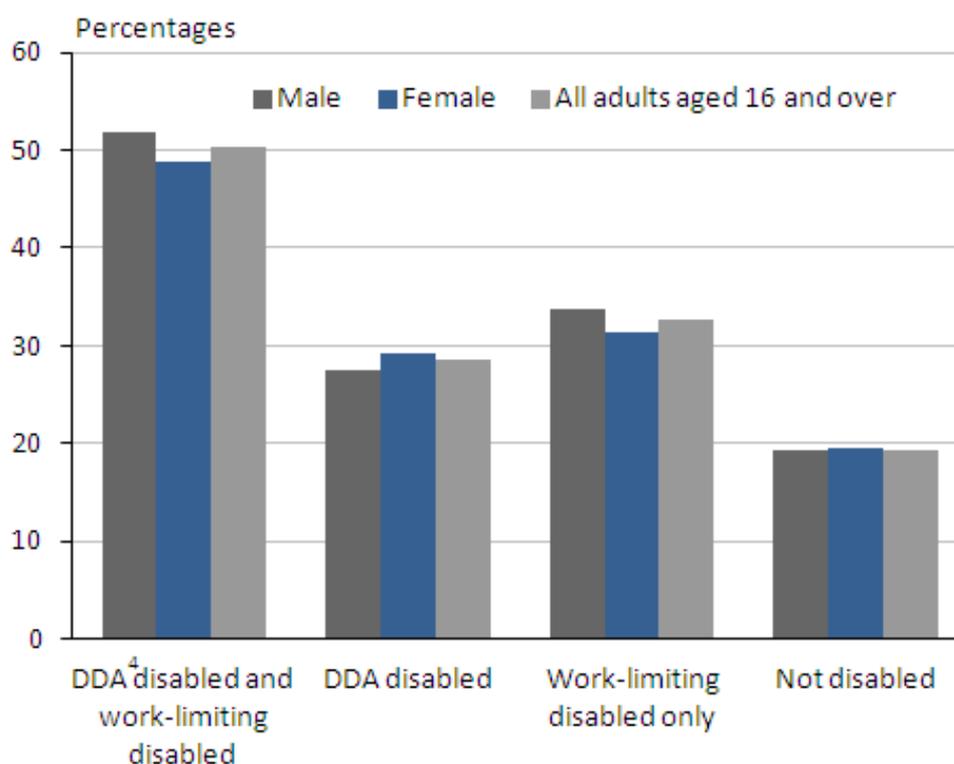
Physical health has a strong association with individual well-being. As reported in the section describing health and life satisfaction, those who report very bad or bad health are much more likely to report lower levels of well-being. This section will discuss self-reported disability, disease and ill health, and will include information about changes in the prevalence and survival following a diagnosis of cancer.

Reported Disability

Nearly one in five (18 per cent) adults aged 16 and over report a current disability¹. **Figure 4** shows the variations in proportions of disabled and non-disabled people reporting medium to high (7 to 10 on a scale of 0 to 10 where 0 is not at all and 10 is completely) and low (0 to 6) ratings for 'life satisfaction'.

Figure 4. Current disability and low satisfaction (1) with life overall (2,3): by sex, 2011/12

United Kingdom



Source: SWB experimental APS dataset, ONS (April 2011–March 2012)

Notes:

1. Adults aged 16 and over were asked 'Overall, how satisfied are you with your life nowadays?' where 0 is 'not at all satisfied' and 10 is 'completely satisfied'.
2. All data weighted.
3. Non-respondents not included.
4. Disability Discrimination Act.

Download chart
[XLS](#) [XLS format](#)

(30 Kb)

People who report having a disability are a very wide ranging group. The group includes those who have a disability which substantially limits their day-to-day activities, referred to in Figure 4 as 'DDA disabled'. This is because their reported disability fits the description of disability in the Disability Discrimination Act (DDA). There is a second group who have a disability which limits the work they can do. From these two groups a third can be constructed which is those with both DDA and work-limiting disability. This analysis looks at the three separate groups: those who are DDA disabled only (about 11 per cent of those aged 16 and over), those who are work-limiting disabled only (about 3 per cent of those aged 16 and over) and those who are both DDA disabled and work-limited disabled (about 11 per cent of those aged 16 and over). The subjective well-being of these

three groups is compared with those who are neither DDA nor work-limiting disabled (the remaining 75 per cent).

Nearly 2 in 10 of those with no disability reported low overall life satisfaction (19 per cent). This compares to around 3 in 10 of those classed as DDA disabled only or having a work-limiting disability only (29 and 33 per cent respectively), and half of those classed as both DDA disabled and work-limiting disabled. This pattern is similar for responses about feeling that things in life are worthwhile or being happy yesterday. Also those who do not report to being DDA disabled or having a work-limiting disability are much more likely to report high anxiety yesterday. Life satisfaction seems to be most affected by being DDA disabled only or having a work-limiting disability followed by happiness, worthlessness and anxiety respectively.

Ill health

Apart from the measures of self-reported illness in the Annual Population Survey² and similar measures in the Census and other surveys, there is no single source of objective data from which the number of people who are in good health or who have an illness at any one time can be estimated. However, changes in the use of health care can be taken as an indication of the numbers who have conditions which need treatment. For example, hospital admissions, particularly admissions for elective treatment or surgery, can give some indication of changes in the frequency of the need for inpatient care. However, it should be remembered that individuals can be admitted more than once during a year for the same or a different condition and improvements in treatment and screening and their availability and resourcing level can lead to more admissions. Between 2000/01 and 2010/11 hospital admissions in England increased by over a third per cent from just over 11 million to nearly 15 million. In 2010/11, 1 in 9 admissions were related to cancer (that is for neoplasms) an illness for which multiple admissions are more likely. Other diagnoses which accounted for relatively high proportions of admissions in England in 2010/11 were diseases of the digestive system (11.6 per cent) and additional admissions from pregnancy and childbirth (9.1 per cent) (HES, 2011).

Disease prevention and low birth weight

In the UK, there are several disease prevention measures to improve our health and protect individuals and the community from serious diseases. Throughout the UK, young people and adults can receive screening for abdominal aortic aneurisms, diabetes, several cancers and receive various antenatal and newborn diagnostic tests. In addition to this, immunisations and vaccinations are available including Flu prevention, Measles, Mumps and Rubella, Meningitis and Tetanus.

One issue which has been shown to affect the future health of individuals is being born at a low birth weight. This is also a measure of possible poor maternal health. Reduction in the number of low birth weight babies is an important public health issue. Low birth weight babies face immediate and life-long risks to their health and development, including poor health in the first four weeks of life, and a higher risk of infant mortality. In the longer term, low birth weight has a higher association with premature death from coronary artery disease, and delayed physical and cognitive development in early childhood and adolescence (Department of Health, 2012). Of all live deliveries in England and Wales in 2009, 7.2 per cent of the babies had a birth weight of less than 2,500 grams (5 pounds 8 ounces) which is considered low for a full term baby. However, many of these babies had a low birth

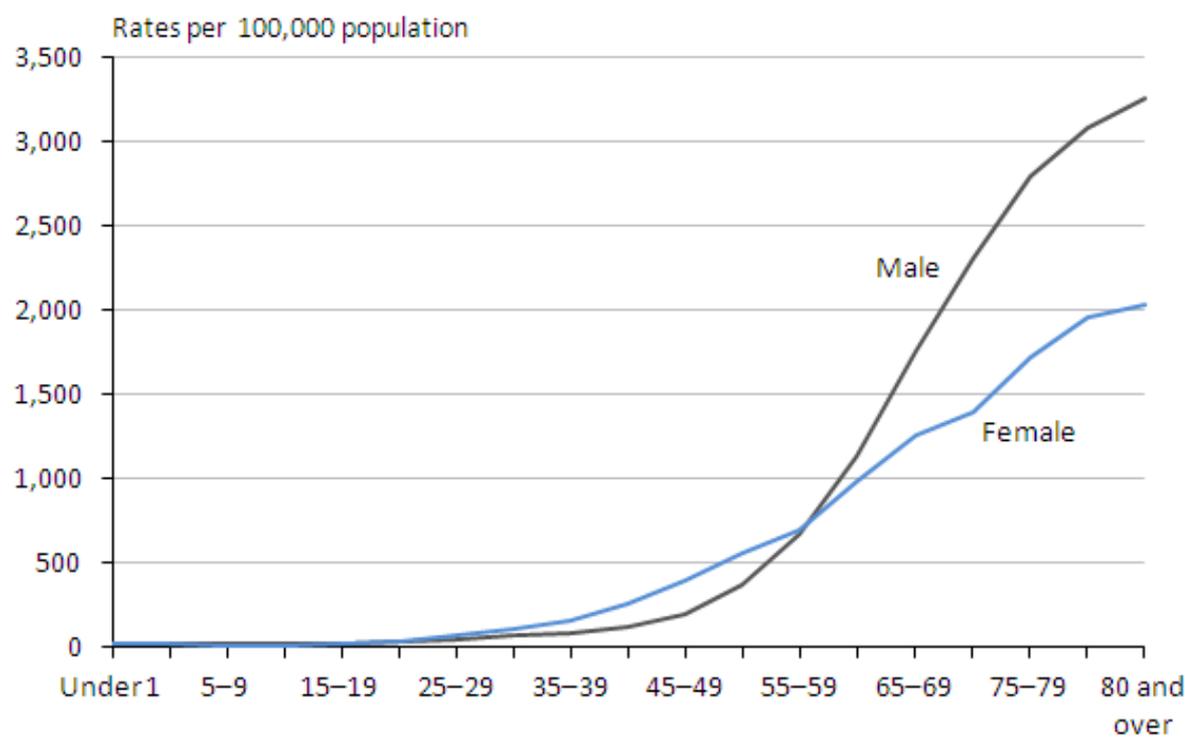
weight because they were born earlier than would normally be expected. When gestational age (the estimated time from conception) is considered, a much smaller proportion of babies born full term had a low birth weight. Of those babies whose gestational age was known and who were considered to be born at full term or after, only 3.0 per cent had a birth weight of less than 2,500 grams (ONS, 2009).

Cancer

Cancer is both the leading cause of death and the most frequent reason for being admitted to hospital as an inpatient in the UK. It is estimated that 1 in 3 people will develop some form of cancer during their lifetime (Cancer Research UK, 2010a). The UK is widely acknowledged as having one of the most comprehensive cancer registration systems in the world. There are currently 11 cancer registries in the UK, each covering populations of between approximately 1.7 and 13.8 million people³.

The number of newly diagnosed cases of cancer recorded each year has increased considerably from around 150,000 in 1971 to over 250,000 in 2001 and to nearly 290,000 in 2010 (ONS, 2010d). Cancer can develop at any age but is most common in older people. **Figure 5** shows a considerable increase in the number of cancer patients in the older groups. For example in 2010 more than 6 in 10 newly diagnosed cases of cancer were for those aged 65 and over. Figure 5 shows wide differences between the sexes and across the age groups. Following a small decrease in rates after early childhood, rates increased continuously across the age range for both males and females. From the 20 to 24 age group up to the 55 to 59 age group, rates of cancer were higher in females than in males, ranging from 30 to 671 per 100,000 population for men and 32 to 694 per 100,000 of the population for women. In the 40 to 44 age group, the rate in females was more than double that for males (251 compared to 117 per 100,000 population). This can be partially explained by the prevalence of cervical and breast cancer in these age groups. Rates of cancer were higher in males than females from the 60 to 64 age group onwards, with an increasing difference in rates between the sexes with age up to 85 years and over, ranging from 1,130 to 3,248 per 100,000 population for men and 979 to 2,028 per 100,000 population for women. Rates of cancer were 40 per cent higher for males than for females in the 65 to 69 age group, but were 65 per cent higher in those aged 70 to 74 and over (ONS, 2010d). Around 1 per cent of cancers occur in children, teenagers and young adults (up to age 24) (Cancer Research UK, 2010a).

Figure 5. Cancer incidence rates (1): by sex and age-group, England, 2010
England



Source: Office for National Statistics

Notes:

1. All malignant neoplasm's (excluding non-melanoma skin cancer).

Download chart

[XLS](#) [XLS format](#)

(28 Kb)

As some of the increase in diagnosed cases of cancer can be accounted for by the change in the distribution of ages within the population⁴, annual cancer rates are standardised to the age distribution of the population so that comparisons over time can be made. Between 2001 and 2010 there was an increase in the age standardised rate for all cancer⁵, from 417.1 to 422.6 per 100,000 population for males and 349.3 to 369.6 per 100,000 population for females of all ages (ONS, 2010d).

While cancer rates have risen, survival rates from cancer have also improved. Half of people diagnosed with cancer now survive their disease for at least five years (Cancer Research UK, 2010a). **Table 2** shows that cancer patients diagnosed between the years 2005 and 2009 are more

likely to have survived five years after diagnosis than those diagnosed between 1993 and 2003 for all types of cancer (ONS, 2010e). The largest improvement in survival rate was for patients with Lymphoma, where men are 10 percentage points more likely and women 9 percentage points more likely to survive than those diagnosed between 1993–2003.

Table 2: Five-year age-standardised (1) relative survival for adults (aged 15–99 years)

England and Wales (Percentages (2))

Cancer³		Diagnosis 1993–2003, follow up 2004	Diagnosis 2005–2009, follow up 2010
Lung	Men	7	8
	Women	8	9
Colon	Men	50	54
	Women	51	55
Non-Hodgkin lymphoma	Men	51	61
	Women	57	66
Prostate	Men	74	81
Testis	Men	97	97
Breast	Women	81	85
Ovary	Women	39	43
Cervix	Women	63	67

Source: Office for National Statistics, London School of Hygiene and Tropical Medicine

Table notes:

1. Age-standardisation requires the estimation of survival for each age group. Age-specific estimates may not be obtained if there are too few events (deaths) in a given age group; this can happen because survival is very high (there are very few deaths) or because it is very low (most of the patients die early in the five-year period of follow-up). When age-standardisation was not possible, un-standardised estimates are reported instead, italicised and underlined.
2. Relative survival is an estimate of the probability of survival from the cancer alone. For convenience, it is expressed as a percentage in the range 0–100 per cent. It can be interpreted as the survival of cancer patients after taking into account the background mortality that the patients would have experienced had they not had cancer. Background mortality is derived from life tables of all-cause mortality rates in the general population. Relative survival varies with age, and the age profile of cancer patients can vary with time and between geographical areas, so the estimates are age-standardised to facilitate comparison.
3. Cancers were defined by codes in the International Classification of Diseases, Tenth Revision (ICD-10) and International Classification of Diseases for Oncology, Second Edition (ICD-02)

Download table

XLS [XLS format](#)

(30 Kb)

Some cases of cancers are diagnosed for the first time as the result of screening. This is designed to diagnose cancer early and give the patient a greater chance of survival. The UK has several screening initiatives that are nationally coordinated, including the NHS breast, cervical, and bowel cancer screening programmes.

Notes

1. Includes those classified as having a limiting long standing illness or disability which would be classified as a disability under the Disability discrimination Act The Disability Discrimination Act (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

2. [Annual Population Survey \(APS\)](#)

3. **How is cancer registration organised in the UK?**

The UK is widely acknowledged as having one of the most comprehensive cancer registration systems in the world. There are currently 11 cancer registries in the UK, each covering populations of between approximately 1.65 and 13.8 million people. Cancer registration in England is conducted by eight regional registries, which also submit a standard dataset of information to the Office for National Statistics (ONS), for the collation of national cancer incidence data. Northern Ireland, Scotland and Wales each have one, national, cancer registry.

Although changes in health geography, including the introduction of cancer networks in response to the Calman Hine report for commissioning cancer services, have led to some cross-boundary issues for the English registries, the registries still provide complete coverage of the UK for the collection of population-based cancer data.

Commissioning for the provision of the cancer registration system in the UK is now shared between the Department of Health in England, the National Assembly for Wales Department of Health and Social Care, the Scottish Executive Health Department, and the Department of Health, Social Services and Public Safety in Northern Ireland. Consequently, the UKACR has an essential role in providing a focus for cancer registration in the UK, especially by ensuring that registries are fully aware of any cross-national issues or relevant legislation.

4. For more information see [Social Trends 42 - Population](#).

5. Apart from non-melanoma skin cancer which is believed to be greatly under-registered.

Mental health

'Mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and to be creative and active citizens. Mental health is an essential component of social cohesion, productivity and peace and stability in the living environment, contributing to social capital and economic development in societies' (WHO, 2005).

Positive mental health is people thinking and feeling good about themselves and feeling able to cope with their problems and such positivity is very important to an individual's well-being. The term is used to distinguish mental health from mental illness. Mental illness covers a range of mental health problems which can cause marked emotional distress and interfere with daily function and include different types of depression and anxiety. These types of problems can also have a significant effect on an individual's well-being.

Several ways of measuring those with some degree of mental health problems are in use in the UK such as the General Health Questionnaire (GHQ-12) and those based on diagnosis such as the Adult Psychiatric Morbidity Survey (APMS). The ONS Measuring National Well-being Programme set of domains and measures currently uses the General Health Questionnaire (GHQ-12) as a headline measure of mental illness. The GHQ-12 measure has been used regularly on the British Household Panel Survey in the UK and therefore allows some measurement of change over time.

GHQ-12 asks 12 questions which relate to an individual's state of mind and returns a score for the individual of between 0 and 12. High scores are an indication of conditions such as anxiety and depression although they do not provide a diagnosis of specific psychiatric problems. Between 2002/03 and 2008/09 around a fifth of GHQ-12 respondents had a score of four or more¹, which indicates some element of psychological distress. For the same period, between 3.0 and 3.5 per cent had a score of eleven or twelve, indicating a much higher level of distress ([Table 3: GHQ-12 assessment of psychosocial health \(29.5 Kb Excel sheet\)](#)).

The Adult Psychiatric Morbidity Survey² (APMS) estimates the number of adults suffering from common mental disorders (CMDs) such as anxiety and depression. Results showed that in England in 2007 around 1 in 6 adults (17.6 per cent) met the diagnostic criteria for at least one CMD in the week prior to interview (**Table 4**). Between the surveys conducted in 1993 and 2000 there had been an increase in the prevalence of both mixed anxiety and depressive disorders and a slight increase in generalised anxiety disorders (from 7.5 to 9.4 per cent and 4.4 to 4.7 percent respectively) , but there were only small changes between 2000 and 2007 (HSCIC, 2009).

Table 4: Prevalence of a common mental disorder (CMD) in past week (1)

England (Percentages)

	1993	2000	2007
Mixed anxiety and depressive disorder	7.5	9.4	9.7
Generalised anxiety disorder	4.4	4.7	4.7
Depressive episode	2.2	2.8	2.6
All phobias	2.2	2.8	2.6
Obsessive compulsive disorder	1.4	1.2	1.3
Panic disorder	1.0	0.7	1.2
Any CMD	15.5	17.5	17.6

Table source: Information Centre for Health and Social Care

Table notes:

1. An individual can have more than one CMD. Adults aged 16 to 64 and living in England.

Download table

[XLS](#) [XLS format](#)

(31 Kb)

The Welsh Health Survey 2010 showed that in Wales, 9 per cent of adults over 16 reported currently being treated for depression, 6 per cent for anxiety and 10 per cent for any mental illness (Welsh Government 2011).

There are a number of other measures which assess mental and psychological well-being which are also available. For example the Health Survey for England 2010 included EQ-5D and the Warwick-Edinburgh Mental Well-being Scale³ (WEMWBS) as well as GHQ-12. WEMWBS was developed to capture a broad concept of positive mental well-being and includes psychological functioning, cognitive-evaluative dimensions and affective-emotional aspects of well-being. The scale is based on 14 statements and the responses are aggregated so that the result ranges from 14 (those who answer 'rarely' on every statement) to 70 (those who answer 'All of the time' to all statements), so that the higher the score the greater the individual's positive mental well-being. In the Health Survey for England in 2010 the average score for all adults was 51.0, with very little difference between men and women. While most scores (77 per cent) were in the 40-62 range 11 per cent of the population had a score of 39 or less and. There was a U-shape in the relationship between age and WEMWBS score with the lowest scores for both men and women in the middle age groups (49.9 for men aged 35-44, 49.7 for women aged 45-54), while scores were highest in the 65-74 age group (53.3 and 52.4 respectively). (HSCIC, 2011a). In the Scottish Health Survey in 2010 the average WEMWBS

score for adults was 49.9 which was little changed from the previous two years and showed a similar distribution by age as the data for England (Scottish Government, 2010).

Analysis of this survey and of similar surveys which use both GHQ-12 and WEMWBS have shown a very strong negative correlation between WEMWBS and GHQ12. In other words, respondents with below average mental well-being tended to have high GHQ-12 scores while those with above average mental well-being tended to have low GHQ-12 scores (a score of four or more). For example see the analysis of the 2008 Scottish Survey of Public Attitudes to Mental Wellbeing and Mental Health Problems (Scottish Government, 2008).

The Attitudes to Mental Illness (HSCIC, 2011b) report shows that there is an increasingly positive response to mental illness. In England in 2011 those with a mental illness were less commonly viewed as a burden on society (a reduction from 10 per cent of respondents in 1994 to 6 per cent in 2011). There also appears to be less of a stigma attached to mental illness. The percentage of people agreeing that 'Mental illness is an illness like any other' increased from 71 per cent in 1994 to 77 per cent in 2011 and the percentage of people saying they would be comfortable talking to a friend or family member about their mental health increased from 66 per cent in 2009 to 70 per cent in 2011.

Notes

1. The GHQ-12 questionnaire concentrates on the broader components of psychological morbidity and consists of twelve items measuring general levels of happiness; depression and anxiety; sleep disturbance; and ability to cope over the last few weeks. The twelve items are rated on a four-point response scale, where a score of 0 is given to responses such as that the symptom is present 'not at all' or 'no more than usual' and a score of 1 is given to responses symptom is present 'not at all' or 'no more than usual' and a score of 1 is given to responses such as 'rather more than usual' or 'much more than usual'. Consistent with analysis of other surveys, a GHQ12 score of 4 or more is referred to as a 'high GHQ12 score', indicating probable psychological disturbance or mental ill health.
2. The Adult Psychiatric Morbidity Survey (APMS) series provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over).
3. The WEMWBS scale is based on 14 statements, for each of which participants are asked to tick the box that best describes their experience over the previous two weeks. They can answer on a 5-point scale: 'None of the time', 'Rarely', 'Some of the time', 'Often', or 'All of the time'. The statements are all expressed positively – for example, 'I've been feeling optimistic about the future'. The responses, numbered 1 to 5, are aggregated to form an Index which ranges from 14 to 70.

Lifestyles

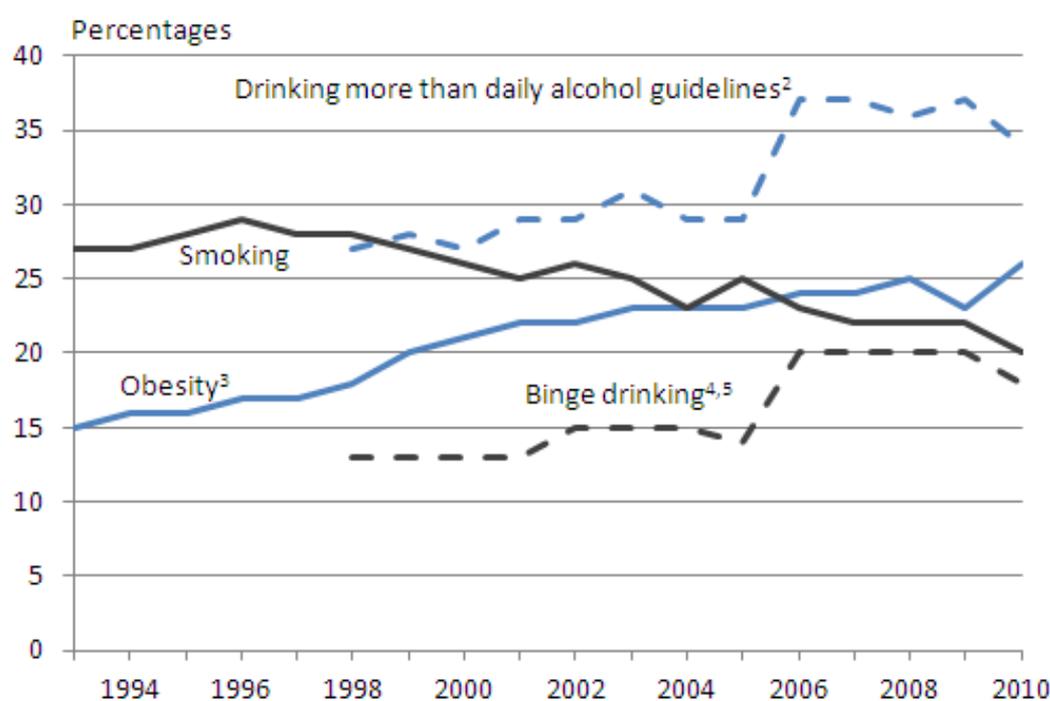
This section discusses some lifestyles which may have a negative effect on a person's health, such as the use of tobacco, alcohol and drugs and the growing levels of obesity. More information about

the more positive aspects of individuals' lifestyles, such as physical activity and engagement in other leisure activities, is available in the Measuring National Well-being article 'What we do'¹.

Figure 6 shows that, for England, there has been a decrease in the number of smokers over the last 20 years but a considerable increase in other lifestyle behaviours which may have a negative impact on health. Those drinking more than the Department of Health's daily alcohol guidelines (3–4 units for men, 2–3 units for women) and those considered binge drinkers (drinking double the recommended daily guideline on at least one occasion over the week prior to interview), in addition to those classed as obese have increased over the last two decades. Each of these behaviours, in addition to drug use, is discussed in more detail in below.

Figure 6. Obesity, smoking and drinking over time (1)

England



Source: Health Survey England (HSE) tables, 2010

Notes:

1. Data up to 2002 are unweighted; from 2003 onwards data have been weighted for non-response.
2. Includes those who drank 3 units for women and 4 units for men on at least one day in the week prior to interview.
3. Obese = BMI 30 or more (includes morbidly obese = BMI 40 or more).
4. Includes those who drank 6 units for women and 8 units for men on at least one day in the week prior to interview.
5. Results from 2006 include longitudinal data. From 2006, figures produced using the updated methodology for converting volumes of alcohol to units assuming an average wine glass size.

Download chart

XLS [XLS format](#)
(30.5 Kb)

Tobacco

The causal link between smoking and lung cancer was established over 50 years ago. In the UK, tobacco consumption is now recognised as the single greatest cause of preventable illness. Early death from smoking-related disease was responsible for more than 102,000 deaths in 2009 (Cancer Research UK, 2010b).

In 2010, around one in five (22 per cent of men and 18 per cent of women in England) smoked regularly. Over the last 20 years the proportion of the population who use tobacco has declined by 7 percentage points in England (HSE, 2010). According to the 2008/2009 Opinions Survey, around two-thirds (67 per cent) of smokers in Great Britain reported that they would like to stop smoking: the most common reason given was “at least one health reason” (ONS, 2009b).

The European Commission ‘Attitudes of Europeans towards Tobacco Survey’ in 2012 showed that 28 per cent of the EU population smoke, a decrease of 1 per cent since 2009. In the same survey the UK was just below the EU average (at 27%) although the methodology differed from the HSE Survey above. Since the late 1980s, the European Union has worked to encourage the trend towards fewer people starting to smoke, more people quitting smoking and more citizens living and working in smoke-free environments. EU legislation on the control of tobacco regulates the marketing of tobacco products for public health reasons and ensures appropriate consumer information.

Alcohol

The World Health Organisation has estimated that alcohol consumption accounts for 4.5 per cent of all disease burden² worldwide although this excludes many of the indirect effects of alcohol (WHO, 2011). Alcohol consumption can lead to an increased likelihood of developing health problems such as high blood pressure, cancer and cirrhosis of the liver. 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 (HSCIC, 2010).

The excessive consumption of alcohol is a major preventable cause of premature mortality with alcohol-related deaths accounting for almost 1.5 per cent of all deaths in England and Wales in 2010 (ONS, 2010f). In 2008, the Department of Health published a report titled ‘The cost of alcohol harm to the NHS in England’ (Department of Health, 2008) which estimated that the cost of alcohol harm to the National Health Service (NHS) in England is £2.7 billion each year (2006/07 prices).

In 2010 there were 8,790 alcohol-related deaths³ in the UK, 126 more than in 2009 (8,664). The age-standardised rate has increased from 6.9 per 100,000 in 1991 to 12.9 per 100,000 in 2010 but this is lower than a peak of 13.6 per 100,000 in 2008 (ONS, 2010f).

The proportion of men and women who drank more than the Department of Health's daily alcohol guidelines on at least one occasion during the week prior to interview (3-4 units for men, 2-3 units for women) increased by 5 percentage points for men (36 to 41 per cent) and 8 percentage points (20 to 28 per cent) for women between 1998 and 2010. Those considered binge drinkers, i.e. drinking double the recommended daily guideline, increased by 3 percentage points for men (20 to 23 per cent) and 7 percentage points (7 to 14 per cent) for women in the same time period (HSE, 2010).

Drugs

According to the British Crime Survey, 12 million people (36.3 per cent or more than 1 in 3) in England and Wales reported that they had used drugs at least once in their lifetime and 5 million (15.2 per cent or 1 in 6) had used a class A drug (Home Office 2011). Cannabis was the most frequently used drug in almost a third (30.7 per cent) of all cases reported by drug users.

Between 1993 and 2009, deaths related to drug misuse⁴ in England and Wales more than doubled, from 831-1,784 deaths. Males were more considerably more likely than females to die from drug misuse in all years. In 2010, men were almost 3.5 times more likely to die from drug misuse than women. Although there was an increase in deaths overall, the number of deaths fell among the youngest and oldest adult population. Among those aged under 20 numbers have fallen 30 per cent to 35 deaths. For those over 70, numbers have fallen 23 per cent to 68 deaths (ONS, 2010g).

Obesity

Another area which is related to lifestyle is obesity. Obesity can lead to heart disease, Type-2 diabetes and hypertension. It can reduce the quality of a person's life, contribute to feelings of low self-esteem, increase the risk of premature death and create a strain on health services. In 2010, just over a quarter of adults (26 per cent of both men and women aged 16 or over) were classified as obese⁵. This has increased considerably since 1993 from 13.2 per cent and 16.4 per cent for men and women respectively. In 2010, 17 per cent of boys and 15 per cent of girls (aged 2 to 15) were classed as obese, an increase from 11 per cent and 12 per cent respectively since 1995 (HSCIC, 2012).

An indication of the increase in health problems associated with obesity is the total number of hospital admissions related to obesity. The total number of admissions in England increased from just over 2,000 in 2004/05 to about 5,000 in 2007/08 and over 11,500 in 2010/11 (although it should be noted that some individuals may have been admitted more than once in a given year) (HSCIC, 2012).

Further information for healthy lifestyles across England can be found from the network of Public Health Observatories Health Profiles.

Notes

1. [Measuring National Well-being - What we do](#)
2. Global Burden of Disease analysis provides a comprehensive and comparable assessment of mortality and loss of health due to diseases, injuries and risk factors for all regions of the world.

The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health.

3. [Alcohol-related deaths in the United Kingdom index](#)
4. These figures represent the number of deaths where the underlying cause of death is regarded as poisoning, drug abuse or drug dependence and where any substances controlled under the Misuse of Drug Act (1971) was mentioned on the death certificate. The data on drug misuse deaths do not include deaths from other causes that may have been related to drug taking (for example, road traffic accidents or HIV/AIDS).
5. Individual's that had a Body Mass Index (BMI) 30 {i.e. weight in kg/ height in metres squared} or over).

Social care

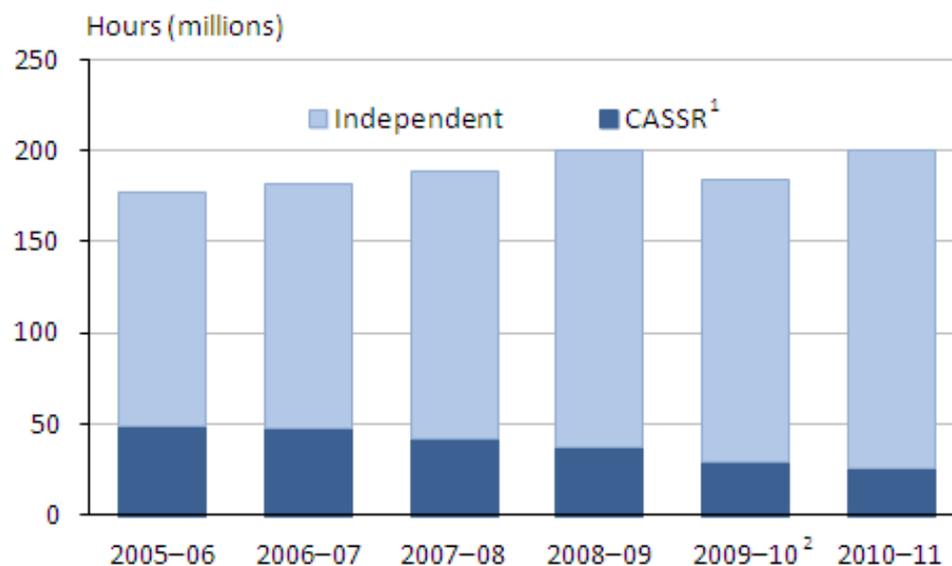
Information about life expectancy and potential need for health intervention and social care is very important for future planning of healthcare and expenditure, as is the role of caring which is discussed in the Measuring National Well-being article 'What we do'¹. Social care is one area which can help maintain and improve the quality of life of the individuals who need it. This section discusses social care provision, trends in demand and services, and satisfaction with care received.

In England, in July 2011, there were 2,500 independent hospitals; around 4,600 care homes with nursing; nearly 13,500 care homes without nursing; and around 5,900 home care agencies. Nearly half (45 per cent) of care home places are occupied by people who are self funding rather than paid for by the state (CQC, 2011).

In England during 2010/11 over 1.3 million adults received caring services: of these 885,000 received community-based services, such as meals on wheels, house cleaners, housing modifications for the elderly or those with disabilities, or day-care centres. The largest users of services, around two-thirds of the total, were the 873,000 clients aged 65 and over. There were also more than 467,000 clients aged 18 to 64 (HSCIC, 2011c). Recently there has been a rise in demand for services. The Care Quality Commission (2011) report indicated a 4 per cent increase in new contacts for councils responsible for providing social care.

Figure 7 shows the total number of contact hours of home care in England increased between 2005-06 and 2008-09 from 176.9 to 200.2 million hours and the total number of hours recorded in 2010-11 was very similar to 2008-09 (200.3 million hours). Data for 2009-10 indicated a fall in the total number of hours of contact time to 183.2 million hours, but this may have been because of errors in data recording. In contrast the hours provided by councils with social services responsibilities (CASSR) has gone down from 48.7 to 25.6 million hours a year. This may be due to a higher reliance on informal care-giving due to both cuts in services and new types of provision developed which enable people to live at home for longer. For example, residential care services fell by 10 per cent between 2004 and 2010 (CQC, 2011).

Figure 7. Actual number of contact hours of home care provided during the year: by sector
England



Source: The NHS Information Centre for health and social care, Community Care Statistics 2009-10: Social Services Activity Report, England

Notes:

1. CASSR - Councils with social services responsibilities.
2. The 2009-10 data should be treated with caution as it looks out of line with the trend from previous years. This may be because some councils under recorded those receiving home care via a personal budget to tie in with changes made to the RAP return and although the definitions were not changed, it is possible some councils may have recorded home care hours differently. The change was reverted back to 2008-09 definitions so the 2010-11 figures are unaffected.

Download chart

[XLS](#) [XLS format](#)
(28.5 Kb)

Responses to the Personal Social Services Adult Social Care Survey in England indicate that nine out of ten users who responded to the survey in 2010/11 reported that their quality of life was very good, good or alright². Nine out of ten also reported that they were very satisfied, satisfied or fairly satisfied with the care and support services they had received (HSCIC, 2011d). Further, the Care Quality Commission, 2011 found that of 17,000 respondents to the 2011 survey of people who use community mental health services, 29 per cent rated their received care as excellent, 30 per cent as

very good and 20 per cent as good. Respondents also felt they were listened to and had trust in their care providers and social workers.

Notes

1. [Measuring National Well-being - What we do](#)
2. The User Experience Survey Programme of Adult Social Services in England seeks opinions over a range of outcome areas to gain an understanding of service users' views rather than measuring quantities of care delivered. The survey asks all service users aged 18 and over receiving services funded wholly or in part by Social Services. It aims to learn more about whether or not the services are helping them to live safely and independently in their own home and what is the impact on their quality of life.

About the ONS Measuring National Well-being Programme

Nat_well-being general logo



This article is published as part of the ONS Measuring National Well-being Programme.

The programme aims to produce accepted and trusted measures of well-being of the nation - how the UK as a whole is doing. It is about looking at 'GDP and beyond' and includes:

- greater analysis of the national economic accounts, especially to understand household income, expenditure and wealth,
- further accounts linked to the national accounts, including the UK Environmental Accounts and valuing household production and 'human capital',
- quality of life measures, looking at different areas of national well-being such as health, relationships, job satisfaction, economic security, education and environmental conditions,
- working with others to include the measurement of well-being of children and young people as part of national well-being,
- measures of 'subjective well-being' - individuals' assessment of their own well-being,
- headline indicators to summarise national well-being and the progress we are making as a society,
- the programme is underpinned by a communication and engagement workstream, providing links with Cabinet Office and policy departments, international developments, the public and other

stakeholders. The programme is working closely with Defra on the measurement of 'sustainable development' to provide a complete picture of national well-being, progress and sustainable development.

Find out more on the [Measuring National Well-being](#) pages.

Background notes

1. © Crown copyright 2012

Under the terms of the [Open Government Licence](#) and UK Government Licensing Framework, anyone wishing to use or re-use ONS material, whether commercially or privately, may do so freely without a specific application for a licence, subject to the conditions of the OGL and the Framework.

For further information, contact the Office of Public Sector Information, Crown Copyright Licensing and Public Sector Information, Kew, Richmond, Surrey, TW9 4DU.

Tel: +44 (0)20 8876 3444

Email psi@nationalarchives.gsi.gov.uk

2. Follow ONS on [Twitter](#) or [Facebook](#) or view our podcasts on [YouTube](#).
3. Details of the policy governing the release of new data are available by visiting www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html or from the Media Relations Office email: media.relations@ons.gsi.gov.uk

Copyright

© Crown copyright 2012

You may use or re-use this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence/ or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

This document is also available on our website at www.ons.gov.uk.

References

1. Cancer Research UK (2010a). Cancer Stats – Key Facts. Available at [Cancer Research UK \(2010a\). Cancer Stats – Key Facts](#)
2. Cancer Research UK (2010b). Smoking Statistics – Smoking and Cancer.' Available at [Cancer Research UK \(2010b\). Smoking Statistics – Smoking and Cancer](#)
3. CQC (2011) Care Quality Commission The state of health care and adult social care in England. Available at [CQC \(2011\) Care Quality Commission: The state of health care and adult social care in England](#)
4. Department of Health (2008). The cost of alcohol harm to the NHS in England. Available at [Department of Health \(2008\). The cost of alcohol harm to the NHS in England](#)
5. Department of Health (2012). 'Healthy lives, healthy people: Improving outcomes and supporting transparency'. Available at [DH: Healthy lives, healthy people: Improving outcomes and supporting transparency](#)
6. European Commission, 2012, Attitudes of Europeans Towards Tobacco. Available at [European Commission: Attitudes of Europeans Towards Tobacco](#)
7. HES, (2011). Health Episode Statistics. Available at [HES: Health Episode Statistics](#)
8. HSE (2010) Health Survey for England 2010 trend tables. Available at [HSE: Health Survey for England 2010 trend tables](#)
9. Home Office (2011) Drug Misuse Declared: Findings from the 2010/11 British Crime Survey. Available at: [Home Office: Drugs misuse](#)
10. HSCIC, (2009). Health and Social Care Information Centre: Adult Psychiatric Morbidity Survey 2007. Available at [HSCIC: Adult Psychiatric Morbidity Survey 2007](#)
11. HSCIC (2010). Health and Social Care Information Centre: Health Survey for England, 2009. Available at [HSCIC: Health and Social Care Information Centre: Health Survey for England, 2009](#)
12. HSCIC (2011a) Health and Social Care Information Centre: HSE 2010 Annual Report, Well-being, Health and Work Chapter. Available at [HSCIC: Health and Social Care Information Centre: HSE 2010 Annual Report, Well-being, Health and Work Chapter](#)
13. HSCIC 2011b) Health and Social Care Information Centre: Attitudes to Mental Illness - 2011 survey report. Available at [HSCIC: Attitudes to Mental Illness - 2011 survey report](#)
14. HSCIC (2011c) Health and Social Care Information Centre: Community Care Statistics: Social Services Activity, England 2010-2011. Available at [HSCIC: Community Care Statistics: Social Services Activity, England 2010-2011](#)
15. HSCIC (2011d) Health and Social Care Information Centre: Personal Social Services Adult Social Care Survey, England 2010-11 (Final Release). Available at [HSCIC: Personal Social Services Adult Social Care Survey, England 2010-11](#)