# MRC/CSO Social and Public Health Sciences Unit Consultation Response

## Title of consultation
Health Survey for England: Consultation

## Name of the consulting body
Health & Social Care Information Centre (HSCIC)

## Link to consultation
http://www.hscic.gov.uk/public-health

## Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?
A considerable number of Unit researchers utilise these population-sampled survey data

## Our consultation response

1. **Reduce planned spend on website development**
   Reporting of HSE on the web is a sustainable and cost-effective means of disseminating key survey results and maintaining the profile of the survey. The website is a means for the public (including respondents) to find out more about the survey. As such it must look professional and inspire confidence in the survey, the survey team, and the users and uses made of the data. The distinction between development and presence is not clear. If the HSE report were not to be made available online, it is not clear how it will be reported. Any scaling back should be minimised. Assuming that these issues can be addressed we would see the website as a lower priority.

2. **Reducing the scale of reporting**
   The impact of the proposal to reduce the scale of reporting would be medium. Reduction in the scale of reporting would be preferred over loss of core interview content but this should be kept to a minimum. The HSE data are available for use by interested parties and as such, in some ways, it could be argued that reporting is superfluous. But just as noted in the context of the population estimates, it is preferable to have official figures put out, that have been thoroughly checked and for which there is some official responsibility, rather than encouraging duplication of effort (whereby many researchers would compete to perform the same analysis and publish the results) and have the risk of errors arising. Clearly all potential analyses cannot be presented but the desire to reduce costs should be balanced again the confidence that comes with the official figures.

3. **Reducing core interview content funded by HSCIC**
   There are question modules that we think should be prioritised and retained in the HSE survey. The following priority questions have all been used by researchers in the
MRC/CSO Social and Public Health Sciences Unit and should be retained:

Heaviest drinking day: These data on heaviest alcohol drinking day are a rare means of determining national, age, sex and deprivation-specific estimates of binge drinking for England. Reducing the presence of this question to just once in every four years severely impedes the ability to monitor prevalence of this important public health metric. Given concerns regarding alcohol use and its importance for policy, we do not believe that the item on the heaviest drinking day should be reduced in frequency.

Both GHQ12 and WEMWBS are other important priorities. Infrequent estimation of these mental health metrics would make tracking of trends and evaluating and informing policy very challenging. This is paramount since these are national statistics and mental health is an evermore important public health priority, not least because of concerns of the impact of austerity and cuts.

Since diet and physical activity should certainly be monitored on the basis of their informing on determinants of obesity, we believe that both Fruit and vegetable consumption and IPAQ should be retained.

As a general point, while self-reported measures of alcohol, fruit/veg and physical activity may not be entirely reliable, with the exception of genetic markers to measure lifetime propensity, there is currently no better alternative than these survey-based items.

There is no question modules that we think could be dropped from the HSE survey. As a general principle we believe that as a priority the data collected in the survey should be protected to as great an extent as possible. Where it is not possible to retain all data items at the current level of collection, our preference would be for intermittent collection of all items rather than dropping any completely.

It is important to bear in mind that knowing the prevalence of individual items is not the sole purpose of collecting that information – it is also the relationships between variables that are important. Normative data for different groups defined by various characteristics / identification of key determinants of health and wellbeing are important aspects. For example, the EQ-5D has been listed as an item that could be dropped. The EQ-5D is very widely used so presumably it is not being dropped on the basis of interest level. What the HSE can show is how the EQ-5D varies between groups such as those stratified by socioeconomic status; this could be essential for – for example – undertaking calculations to determine required sample sizes.

If necessary, it may however make sense to reduce the frequency of the collection of some items. Bearing in mind the above point regarding relationships between variables, it may be that rather than smoothing out the omissions (such that the surveys are of approximately the same length each year) it would be better to include more measures in some years than others. For example, those variables collected once per cycle could all be collected in the same year (allowing analysis of the relationship between GHQ-12 and WEMWEBs, for example).

A key advantage of the HSE is its compatibility with other national survey data sources such as the Scottish Health Survey. For many health topics of interest, the questions and categories are equivalent across surveys which facilitates the appending of data. This combining enables both increases in sample size and national
comparisons. Reduction of core interview content would threaten the compatibility between HSE and other national surveys and thus more broadly limit the use of HSE data.

4. Reducing the scale of nurse fieldwork
The impact of proposed changes would be medium. Modest reductions in nurse visits with protection of core interview content would be preferable to loss of core content. Offering 80% of households a nurse visit would be preferred compared with dropping the visit in alternate years. We suggest consideration of offering 50% of respondents a nurse visit each year as another alternative to the latter.

We also suggest that greater use could be made of linkage to, for instance, biochemical results, rather than solely hospitalisations and mortality which might ameliorate the impact of the proposed reductions.

When was the response submitted?
23 June 2016

Find out more about our research in this area
http://www.sphsu.mrc.ac.uk/research-programmes/in/

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