

## **National consistency: United Kingdom**

### **Broad overview on data availability in the UK**

*Please note that this overview has been provided with advice from Romyani Gupta – Information Specialist at the Lung and Asthma Information agency and through perusal of online descriptions of data provided on the internet. Sections of the text within this document are generated by 'cut and paste' from websites that describe data available in the UK. This is a broad overview and there are likely to be errors in the detail.*

The UK comprises four nations – England Scotland Wales and Northern Ireland. The information systems for each are slightly different and those for England are the ones that are easiest to get information about. Asthma and COPD have quite a lot of information largely due to the success of The Health Survey for England.

Populations composition is available by age and gender and geographical area. Ethnicity and social class are collected during the census but the groupings may be different to those being proposed. Income norms for the population are available through surveys but would imagine that more robust data are available using information from taxation. Educational level is available from the British Labour Force Survey (and probably others)

Mortality data are available for all four nations using standard techniques. Standardised death rates are produced but I have not seen anything at UK level with asthma or COPD as contributory cause. If mortality data is available PYLL can be determined.

Morbidity from asthma and COPD can be obtained from health examination surveys. The Health Survey for England is a national survey of a representative sample. Each year different health problems are addressed. Detailed information on asthma, allergy and lung function has been collected in the past and it would be envisaged that in future years respiratory disease would again be the theme. The data are aggregated and summarised in tables which are freely available. The data sets are available to researchers through a formal application procedure. The data permit generation of prevalence of respiratory symptoms, asthma, COPD, specific IgE to house dust mite and the means total IgGE and FEV1. They also can be used to produce figures for exposure to established risk factors eg smoking, damp homes, obesity. Similar surveys are ongoing in Scotland and Wales and Northern Ireland there are likely to be some data on respiratory disease from these: examples of the way these data are currently available published attached. The precise wording of questions needs closer inspection. The health surveys allow linkage of exposures to respiratory disease at individual level. More specific morbidity data is available on children as the ISAAC study had many centres in England Scotland and Wales and might be considered 'nationally representative'.

Information on smoking, alcohol, diet and physical activity is and will continue to be collected through the Health Surveys. As smoking is government priority area a wealth of data will need to come from all four nations as part of monitoring. Some changes are being made as part of the National Health Service Frameworks.

Nutritional intake must be able to be determined from food surveys. The National Food Survey is a continuous sampling enquiry into the domestic food consumption and expenditure of private households in the United Kingdom (since the introduction of Northern Ireland in January 1996). Each household which participates in the survey does so voluntarily, and without payment, for one week only. By regularly changing the households surveyed, information is obtained continuously throughout the year. Each household is provided with a specially designed log-book in which the person principally responsible for domestic food arrangements provides information about each household. The main diary-keeper keeps a record each day for seven days, with guidance from an interviewer, of all food entering the home intended for human consumption. Information about characteristics of the household and of its members is recorded on a separate questionnaire. From 1994 an extension to the Survey was included to cover food and drink consumed outside the home, ie. not from household supplies. The Eating Out Extension provides estimates of average consumption, expenditure and the nutritional value of food eaten out, classified by the same household characteristics as the main survey and also by personal characteristics such as age and gender. This survey would have the capacity to produce the nutrient indicators required at population level.

Air pollution data is increasingly being collated at national level – broadly speaking levels can be obtained although PM2.5 is patchy and some parts of the country may be less well monitored than others (usually the areas with perceived low levels)

Occupation is collected during the census but not linked to exposures – so proportions exposed to risky jobs unknown.

Exposure to allergens is unknown although pollen counts are available

There is a major drive to encourage people to stop smoking . Smoking cessation clinics have been developed and each health authority (PCT) is expected to return collated data on coverage. However this activity could only be linked to disease status through health surveys.

Health authorities keep data on number of GPs and primary health care centres in their area. I cannot believe there is information kept on number of allergy or pneumology units. The availability of management plans can only come from health surveys and I do not think these questions have been asked.

Hospital admission data are collected with diagnostic codes, length of stay and basic demographic information. The data are usually available on

request. But the data for the four nations are held separately and not collated routinely. However our indicators require as the denominator the 'disease group' – no one has these data as far as I am aware although the Health Surveys may give some indication. There are no national data on attendances at emergency rooms.

There is a growth in the amount of data available from general practice through the General Practice Research Databases. These data originate from general practitioners computerised symptoms and record consultations the GPs, diagnostic codes and basic demographic information from the entire population registered with that GP. These databases are mainly exploited by research groups with an expertise in their management – they are time consuming to manipulate but can provide valuable information on some aspects. These data bases cover populations of up to 300,000 and are currently available with payment. These databases could be used to generate rates of attendance but strictly speaking would not be nationally representative.

The GP sentinel practice system which records all consultations and forwards this to Royal College of General Practitioners has been exploited by researchers for monitoring asthma and COPD. While a major purpose of this data collection process is to identify increases in community infection (ie tracking of influenza outbreaks') it has been usefully exploited to monitor trends in consultations for allergic diseases. Data are collected routinely from a network of approximately 73 practices, well distributed across England and Wales. The practices provide a tabular summary of the number of patients seen each week categorised by gender, age group and disease or disease group. The disease-based information is classified according to the Read code classification system and data on new episodes of illness are collected separately from data on ongoing or follow-up consultations. The detailed age specific practice registered population is also collected with each set of data transferred. At the Birmingham Research Unit the data are processed to provide incidence and prevalence rates of diseases.

Scotland has developed a Continuous Morbidity Reporting System under similar lines. PTI (Practice Team Information) is a system for the collection of primary care data from general practice. This includes the data for General Practitioners, practice and community nurses. It is part of the Scottish National Dataset. Practices are broadly representative of the Scottish population in terms of age, sex, deprivation and urban/rural mix. Data are collected from every face-to-face contact between a member of the practice team and patient. All contacts with practice patients (including temporary residents) are captured. Contacts are recorded by every doctor (including locums), practice and community nurses. Up to ten problems can be recorded for each contact with a doctor and four for nursing staff. Doctors are asked to describe the problem as specifically in diagnostic terms as possible. Each diagnosis is given a Read code along with an appropriate modifier. Nursing staff are strongly recommended to record an activity from the nursing activity list (Appendix 3) along with an appropriate modifier. They are also asked to provide an associated morbidity (if appropriate), along with an appropriate modifier, in certain

circumstances depending on their discipline type. The data are entered onto the practice Gpass system. Monthly extractions are sent to Information and Statistic Division for analysis. The practices involved may not be representative of Scotland. I know little about the Northern Ireland information availability.

The vast majority of asthma and COPD drugs are provided through the NHS. Pharmacists are reimbursed through the Prescribing Pricing Authority. Therefore high total numbers of prescriptions can be counted. However these data only seem to be available for England and I am not certain about the other nations. The data do not contain AGE or DIAGNOSIS which limits their use.

The costs of the health service are difficult to find out –

Health outcomes require information from the Health Surveys – some of the areas considered will be covered.

## **Other National Sources**

### **British Household Panel Survey (BHPS)**

The BHPS is carried out by the Institute for Social and Economic Research (ISER), incorporating the ESRC Research Centre on Micro-Social Change, at the University of Essex. The main objective of the survey is to further understanding of social and economic change at the individual and household level in Britain (the United Kingdom from Wave 11 onwards), to identify, model and forecast such changes, their causes and consequences in relation to a range of socio-economic variables. The BHPS is designed as a research resource for a wide range of social science disciplines and to support interdisciplinary research in many areas.

The BHPS provides information on household organisation, employment, accommodation, tenancy, income and wealth, housing, health, socio-economic values, residential mobility, marital and relationship history, social support, and individual and household demographics.

A major development at Wave 9 was the recruitment of two additional samples to the BHPS in Scotland and Wales. There were two main aims of the extensions. Firstly, to increase the relatively small Scottish and Welsh sample sizes (around 400-500 households in each country in the initial BHPS sample) in order to permit independent analysis of the two countries. Second, to facilitate analysis of the two countries compared to England in order to assess the impacts of the substantial public policy changes which may be expected to follow from devolution. The target sample size in each country was 1500 households.

At Wave 11 an additional sample from Northern Ireland, which formed the Northern Ireland Household Panel Survey (NIHPS), was added to increase the representivity of the whole of the United Kingdom. The target sample size was 2000 households.

The BHPS may be able to provide some of the information required. As regards linking it to health it is not suitable as the one question regarding asthma and COPD considers both within 'chest/breathing problems'.

### **General Household Survey**

The General Household Survey (GHS) is a continuous national survey of people living in private households conducted on an annual basis, by the Social Survey Division of the Office for National Statistics. The main aim of the survey is to collect data on a range of core topics, covering household, family and individual information..The GHS consists of a household questionnaire, completed by the Household Reference Person, and an individual questionnaire, completed by all adults aged 16 and over resident in the household. A number of different trailers each year covering extra topics are included in later (post-review) surveys in the series, from the 2000-2001 survey (SN: 4518) onwards. The household questionnaire covers the following topics: demographic information about household members, household and family information, household accommodation, housing tenure, consumer durables including vehicle ownership, and migration.

The individual questionnaire includes sections on employment, pensions, education, health and use of health services, smoking, drinking in the last seven days, family information including marriage, cohabitation and fertility history, and income.

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