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Project Final Report

Health behaviour and health behaviour change among adults in England

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Abbreviations and glossary of key terms

Abbreviations

CAPI	Computer assisted personal interview
F&V	Fruit and vegetable
PA	Physical activity
UKHLS	<i>Understanding Society</i> : the UK Household Longitudinal Study
AMEs	Average Marginal Effects
ORs	Odds ratios

Key terms used in the report

Risk behaviour: a behaviour that does not meet government recommendations e.g. eating fewer than five portions of fruit and/or vegetables per day.

Average Marginal Effects: Average Marginal Effects (AMEs) are estimates derived from non-linear multivariate analysis (e.g. logistic regression) of the impact of a change in an explanatory variable on the overall predicted probability, holding other variables constant. They provide an intuitive way of illustrating the size and direction of relationships between variables of interest and the health behaviour under study. Like Odds Ratios, AMEs are evaluated relative to a reference category and show the direction of the association with the outcome variable. They additionally provide a direct estimate of the size of the association

Social patterning of risk behaviours: an association between a socio-demographic (for example, age, gender, ethnic group) or socio-economic (for example, household income) factor and the risk behaviour.

Preface: What the project adds to knowledge

This project investigates four behaviours linked to ill-health and premature mortality - smoking, harmful alcohol intake, low fruit and vegetable (F&V) intake, and low physical activity - and examines stability and change in these behaviours over time. It also explores whether life events and transitions that many people experience in the course of their adult lives are associated with changes in their health behaviours.

Analyses are based on *Understanding Society*, the UK Household Longitudinal Study (UKHLS), a large nationally representative study of adults and children living in private households who have been surveyed every year since 2009/10. The project focuses on adults living in England and on the two waves of the UKHLS where information on health behaviours was collected: 2010/11 and 2013/14.

The report describes findings from the first analysis to have been carried out on stability and change in health behaviours in the adult population of England. It is also the first study to use a national survey of adults to examine the relationship between a range of life transitions and positive and negative changes in four key health behaviours.

The project adds to knowledge about health behaviours among adults living in England by:

- *Enriching understanding of the social patterning of health behaviours.* The project confirmed that, in broad terms, social disadvantage was associated with smoking and with levels of F&V consumption and physical activity that did not meet the recommendations, while social advantage was associated with binge drinking. However, other dimensions of people's lives and identities were also predictors of risk behaviours. These included ethnicity; those from non-white ethnic groups were less likely to smoke and binge drink but more likely to not meet F&V or physical activity recommendations.
- *Shedding light on patterns of stability and change in health behaviours.* Across the three years under study, stability was the norm. The majority of those who met the recommendations for smoking, F&V consumption and binge drinking in 2010/11 continued to do so in 2013/14 and 50% of those meeting the physical activity recommendations in 2010/11 also did so in 2013/14. Conversely, the majority of those not meeting the recommendations in 2010/11 did not do so three years later: this was true of all four health behaviours. The pattern was particularly marked for physical activity and F&V consumption: of those not meeting the recommendations in 2010/11, 84% (physical activity) and 86% (F&V consumption) failed to meet them three years later.
- *Describing the social patterning of changes in behaviour using a wide range of measures of individual circumstances and identity.* For smoking, F&V consumption and physical activity, those in more disadvantaged circumstances were less likely to make positive changes. For binge drinking, the associations were reversed. Social disadvantage was associated with stopping binge drinking and being less likely to start.
- *Providing an exploratory analysis of life transitions and health behaviour change.* We focused on a range of transitions that mark out people's adult lives: changes in relationship status, changes in employment status (including moving from full-time education to employment/unemployment and retiring from paid work), the addition of a child/ren to a

previously childless household and changes in household income. With the exception of changes in income, relatively few people experienced these transitions in the time period of our study (2010/11 to 2013/14). Some transitions (for example, moving out of a relationship) were associated with negative changes in health behaviour (starting smoking and binge drinking). However the reverse transition (i.e. forming a relationship) was not associated with positive changes. Leaving full-time education (FTE) was associated with greater risk of starting smoking, regardless of whether students moved into employment or unemployment.

1. EXECUTIVE SUMMARY

1.1 Introduction

Four behavioural risk factors - cigarette smoking, harmful alcohol intake, poor diet and physical inactivity – underlie the chronic diseases responsible for the majority of premature deaths in England. The government has recommendations in place to encourage healthy lifestyles: adults are advised not to smoke, not to consume excessive amounts of alcohol, to consume a minimum of 5 portions of fruit and vegetables (F&V) a day and take at least 150 minutes of moderate to vigorous physical activity a week (or 75 minutes of vigorous activity).

Most of the evidence on health behaviours comes from cross-sectional studies like the Health Survey for England (HSE) which tell us what is happening at population level. For example, the HSE indicates that, over the last five years, smoking prevalence has declined but there has been no improvement in the proportion of adults achieving the recommended level of physical activity. Much less is known about stability and change in health behaviours at an individual level. Even less is known about whether changes in an individual's circumstances – for example, gaining employment, entering a relationship and experiencing an increase in income – are associated with changes in health behaviour. Our project addresses these gaps.

1.2 Aims and objectives

Our aim is to strengthen the evidence base of public health policies in England by providing detailed information about stability and change in cigarette smoking, alcohol intake (binge drinking), F&V consumption and physical activity among adults in England.

Our objectives were to:

- investigate the prevalence and social patterning of the four health behaviours in 2013/14
- investigate the prevalence and social patterning of changes in the four health behaviours between 2010/11 and 2013/14
- explore whether common life transitions are associated with changes in the four health behaviours. The project focused on changes in relationship status, changes in employment status (including taking up employment, becoming unemployed and retirement), adding a child/ren to a previously childless households and changes in household income.

1.3 Methods

We used a nationally-representative longitudinal survey of the UK population, *Understanding Society*: the UK Household Longitudinal Study (UKHLS), to address the three objectives. In line with the PHRC remit, our analyses focus on adults living in England.

The UKHLS is the largest longitudinal survey of its kind. As well as a large general population sample, it includes a boost sample of ethnic minority groups to facilitate analyses that take account of ethnicity. It is a multi-topic survey which collects a wide range of information on the socio-demographic (e.g. ethnic group, age, partnership status) and socio-economic position (e.g. education, social class, income) of individuals. It is also possible to match neighbourhood level data, such as the Indices of Multiple Deprivation, to respondents based on their address. Study

participants are interviewed every year, with annual measures of core information (e.g. income, partnership status) and less frequent measures of other aspects of people's lives. UKHLS participants provided information on health behaviours (cigarette smoking, diet, physical activity and alcohol consumption) in 2010/11 and 2013/14. We derived measures of health behaviour that align as closely as possible to government recommendations for the four behaviours at the time study participants were interviewed (i.e. 2010/11 and 2013/14).

1.4 Findings

Health behaviours:

- Most adults did not smoke (less than one in five men and women) or binge drink (around 3 out of 4 men and women did not binge drink). However, the large majority of men and women did not meet recommendations for F&V or physical activity.
- Engagement in risk behaviours was related to people's socio-economic circumstances. In broad terms, social disadvantage was associated with smoking and with levels of F&V consumption and physical activity that did not meet the recommendations while social advantage was associated with binge drinking.
- However, other dimensions of people's lives and identities were also important predictors of risk behaviours. These included ethnicity; those from non-white ethnic groups were less likely to smoke and binge drink but more likely not to meet F&V or physical activity recommendations.

Stability and change in health behaviours

- Stability in adult health behaviours is the norm. Most people did not smoke or binge drink in 2010/11 and continued not to do so in 2013/14. Equally, most people did not meet the F&V or physical activity recommendations in 2010/11 and continued not to do so in 2013/4.
- While only a minority changed their behaviour, there is some evidence that change is socially patterned.
- For smoking, F&V consumption and physical activity, those in disadvantaged circumstances were less likely to make positive changes. Specifically, those with lower levels of educational attainment, who were unemployed and who were not married were less likely to stop smoking. Conversely, those who had lower levels of educational attainment, were not married and were younger were more likely to start smoking.
- With respect to F&V consumption, those less likely to start meeting recommendations had lower levels of educational qualifications, were unemployed, not married and from South Asian groups. Those with lower levels of educational attainment and those from non-White ethnic groups were also more likely to stop meeting recommendations.
- With respect to physical activity, women, older people, those from South Asian groups, in poor health and with lower levels of educational attainment were all less likely to start meeting the recommendations. Women, those in poor health, those with the lowest levels of educational attainment and with lower household incomes were also more likely to stop meeting recommendations.
- With respect to binge drinking, a markedly different social pattern emerged. Study participants most likely to stop binge drinking were women, those with the lowest levels of educational attainment and those from non-white ethnic groups. Those less likely to start binge drinking were: women, older people, those in poor health, those from non-white ethnic groups and those with the lowest household incomes.

- Taken together, our findings point to some widening of social inequalities in health behaviours over time. With the exception of binge drinking, those with lower levels of educational attainment were typically less likely to make positive improvements in behaviour and more likely to make negative changes. For binge drinking, the opposite pattern was evident; those with no/other educational qualifications were more likely to stop binge drinking than those with a degree or higher.
- It is also notable that social factors strongly associated with current behaviour, such as household income, were less important when looking at behaviour change. Thus, factors predictive of individual behaviour at a single point in time (i.e. when viewed cross-sectionally) are not necessarily associated with change in behaviour over time.

Common life transitions and changes in health behaviour

- Although we focused on life events and transitions that many people experience in the course of their adult lives, these changes were uncommon across the three-year time period of our project (2010/11 to 2013/14). The exception was changes in household income; over a third (36%) experienced an increase of 20% or more and nearly a fifth (18%) saw their household income fall by 20% or more.
- While some transitions were associated with negative changes in health behaviour, the reverse transition did not bring positive change. For example, moving out of a relationship was associated with a greater likelihood of starting smoking and binge drinking - but moving into a relationship did not reduce the likelihood of starting smoking and binge drinking. Similarly, becoming unemployed meant a greater likelihood of starting smoking but becoming employed was not associated with any changes in smoking behaviour.
- Moving from full-time education (FTE) was associated with greater risk of taking up smoking; this is regardless of whether students moved into employment or unemployment, both of which were associated with higher rates of starting smoking than remaining in FTE.
- There was very little evidence that life transitions were associated with changing F&V consumption. Of the transitions we investigated, only moving out of a relationship and becoming unemployed were associated with changes in whether people met the F&V recommendations. Study participants moving out of a relationship were more likely to stop meeting the recommendations than those remaining in a relationship and, compared to those who remained in employment, those becoming unemployed were less likely to start meeting the recommendations.

1.5 Conclusions

Our project adds to the evidence on health behaviours in England that make a major contribution to the burden of disease. They are ones central to the government's ambitions to combine improvements in health with greater improvements among those living in more deprived areas.

We add to the evidence base in two unique ways. For the adult population of England, we provide evidence on stability and change in four key behaviours and we explore the relationship between life transitions and health behaviour change.

Using measures based on government recommendations, the project confirms the stability of health behaviours over time; the majority of those not meeting the recommendations for the four behaviours in 2010/11 were not doing so three years later. In analyses that took account of a wide range of factors, it also points to the social patterning of change. In broad terms, social advantage is

associated with positive changes in health behaviour – with the exception of binge drinking. Ethnicity is also a key factor, both in the patterning of health behaviours and in stability and change over time.

Focusing on transitions many people experience in the course of their adult lives, we found limited evidence that, across the 3 year period for which we had health behaviour data, life transitions were associated with changes in health behaviours. Further, where a transition was associated with behaviour changes, it could encompass both positive and negative changes. For example, moving out of a relationship increased the likelihood of starting smoking, starting binge drinking and stopping meeting the F&V recommendations – but it also increased the likelihood of meeting the PA recommendations. While only exploratory, our study points to the scope for extending analyses of the UKHLS to examine how life course transitions impact on health behaviours over longer periods of time.

2. BACKGROUND, AIMS AND OBJECTIVES

2.1 Introduction

Cigarette smoking, harmful alcohol intake, poor diet and physical inactivity are risk behaviours which underlie the chronic diseases (cardiovascular disease, cancer, lung disease and type-2 diabetes) responsible for the majority of premature deaths in England and in other high-income countries (PHE, 2017; WHO, 2010; 2014). Governments advise the population not to smoke, not to consume excessive amounts of alcohol, to consume a minimum number of portions of fruit and vegetables (F&V) a day and to engage in a minimum amount of physical activity (PA) a week. Recommendations can change over time in line with new evidence on health risks; for this project, we used recommendations from England's Department of Health in place between 2010/11 and 2013/14 (Box 1).

Box 1: Government guidelines on the four health behaviours

ADULTS

Smoking

- do not smoke at all

Alcohol consumption*

- for women on most days do not drink more than 2-3 units of alcohol a day and on no days drink more than 6 units
- for men on most days do not drink more than 3-4 units of alcohol a day and on no days drink more than 8 units

Fruit and vegetable consumption

- eat at least 5 portions of fruit and/or vegetables a day

Physical activity

- engage in at least 150 minutes a week of moderate to vigorous intensity physical activity per week in bouts of 10 minutes or more, or engage in at least 75 minutes a week of vigorous intensity physical activity or an equivalent of the two

Sources: DoH, 2003, 2005, 2009, 2011a 2013a, 2011b, 2013b

*These were the alcohol guidelines at the time that survey data were collected. They have since been updated.

Unhealthy behaviours are socially patterned, contributing to socio-economic inequalities in morbidity and premature mortality (Laaksonen et al. 2008, Stringhini S 2010). Rates of smoking are typically higher among those living in the most deprived areas of Britain (NHS digital, 2016). Meeting F&V recommendations is less likely among those living in the lowest income households than those living in the highest income households. Likewise, those living in the lowest income households or with lower socio-economic status are less likely to engage in PA than those living in higher income households or with higher socio-economic status (PHE, 2013). The evidence for alcohol consumption is more mixed. Higher levels of consumption are evident among those with less disadvantaged backgrounds (NHS digital, 2016; Bloomfield et al, 2006) while rates of alcohol-specific mortality are higher among those living in more deprived areas (ONS 2017a).

Promoting healthy lifestyles is central to public health policy in England, and the government's wider vision of combining improvements in health with greater improvements in disadvantaged communities (DoH 2010; DoH, 2013c; PHE 2014; NHS, 2014). Public Health England, an executive agency of the Department of Health, has identified six behaviour change opportunities which could contribute to meeting this ambition. These include reducing smoking, increasing PA, reducing obesity (and by extension, improving diet as well as levels of PA) and reducing harmful alcohol consumption (DoH, 2014). As a recent report on the *Future of Health* notes, 'unhealthy lifestyle choices' are making an increasing contribution to the burden of ill-health in England and represent a

priority area for both research and policy (Corbett et al, 2017). Lifestyle factors are also highlighted in the Department of Health's statement of its Areas of Research Interest, where it notes the need for social research into the drivers of diseases in which unhealthy behaviours play an important role (DoH, 2017).

The project is set in this policy context. Focusing on adults in England, it investigates (i) the prevalence and social patterning of four key risk behaviours and (ii) the prevalence and social patterning of changes in these behaviours.

2.2 Evidence on health behaviours

Patterns of health behaviour over time are typically measured using repeat cross-sectional surveys, such as the Health Survey for England (HSE). They point to a continuing decline in smoking prevalence: smoking rates among adults fell from 28% in 1998 to 18% in 2015 (NHS digital, 2016). There has also been a decrease in the proportion of adults consuming twice their daily recommended limits of alcohol (often called binge drinking), falling from 20% of adults in 2006 to 15% in 2015. In contrast, trends in meeting F&V and PA recommendations have remained broadly stable in the past decade (NHS digital, 2016).

While cross-sectional surveys are important in capturing trends in health behaviour at a population level, they give little insight into how behaviour is changing for individuals. To date, there has been very little exploration of how engagement in smoking, alcohol, F&V consumption and PA is changing among individuals. Previous studies of individual-level change have had a restricted focus, for example focusing on older adults (c.f. Lang et al, 2007; Colell et al, 2014), or a single health behaviour (c.f. Giordano & Lindstrom, 2010; Staff et al, 2015) or have been based on cohort studies which, while capturing what is happening in the age cohort under study, are not representative of all adults (c.f. Vinther et al, 2016; Barnett et al, 2016). Because little is known about within-person patterns of behaviour over time, little is also known about whether and how changes in health behaviours may be socially patterned, that is, whether certain individuals are more likely to change health behaviours than others.

Our project addresses these gaps. We use a large, nationally representative panel survey – *Understanding Society*: the UK Household Longitudinal Study - to explore changes in the four health behaviours between 2010/11 and 2013/14. By exploring change within individuals, we can examine the characteristics of those most likely to make changes in their behaviour.

The project provides an in-depth picture of changing health behaviours for individuals over a three-year time period. It describes the overall prevalence and patterning of unhealthy behaviours in 2013/14 as well as identifying those most and least likely to make positive changes between 2010/11 and 2013/14. We also explore the relationship between key life transitions and health behaviour change. Such evidence can inform both population-wide and targeted strategies to improve health (DoH 2010; NHS, 2014; PHE, 2014).

2.3 Evidence on health behaviour change

Like other behaviours, many health behaviours are repeated on a daily basis as part of the routines of our everyday lives, such as getting up, caring for children and travelling to work. Repeated in familiar contexts, health behaviours – our eating habits, smoking habits, patterns of PA and alcohol consumption - become habitual. They are elicited without conscious thought by the contexts in which they have been formed (Danner et al, 2008). They are rarely the outcome of deliberation and active planning (Marteau et al, 2012).

Woven into everyday contexts and routines, health behaviours therefore tend to persist over time. Past behaviour – e.g. being a smoker or being physically active – is therefore a strong predictor of current behaviour. For example, levels of PA are relatively stable across adulthood (Telama, 2009); smoking behaviour similarly tends to be maintained over time, with nicotine dependence adding to the habitual nature of regular smoking (Breslau, 2001). Habits laid down in childhood and adolescence can influence adult health behaviours, including PA and smoking (Telama et al, 2005; NHS Digital 2016). Like dietary habits and PA, smoking careers are patterned by social disadvantage; those from more disadvantaged backgrounds are more likely to smoke in adolescence and early adulthood, and to remain smokers across their adult lives (Gilman et al, 2003; Jefferis et al, 2004).

Because health behaviours are embedded within the contexts and routines of everyday life, they can be resistant to change. However, changes in an individual's circumstances can facilitate behaviour change, including life transitions that are an expected part of adulthood. For example, leaving higher education, entering a cohabiting relationship, becoming a parent and retiring from paid work may each provide a stimulus for behaviour change. However, evidence on life transitions and lifestyle change is limited (see chapter 6 for a more extended discussion). Pregnancy, and particularly first pregnancy, is associated with positive changes in health behaviours, including quitting smoking (Graham et al, 2010), reduced alcohol consumption and healthier food choices (Crozier et al, 2009; Olson, 2005). There is also some evidence that retirement is associated with an increase in PA (Engberg et al, 2012); however, a UK-based study found that the increase in recreational and home-based activity was more than offset by reductions in occupational and travel activity (Barnett et al, 2013).

A major challenge to advancing understanding of life transitions and lifestyle change is the paucity of datasets. A key source of evidence is the UK's cohort studies, including the national birth cohort studies established in Britain in 1958, 1970 and 2000/01 which follow study participants across their lives. While a rich resource for longitudinal analyses, their design means the evidence relates to a particular age group rather than to the adult population as a whole. There are very few UK datasets that enable the behaviours of adults of all ages to be tracked over time and for patterns of stability and change to be set within the context of wider life changes and transitions. The UKHLS is unique in both respects. It enables analysis of individual-level stability and change in health behaviours over time; it also enables exploration of the impact of life events and transitions on health behaviours.

To inform our analysis, we undertook a Rapid Evidence Assessment (REA) to identify evidence relating to life transitions and changes in health behaviour. This is described in Chapter 3.5.

2.4 Project aim and objectives

We aim to strengthen the evidence base of public health policies in England by providing up-to-date information for adults in England on cigarette smoking, alcohol intake (binge drinking), fruit and vegetable consumption and PA. Our analyses focus on patterns of engagement in each health behaviour and how they change over time.

Our specific objectives were to:

- investigate the prevalence and social patterning of the four health behaviours in 2013/14
- investigate the prevalence and social patterning of changes in the four health behaviours between 2010/11 and 2013/14
- explore whether certain life transitions are associated with changes in the four health behaviours.

The report is structured around these objectives (Box 2).

Box 2: Objectives and the structure of the report

	Chapter
<u>Objective 1: Prevalence and social patterning of the four health behaviours:</u>	4
<ul style="list-style-type: none">• Prevalence of the health behaviours• Social patterning of the health behaviours	5
<u>Objective 2: Prevalence and social patterning of changes in each health behaviour over time</u>	6
<ul style="list-style-type: none">• Stability and change in the health behaviours• Social patterning of stability and change in the health behaviours	
<u>Objective 3: Exploratory analysis of the relationship between life transitions and changes in each health behaviour</u>	
<ul style="list-style-type: none">• Experience of life transitions• Relationship between life transitions and the health behaviours	

3. DESIGN AND METHODS

3.1 Data sets

We used a nationally-representative longitudinal survey of residents in England: *Understanding Society*: the UK Household Longitudinal Study (UKHLS) ¹ to address the three project objectives. An overview of the UKHLS is provided in Box 3 (for details see Knies, 2017).

Box 3: Overview of UKHLS

Understanding Society: the UK Household Longitudinal Study (UKHLS) has conducted annual surveys since 2009 of participants from a representative sample of around 28,000 UK households who, together with an ethnic minority boost sample of around 4,000 households, are followed over time. Health behaviour data were gathered in the second wave (2010/11) from 51,000 adults in UK households (33,000 adults in English households). More information about the UKHLS is available at <https://www.understandingsociety.ac.uk/>

We selected the UKHLS because of its unique strengths:

- The UKHLS is large and population-wide.
- Along with rich social data, it collects information on health behaviours (cigarette smoking, diet, PA and alcohol consumption) that can be aligned to DoH recommendations along with rich social data. Social data include socio-economic measures relating to the individual (e.g. educational attainment), the households they live in (household income) and their areas of residence (Index of Multiple Deprivation).
- Its longitudinal structure means that within-person changes in health behaviour can be measured over time. In contrast to intervention studies, where behaviour change is usually measured across relatively short time periods (of weeks or months), the UKHLS enables change to be measured over a number of years. In 2010/11, the second wave of the UKHLS collected information on the four health behaviours; information on the same set of behaviours was also collected in the fifth wave of the UKHLS, in 2013/14. Its longitudinal structure also means that between-wave life transitions can be identified: we could therefore examine whether changes in people's circumstances (e.g. moving into or out of a relationship, or moving from employment to unemployment) were associated with changes in meeting recommendations for the four health behaviours.

The UKHLS data can be analysed cross-sectionally for a given year to examine the prevalence of different health behaviours in that year and longitudinally to explore change in health behaviours over time. This report uses both methods. In line with the remit of the DoH PHRC, all analyses are

¹ Understanding Society is an initiative funded by the Economic and Social Research Council and various Government Departments, with scientific leadership by the Institute for Social and Economic Research, University of Essex, and survey delivery by NatCen Social Research and Kantar Public. The research data are distributed by the UK Data Service. University of Essex. Institute for Social and Economic Research, NatCen Social Research and Kantar Public, [producers]: *Understanding Society: Waves 1-7, 2009-2016 and harmonised British Household Panel Survey: Waves 1-18, 1991-2009*. [computer file]. 9th Edition. Colchester, Essex: UK Data Service [distributor], November 2017. SN: 6614, <http://dx.doi.org/10.5255/UKDA-SN-6614-9>.

based on data for England. Further details of the design and methods of the studies can be found in Appendix A.

3.2 Data on health behaviour

Like other large surveys, the UKHLS relies on self-reported data. Self-reported data tend to underestimate the prevalence of health-damaging behaviours (Tipping et al, 2010). However, the lack of available instruments and/or cost constraints, together with the burden on participants and the consequent challenge of obtaining a sufficiently high response, means that objective measures of health behaviours (e.g. using biological samples) are not often used in large studies.

Questions on health behaviours were administered and asked in the same way at waves 2 and 5, providing a consistent set of measures for our analyses of changes in health behaviours. Information on smoking, F&V consumption and PA was collected from adults as part of the main computer assisted personal interview (CAPI). Alcohol consumption was collected by a separate self-completion questionnaire.

The exact questions asked about each health behaviour are shown in Appendix A. Because of the broad coverage of the survey and the consequent constraints on space in the questionnaire, data collected about PA, F&V consumption and alcohol consumption are more limited in the UKHLS than other comparable surveys, such as the Health Survey for England (HSE).

With respect to PA, the UKHLS asks questions on a wide range of sports activities (including fitness, gym and conditioning activities) in the last week and on days of fast/brisk walking for 30 minutes or more in the last four weeks, but no questions on other types of activity. Previous analysis has shown that with this more restricted set of activities, a larger proportion in the UKHLS are classified as failing to meet the PA recommendation than in other studies (Graham et al, 2016a).

Similarly, the UKHLS questions about F&V consumption are less detailed than other studies like the HSE, asking only about number of days the individual consumed tinned, frozen, dried and/or fresh fruit/vegetables and a single follow-up question on number of portions covering both fruit and/or vegetables. Despite these differences, our earlier study of parents found that similar proportions of parents from the UKHLS and HSE were identified as failing to meet F&V recommendations (Graham et al, 2016a).

Finally, the UKHLS collects less detailed information about the type and number of alcoholic drinks consumed than studies like the HSE. Information is collected using a confidential self-completion questionnaire, a method likely to be less subject to social desirability bias. Previous comparisons with the HSE indicate that the UKHLS gives higher reported proportions of people not meeting alcohol recommendations (Graham et al, 2016a).

3.3 Health behaviour measures and government recommendations

We derived measures of the four risk behaviours that aligned as closely as possible to government recommendations at the time of data collection (2010/11 and 2013/14) (see Box 4). Two points should be noted about these measures. For alcohol, we used 'binge' drinking as our measure of harmful alcohol consumption, i.e. consuming more than twice the daily recommended units of alcohol on a single day. Since 2015, recommendations on alcohol consumption have changed and there is less focus on binge drinking and more on reducing total alcohol consumption. However,

these recommendations were not in place at the time of data collection (2010/11 and 2013/4) and therefore our analyses focus on those who adhered (or not) to the binge drinking recommendations in place at the time. The more limited questions on PA in the UKHLS meant that we relied on an approximate measure (see Appendix A for more details).

Box 4: Government recommendations and measures of risk behaviour used in the report

For adults in 2010/11 and 2013/14, government recommendations for a healthy lifestyle were:

Smoking

- do not smoke at all
We use a measure of not smoking at least one cigarette per day.

Fruit and vegetable consumption

- eat at least 5 portions of fruit & vegetables a day
We used this measure.

Physical activity

- engage in at least 150 mins a week of moderate to vigorous intensity physical activity, e.g. 30 minutes on at least 5 days a week
We used a measure based on two questions in UKHLS which collected information on (i) the number of days in the past four weeks of 30+ minutes of brisk/fast walking and (ii) the frequency of moderate sporting activities. We defined meeting the physical activity recommendation as: 30 minutes or more of brisk or fast walking in a day 20 times in the past four weeks; or 3 days or more a week moderate to vigorous sporting activity of 30 mins or more¹; or 1-2 times a week moderate to vigorous sporting activity and 4 days a week brisk or fast walking for 30 minutes or more.

Alcohol consumption*

- for women on most days do not drink more than 2-3 units of alcohol a day and on no days drink more than 6 units
- for men on most days do not drink more than 3-4 units of alcohol a day and on no days drink more than 8 units
We used twice the average daily recommended amount (i.e. binge drinking) in the last 7 days: more than 6 units for women and more than 8 units for men on their heaviest drinking day.

*These were the alcohol guidelines at the time that survey data were collected. They have since been updated.

Chapter 4 looks at the prevalence of each risk behaviour using the latest UKHLS data available at the start of the project (2015), that is, data from 2013/14.

Chapter 5 examines stability and change in health behaviour across a three-year period. The chapter begins by looking at stability and change in terms of meeting and not meeting recommendations between 2010/11 and 2013/14. For each risk behaviour, the following analytical groups were created:

- Stable: met health behaviour recommendations in both 2010/11 and 2013/4
- Stable: did not meet health behaviour recommendations in both 2010/11 and 2013/14
- Started: Met health behaviour recommendations in 2013/4 but not 2010/11
- Stopped: Met health behaviour recommendations in 2010/11 but no longer did so in 2013/14.

¹ Note: constrained by the measures available in the UKHLS, this measure of physical activity (a minimum of at least 90mins of moderate to vigorous physical activity) is less exacting than the one on which the recommendation is based (at least 150 minutes).

As health behaviour data were only collected in 2010/11 and 2013/14, we acknowledge that there could be further variation in risk behaviours between these two time points. For example, some

people classified as stable might have more variable risk behaviours but happened to have consistent patterns in 2010/11 and 2013/4.

These risk behaviour measures are binary ones (meeting/not meeting the relevant recommendation). These binary measures are used in Chapters 4, 5 and 6. However, in Chapter 5, which looks at changing health behaviour over time, we moved beyond this set of dichotomous measures for smoking and drinking behaviour. Four further analysis groups were identified:

- persistent smokers who improved their smoking behaviour by smoking fewer cigarettes than previously;
- persistent smokers whose smoking behaviour worsened by smoking more cigarettes than previously;
- persistent binge drinkers who improved their drinking behaviour by consuming fewer units of alcohol on their heaviest drinking day than previously;
- persistent binge drinkers whose drinking behaviour worsened by consuming more units of alcohol on their heaviest drinking day than previously.

Among persistent smokers, an improvement in smoking behaviour was categorised as a reduction of five or more cigarettes smoked per day between 2010/11 and 2013/14. Worsening smoking behaviour was categorised as an increase in daily cigarette consumption of five cigarettes or more. The threshold of five or more cigarettes per day was chosen based on inspection of the data which showed higher than expected frequencies of people reporting smoking 5, 10, 15 and so on cigarettes per day. This 'heaping' suggests that people tend to round their cigarette consumption to units of 5. A change of five or more cigarettes between the two surveys was therefore most likely to represent real change in behaviour.

For persistent binge drinking, there were no equivalent data to guide the cut-point. Because of this, change was represented by +/- one standard deviation of the mean number of units consumed by binge drinkers. This value varied slightly for men and women but broadly meant that participants had reduced/increased their consumption by 6 units of alcohol on their heaviest drinking day to be defined as improving or worsening their alcohol consumption.² This approach has also been used by Vladimirov et al (2015). (See Appendix A for further details).

Because of the way data were collected, it was not possible to produce similar analysis for F&V consumption or PA (see Appendix A).

3.4 Socio-demographic and socio-economic measures

Throughout the report, we use a consistent set of socio-demographic and socio-economic measures to explore the extent to which health behaviours and changes within them are socially patterned. Some of these variables relate to individual characteristics, such as age, gender, ethnic group and marital and cohabitation status. Others relate to socio-economic factors, such as educational attainment, household income, economic activity and area deprivation. Self-reported general health status was also included as health behaviours are typically related to overall health status and it was important to take this into account. (See Appendix A for more detail on the measures included).

² This may seem like a large change in alcohol consumption but the focus is on stable binge drinkers and equates to reducing/increasing alcohol consumption by approximately 3 glasses of wine or 3 pints on the heaviest drinking day.

The socio-economic measures included individual-level (educational attainment, economic activity), household-level (household income) and area-level circumstances (Index of Multiple Deprivation) and our multivariate analysis allowed us to take these different dimensions into account.

3.5 Life transitions

The individual life course is marked out by a series of life transitions and events. These include changes in economic status (e.g. leaving full-time education, entering employment, retiring) and relationship status (e.g. entering into a cohabiting relationship, becoming a parent) as well as changes in income. In selecting transitions for analysis, the project team focused on transitions (i) that most people may experience at some point in their lives (ii) where there was evidence and/or a plausible hypothesis suggesting that the transition may impact on health behaviours and (iii) there were sufficient numbers of people in the UKHLS experiencing these changes between 2010/11 and 2013/14 to allow analyses to be performed.

With respect to our first criteria, we identified life transitions that characterise the life course of many adults in the UK. For example in England, over 300,000 of those aged 18 to 30 enter higher education every year, and across the time period of our study (2010/11 to 2013/14), nearly half (48%) of adults aged 17 to 30 years and domiciled in England went on to higher education at a UK institution (BIS, 2015). The large majority of students (87%) move into employment following graduation (BIS, 2016). Overall, 75% of adults aged 16 to 64 in England and Wales are in paid employment (ONS, 2017a). Across the period of our study (2010/11 to 2013/14), the majority of adults (60%) were living as a couple (married/civilly partnered or cohabiting (ONS, 2015) and most adults go on to become parents (OECD, 2011; Graham et al, 2017).

To apply our second criteria, we undertook a Rapid Evidence Assessment (REA). REA is a technique recommended by the Government Social Research Unit (GSRU, 2008) and is a delineated form of evidence review undertaken to establish the scope and strength of the evidence in areas where existing review evidence is limited. It uses the same principles as a broader evidence assessment in that it is conducted with clear research questions and predefined inclusion and exclusion criteria but, as a rapid review, it is conducted within a short time frame and thus considers fewer outputs in less detail. Details of the REA protocol are given in Appendix F.

We conducted separate REAs for each of the transitions (changes in relationship status, changes in employment status, changes in household income and having/adding a child to a household) and each of the health behaviours (smoking, drinking, F&V consumption, PA). This meant sixteen different REAs were conducted in total. Findings are discussed in Chapter 6.2. (See Appendix F for the protocols and further details of findings).

Alongside the REA, we also undertook preliminary analyses of the UKHLS dataset to establish that the numbers of adults experiencing the transition would support analyses of its association with stability and change in health behaviour.

On the basis of the REA and our preliminary analyses, the following transitions were identified for inclusion in our analyses:

- Changes in relationship status (moving in or out of a relationship)

- Changes in family composition (adding at least one child to a previously childless household)³
- Changes in employment status (moving from employment to unemployment; unemployment to employment; being a student to employment or unemployment and employment to retirement)
- Changes in income (changes in equivalised household income of +/- 20% or more)

3.6 Data on life transitions

Details of how the four transitions were defined are given in Box 5.

Box 5: Overview of life transitions used in analysis

Life transition	Definition	Consideration
Changes in relationships: Moved into a relationship Moved out of a relationship	Those who were single, never married or single, divorced, widowed (and not cohabiting) in 2010/11 and cohabiting or married in 2013/14 Those who were cohabiting or married in 2010/11 and single, never married or single, divorced or widowed (and not cohabiting) in 2013/14	Those who are in a relationship but not cohabiting will be excluded from this definition. Those who are in a relationship but not cohabiting will be excluded from this definition.
Adding children to the household	Those where the number of children in the household was 0 in 2010/11 and was 1 or more in 2013/14	Most only added one child to the household but 20% added more than one.
Employment transitions: Moved into employment Moved out of employment Student to employment Student to unemployment Moved into retirement	Those who were unemployed in 2010/11 and employed or self-employed in 2013/14 Those who were employed or self-employed in 2010/11 and unemployed in 2013/14 Those who were full-time students in 2010/11 and were employed/self-employed in 2013/4 Those who were full-time students in 2010/11 and were unemployed in 2013/4 Those who were employed/self-employed in 2010/11 and were retired in 2013/4.	As data are measured only at two points, participants may have had periods of different employment status between 2010/11 and 2013/14.
Income change: Income increased Income decreased	Those whose equivalised household income increased by 20% or more between 2010/11 and 2013/14 Those whose equivalised household income decreased by 20% or more between 2010/11 and 2013/14	A 20% change (or more) was chosen as this magnitude of change suggests real income changes rather than year-on-year changes in line with inflation.

³ In the literature, and theoretically, it is more usual to consider specifically the *birth* of a first child. However, the way that the UKHLS questionnaire is constructed does not allow us to do this. Calculating the addition of one or more children to a previously childless household is a close proxy. For more details, see Appendix A.

3.7 Analysis techniques

The analyses were adjusted for the complex survey design of the UKHLS; weighting also took account of non-response and over-sampling to produce nationally representative results. Cross-sectional weights for 2013/14 were used for all analyses, including analyses of changing health behaviours (see Appendix A for discussion and rationale). Weighted values are presented in the tables unless otherwise indicated.

Chapters 4, 5 and 6 present Average Marginal Effects (AMEs) from multivariate logistic regression analysis of socio-demographic and socio-economic factors associated with health behaviours/behaviour change. AMEs are the estimated change in the predicted probability of engaging in the behaviour for a given factor net of the other variables.

An example is provided in Table 3.1 below. This shows the predicted prevalence of smoking among men of different ages. Like odds ratios, AMEs are presented relative to a reference category and show how much (if at all) the predicted prevalence varies from the reference group. Unlike odds ratios, they provide a direct interpretation of the association of the factor with the outcome of interest and its relative size.

Table 3.1: Prevalence of cigarette smoking and average marginal effects of being a current cigarette smoker: Men						
	Unadjusted prevalence of cigarette smoking	Bases		Average Marginal Effect* (change in proportion from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		N	N			
	%					
Age^{a,b}						
16-24	20	2271	1704	REF: 0.21		
25-34	24	2087	1537	+0.03	-0.00	+0.07
35-44	20	2339	2048	+0.02	-0.02	+0.05
45-54	22	2563	2267	+0.01	-0.03	+0.05
55-64	18	2262	1965	-0.05	-0.08	-0.01
65+	10	3316	2969	-0.11	-0.15	-0.06

^a Unadjusted prevalence varies significantly by this characteristic, $p < 0.05$

^b Characteristic significant in regression model, $p < 0.05$

*Average Marginal Effects take into account other characteristics entered into the model, in this case educational attainment, ethnic group, employment status, general health, area deprivation, marital and cohabitation status and income (data not shown).

Looking at this example, we can see that, given their other characteristics (in this case, educational attainment, ethnic group, employment status, general health status, area deprivation, marital and cohabitation status and income), the predicted prevalence of smoking among men aged 16-24 was 21%. The unadjusted rate was 20%. Looking at the AMEs, we can see that current smoking varied by age and was lower among those aged 55 and over than among those aged 16-24. For those aged 55-64, the predicted prevalence was 5 percentage points lower than those aged 16-24 (i.e. 16%; calculated as $0.21 - 0.05$). Among those aged 65 and over, the predicted prevalence was 11 percentage points lower than those aged 16-24 (i.e. 10%, calculated as $0.21 - 0.11$).

As with odds ratios, the confidence intervals indicate whether the differences are statistically significant. If the confidence intervals include the value of 0, the difference from the reference category is not significant at conventional levels. In this example, those aged 55 and over had significantly different predicted smoking prevalence to those aged 16-24.

AMEs have advantages over odds ratios as results represent a predicted prevalence of behaviour which can be easier to interpret and understand than odds ratios. This predicted prevalence rate helps to highlight the magnitude of differences from the reference group in a meaningful way. For example, we can see that predicted smoking rates among those aged 65 and over, given their other characteristics, were broadly half that of those aged 16-24 (21% vs 11%).

Results from all models in Chapters 4, 5 and 6 are presented as AMEs. For completeness, odds ratios from the same regression models are included in Appendices C to E.

In Chapter 5 and 6, the logistic regression models were estimated on subsets of the data to explore in more detail the social patterning of health behaviour change (Chapter 5) and its relationship to life transitions (Chapter 6). In order to ensure we were comparing like with like, the models compared those who changed behaviours or experienced a life transition with those who had the same behaviour/life circumstance in 2010/11 but had not experienced any change. This is summarised in Box 6.

Box 6: Analytical groups for regression models in Chapters 5 and 6

Chapter 5		
Regression model	Analytical groups	Base for model
Starting smoking	Those who were non-smokers in both 2010/11 and 2013/14 compared with those who were current smokers in 2013/4 but were not in 2010/11	All non-smokers in 2010/11
Stopping smoking	Those who were smokers in both 2010/11 and 2013/14 compared with those who were not current smokers in 2013/4 but were in 2010/11	All smokers in 2010/11
Starting binge drinking	Those who were non-binge drinkers in both 2010/11 and 2013/14 compared with those who binge drank in 2013/14 but had not in 2010/11	All non-binge drinkers in 2010/11
Stopping binge drinking	Those who were binge drinkers in both 2010/11 and 2013/14 compared with those who binge drank in 2010/11 but did not in 2013/4	All binge drinkers in 2010/11
Starting to meet F&V recommendations	Did not meet F&V recommendations in 2010/11 and 2013/4 compared with those who met recommendations in 2013/4 but did not in 2010/11	All who did not meet F&V recommendations in 2010/11
Stopping meeting F&V recommendations	Met F&V recommendations in 2010/11 and 2013/4 compared with those who met recommendations in 2013/4 but did not in 2010/11	All who met F&V recommendations in 2010/11
Starting to meet PA recommendations	Did not meet PA recommendations in 2010/11 and 2013/4 compared with those who met recommendations in 2013/4 but did not in	All who did not meet PA recommendations in 2010/11

	2010/11	
Stopping meeting PA recommendations	Met PA recommendations in 2010/11 and 2013/4 compared with those who met recommendations in 2010/11 but did not in 2013/4	All who met PA recommendations in 2010/11
Chapter 6		
Regression model	Analytical groups	Base for model
Moved into a relationship	Those who were single (never married) or single (separated/widowed/divorced) in both 2010/11 and 2013/4 compared with those who were single in 2010/11 but married or cohabiting in 2013/4	All those who were single (never married) or single (separated, widowed, divorced) in 2010/11.
Moved out of a relationship	Those who were married or cohabiting in 2010/11 and 2013/4 compared with those who were married/cohabiting in 2010/11 but single (either never married, separated, widowed or divorced) in 2013/4	All those married or cohabiting in 2010/11
Moved into employment	Those who were unemployed in both 2010/11 and 2013/4 compared with those who were unemployed in 2010/11 but employed in 2013/4	All those unemployed in 2010/11
Moved into unemployment	Those who were employed/self-employed in both 2010/11 and 2013/4 compared with those who were employed/self-employed in 2010/11 but unemployed in 2013/4	All those employed/self-employed in 2010/11
Moved from full-time student to employment	Those who were a full-time student in 2010/11 and 2013/4 compared with those who were a full-time student in 2010/11 but employed/self-employed in 2013/4	All full-time students in 2010/11
Moved from full-time student to unemployment	Those who were a full-time student in 2010/11 and 2013/4 compared with those who were a full-time student in 2010/11 but unemployed in 2013/4	All full-time students in 2010/11
Moved from employment to retirement	Those who were employed/self-employed in 2010/11 and 2013/4 compared with those who were employed/self-employed in 2010/11 and retired in 2013/4	All employed/self-employed in 2010/11
Added a child	Those who lived in households with no children under the age of 16 in both 2010/11 and 2013/4 compared with those who lived in households with no children aged 16 or under in 2010/11 but with at least one child in 2013/4	All who lived in households with no children under the age of 16 in 2010/11
Increased income	Those whose income was stable (did not change by +/- 20%) compared with those whose household income increased by 20% or more between 2010/11	Those with stable or increasing income
Decreased income	Those whose income was stable (did not change by +/- 20%) compared with those whose household income decreased by 20% or more between 2010/11	Those with stable or decreasing income

4. HEALTH BEHAVIOURS IN 2013/14: PREVALENCE AND SOCIAL PATTERNING

4.1 Introduction

This chapter addresses the first project objective, documenting the prevalence of the four health behaviours and exploring the extent to which these behaviours are socially patterned. Our measures of healthy and unhealthy behaviours are based on government recommendations at the time of data collection; 'risk behaviours' are therefore those that do not meet the recommendations (see Box 1 and 4).

The section begins by looking at prevalence of the four risk behaviours among adults aged 16 and over in 2013/14 and then explores how this varies by different socio-demographic and socio-economic characteristics. Only results that are statistically significant at conventional levels ($p < 0.05$ and $p < 0.01$) are reported in the text.

4.2 Prevalence of each health behaviour among all adults

Figure 4.1 summarises the prevalence of single risk behaviours among all adults in England in 2013/14. Most adults reported behaviours that met government recommendations for cigarette smoking and binge drinking: 82% did not smoke and 76% did not binge drink. For both behaviours, proportions meeting government recommendations were higher for women than men. Details are given in Appendix C (Tables C1, C3, C5 and C7 for men and Tables C2, C4, C6 and C8 for women).

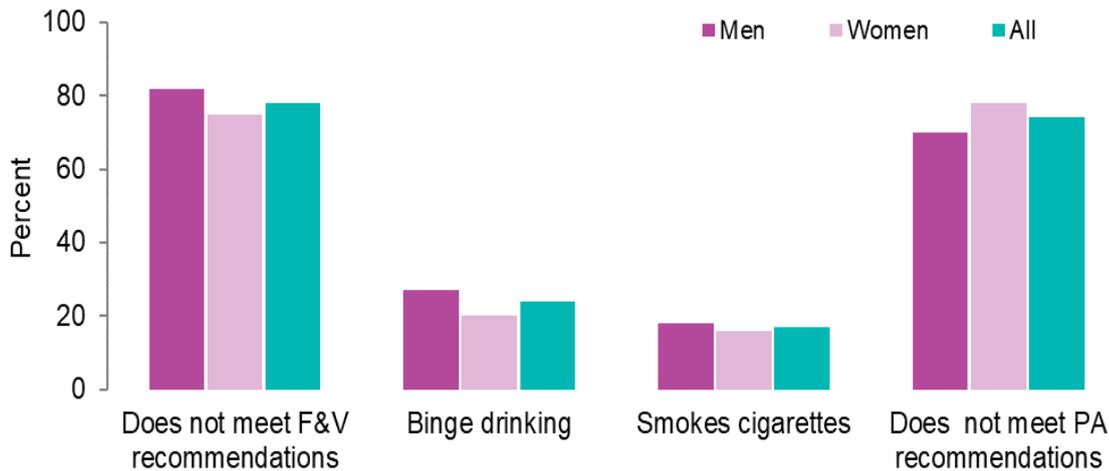
Most adults did not meet government recommendations for F&V consumption (78%) and physical activity (74%). Women were more likely to meet F&V recommendations but less likely to meet physical activity recommendations than men.

For smoking and F&V consumption, these estimates are broadly in line with those reported in the 2015 Health Survey for England (HSE) (NHS Digital, 2016). The HSE estimated that 82% of adults did not smoke and that 74% of adults did not meet F&V recommendations in 2015. HSE estimates for binge drinking were lower than those reported here (15% vs 24%) and the most recent estimates for PA, collected in HSE 2012, showed 62% of adults not meeting PA recommendations, somewhat lower than the UKHLS estimate of 74%. These differences are likely to be due to differences in the way the data were collected.^{4 5}

⁴ See Graham, H et al (2016a) for fuller details.

⁵ For drinking, UKHLS uses a self-completion questionnaire and HSE a face-to-face interview. For physical activity, the UKHLS collects data on a narrower range of activities than the HSE meaning that fewer people are recorded as meeting recommendations.

Figure 4.1: Prevalence of single risk behaviours in England (UKHLS 2013/14)



4.3 Social patterning of the health behaviours

To explore the social patterning of each risk behaviour, we estimated multivariate logistic regression models from which we derived the average marginal effects (AMEs) of each covariate on the four risk behaviours, namely:

- Smoking
- Binge drinking
- Not meeting F&V recommendations
- Not meeting PA recommendations.

The social factors included in the models covered a range of socio-demographic factors (age, ethnic group, marital and cohabitation status), socio-economic factors (educational attainment, employment status, equivalised household income, area deprivation) and general health status. Separate models were estimated for men and women.

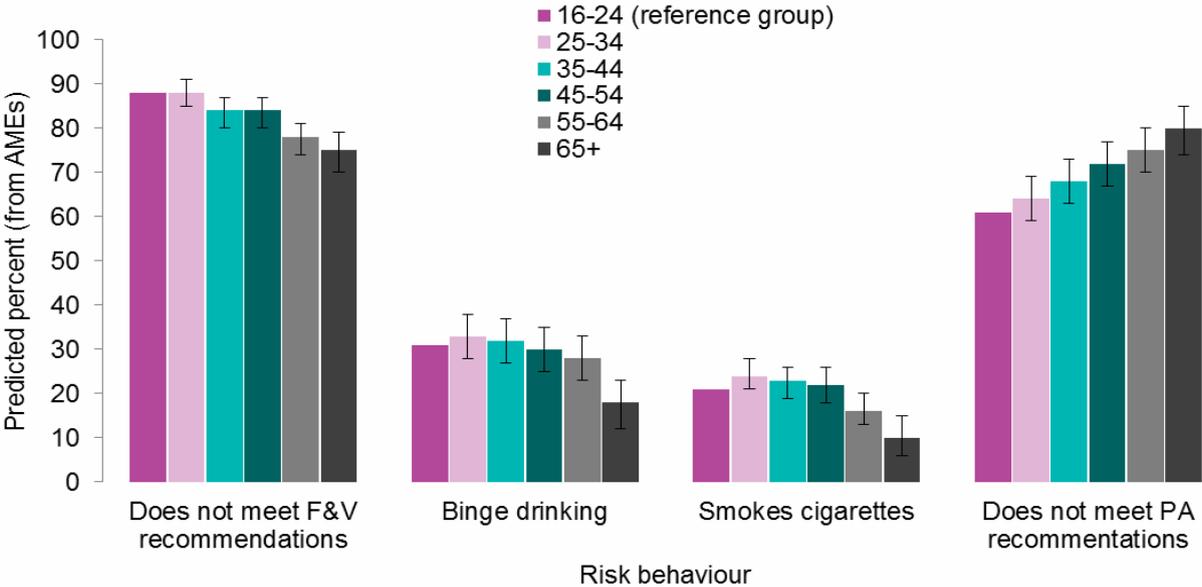
AMEs are the estimated change in predicted values from non-linear multivariate analysis (i.e. from multiple logistic regression). They provide the difference in the predicted probability of the outcome relative to the reference category and net of other covariates (see Section 3.7 for a fuller explanation). We report predicted prevalence derived from the AMEs. Full tables of models and estimates are provided in Appendix C. We organise the rest of this chapter by reporting the relationship between socio-demographic factors and each risk behaviour (Section 4.3.1), socio-economic factors (4.3.2) and health status (4.3.3).

4.3.1 Health behaviours by socio-demographic factors

Looking first at socio-demographic factors, for both men and women, age was associated with all four health behaviours. Older men (broadly those aged 55 and over) were less likely to smoke cigarettes, less likely to binge drink, less likely to meet PA recommendations but more likely to consume the recommended levels of F&V than those aged 16-24. Similar patterns were evident for women, see Figures 4.2 and 4.3 (for further details, see tables in Appendix C).

Figure 4.2: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, men, by age

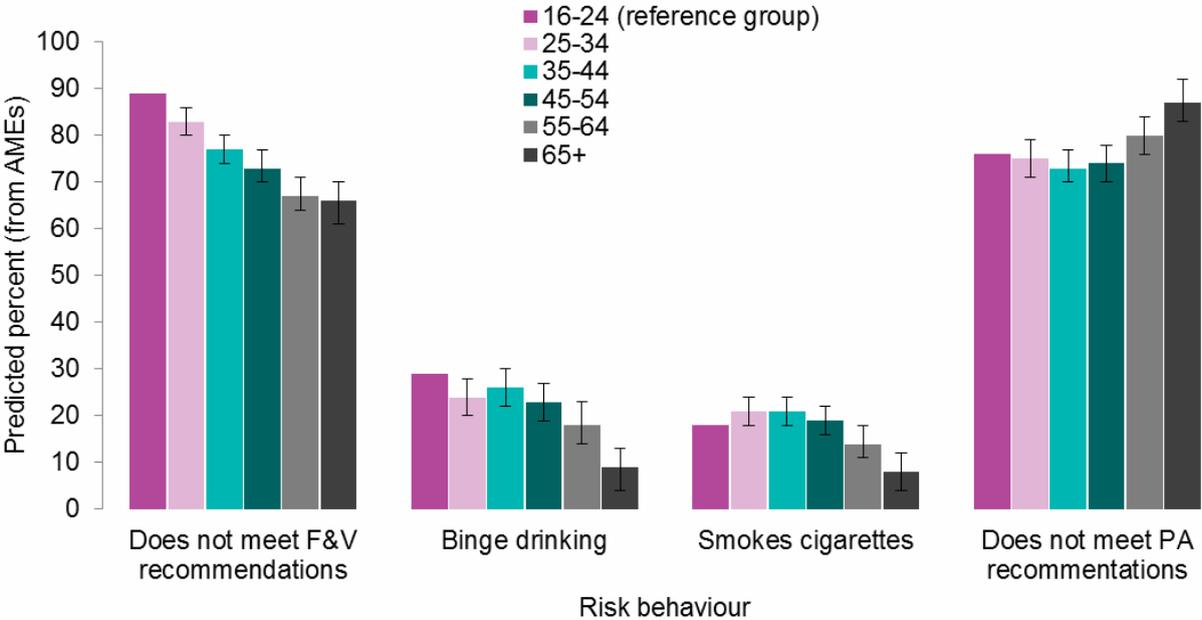
Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



(Appendix C, Tables C1, C3, C5, C7)

Figure 4.3: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, women, by age

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



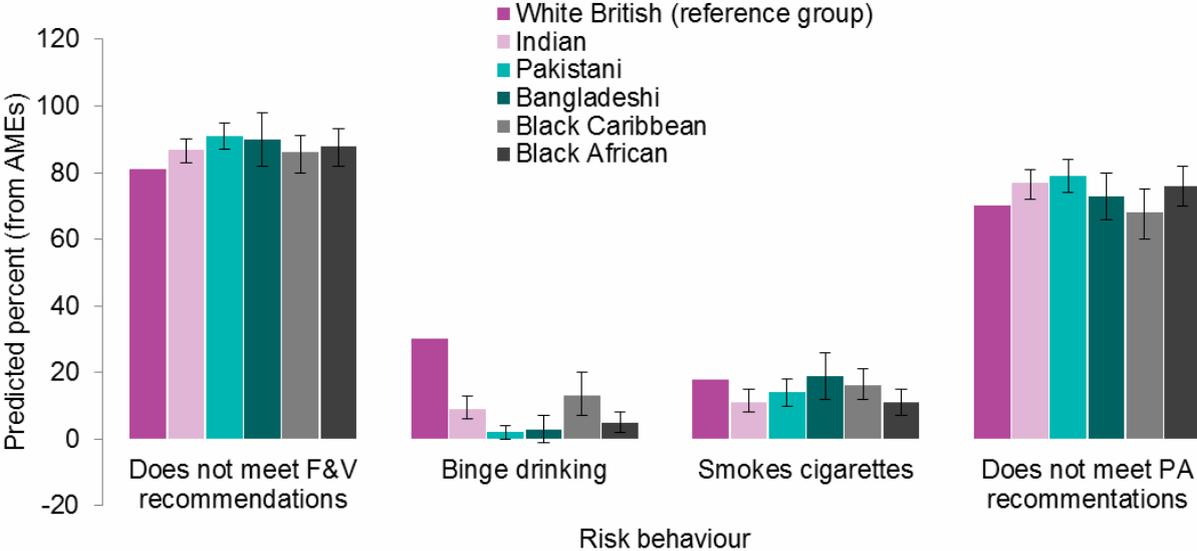
(Appendix C, Tables C2, C4, C6, C8)

For both men and women, ethnic group was associated with all four risk behaviours. For women, the general pattern was that those from non-White British ethnic groups were less likely to smoke and to

binge drink but were more likely to not meet recommendations for F&V or PA.⁶ For men, whilst the broad patterns were the same, there was greater variation for specific ethnic groups. For example, men who were Black African or Indian were less likely to smoke than those who were White British whilst men from all other ethnic groups had predicted smoking rates similar to White British males. Likewise, among men, it was those who were Indian, Pakistani, Bangladeshi or Black African who were more likely to not meet F&V recommendations than those who were White British. The same pattern was evident for meeting PA recommendations. However, like women, men from all non-White ethnic groups were less likely to binge drink than those who were White British. See Figures 4.4 and 4.5.

Figure 4.4: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, men, by ethnic group⁷

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



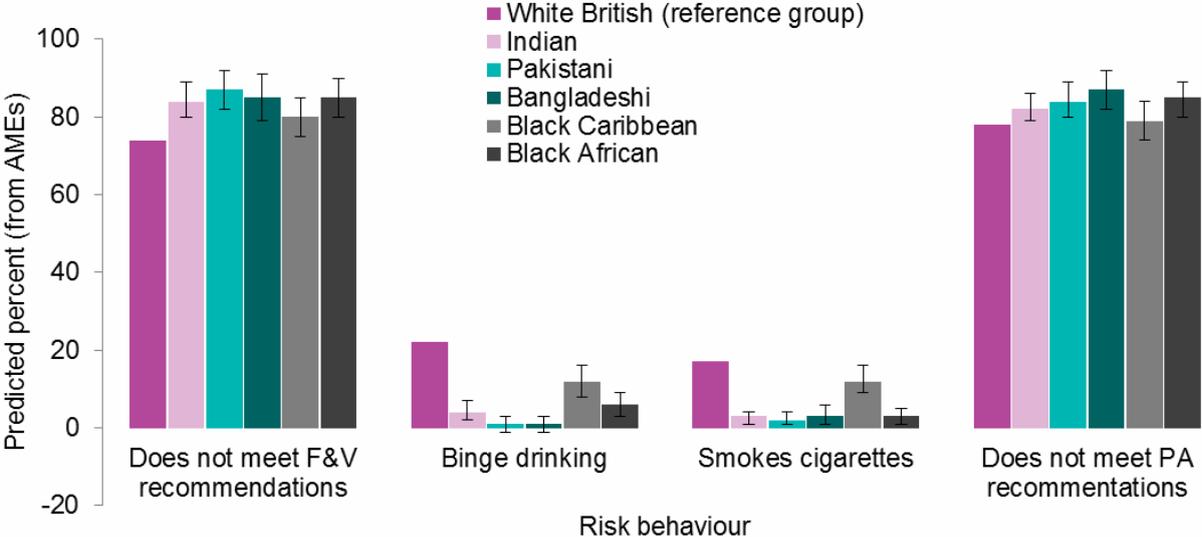
(Appendix C, Tables C1, C3, C5, C7)

⁶ With the exception of Black Caribbean women who had similar levels of meeting PA recommendations to the reference group of White British.

⁷ Confidence intervals straddle zero with low prevalence behaviours for small n groups. This is because the estimate for the reference group itself has a confidence interval around it and confidence intervals for each group represent the level of change from the confidence interval of the reference estimate, which means in some cases they can appear to be lower than zero.

Figure 4.5: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, women, by ethnic group

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



(Appendix C, Tables C2, C4, C6, C8)

Marital and cohabitation status was associated with two out of four risk behaviours for men and three out of four for women. For both men and women, it was associated with smoking and meeting PA recommendations. The predicted prevalence of smoking was lower among those who were married (14% men; 12% women) than those who were single, never married (21% men, 20% women), widowed, divorced or separated (24% men; 19% women) or cohabiting (23% men; 21% women). Among men and women who were single (never married), the predicted prevalence of not meeting PA recommendations (net of other characteristics) were 62% and 75% respectively. This was lower than those who were married (67% men; 79% women). Additionally among women, relationship status was associated with meeting F&V recommendations, with women who were single ((widowed, separated or divorced) being marginally more likely to not meet recommendations (76%) than those who were married (73%).

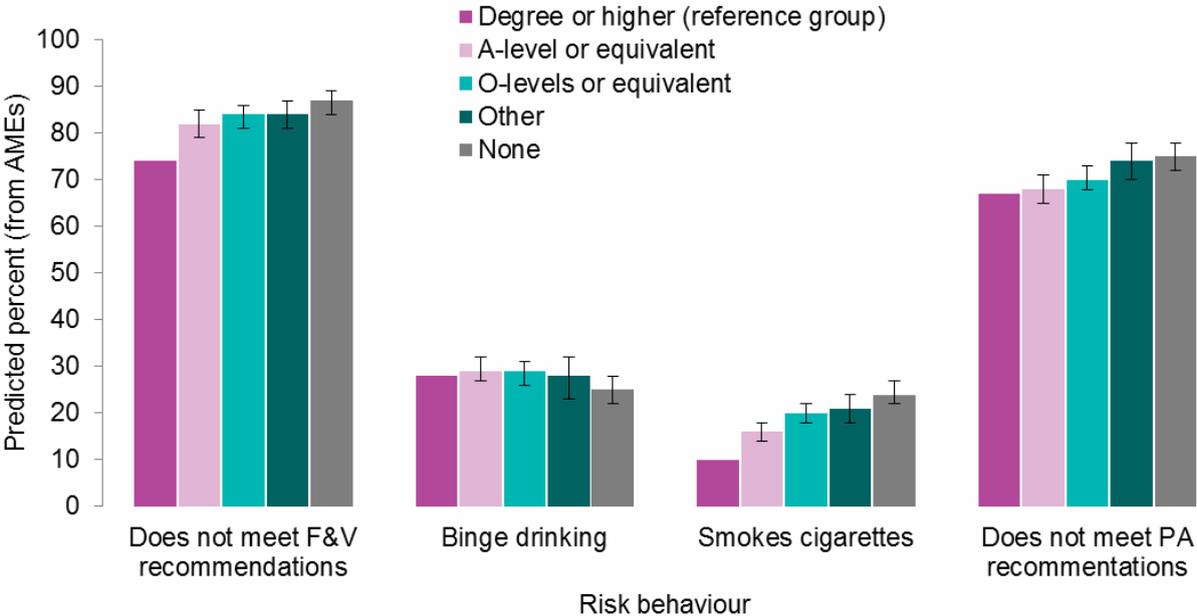
4.3.2 Health behaviours by socio-economic factors

Turning to socio-economic factors, for both men and women, educational attainment was associated with three of the four behaviours: smoking, not meeting F&V recommendations and not meeting the PA recommendations. Those with lower levels of educational attainment were more likely to smoke and more likely to not meet F&V or PA recommendations than those educated to degree level or higher. This pattern was particularly pronounced for smoking. Among women the predicted prevalence of smoking was nearly three times higher among those with no educational qualifications (23%) than those with a degree or higher (8%). Among men, the predicted prevalence of smoking was more than two times higher among those with no educational qualifications (24%) than those

with a degree or higher (10%). Educational attainment was not associated with binge drinking. See Figures 4.6 and 4.7.

Figure 4.6: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, men, by educational attainment

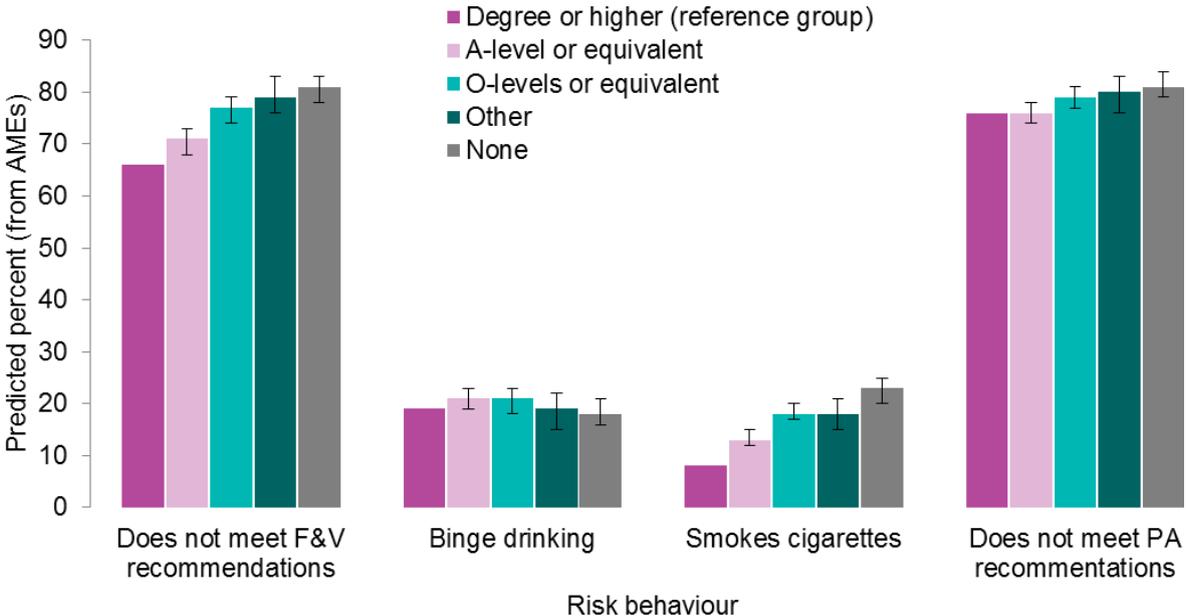
Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



(Appendix C, Tables C1, C3, C5, C7)

Figure 4.7: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, women, by educational attainment

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



(Appendix C, Tables C2, C4, C6, C8)

For men and women alike, current employment status was associated with smoking, where those who were unemployed, students or economically inactive because of long-term illness were more likely to smoke than those in paid employment; an estimated 27% of men who were unemployed and 23% of women who were unemployed smoked compared with 19% of men and 17% of women who were in paid employment, other things being equal. Men and women who were unemployed were also less likely to meet F&V recommendations than those in paid employment; an estimated 88% of men and 81% of women who were unemployed did not meet F&V recommendations compared with 82% men and 76% women who were in paid employment.

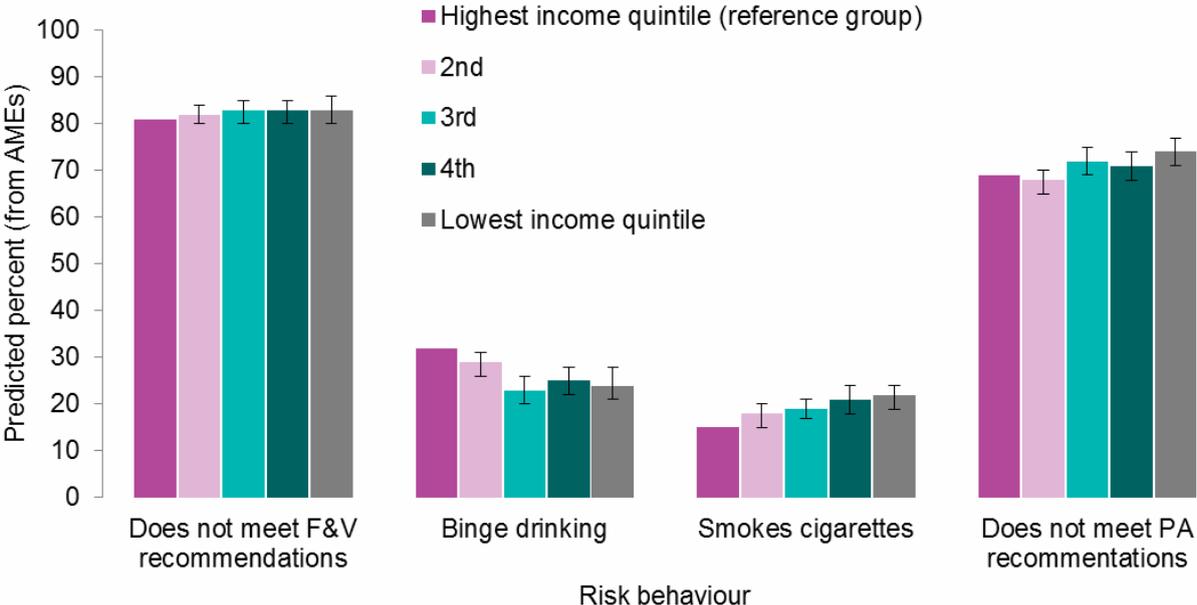
Among men, current employment status was not associated with meeting PA recommendations. Among women those who were economically inactive because of long-term illness were more likely not to meet PA recommendations (predicted prevalence 90%) than women in paid employment (predicted prevalence 78%).

Finally, whilst current employment status was associated with binge drinking, the patterns varied for men and women. Among men, those who were economically inactive because of long-term illness were less likely to binge drink than those in paid employment (predicted prevalence of 18% vs 29% respectively). Among women, it was those who were looking after the family/home and students who were less likely to binge drink. Predicted prevalence estimates were 22% for women in paid employment, 17% among female students and 15% among women who were looking after the family/home.

Figures 4.8 and 4.9 show, for men and women respectively, the predicted prevalence of each risk behaviour by equivalised household income. For both men and women, the prevalence estimates for smoking and meeting PA recommendations varied by income, with those in the lowest income households being more likely to smoke and more likely to not meet PA recommendations. The opposite pattern was true for binge drinking, with the prevalence of binge drinking being higher among those from the highest income households and lower among those from lower income households. Among men, meeting F&V recommendations did not vary by household income but it did for women. Women living in the lowest income households were more likely to not meet F&V recommendations than women living in the highest income households.

Figure 4.8: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, men, by equivalised household income

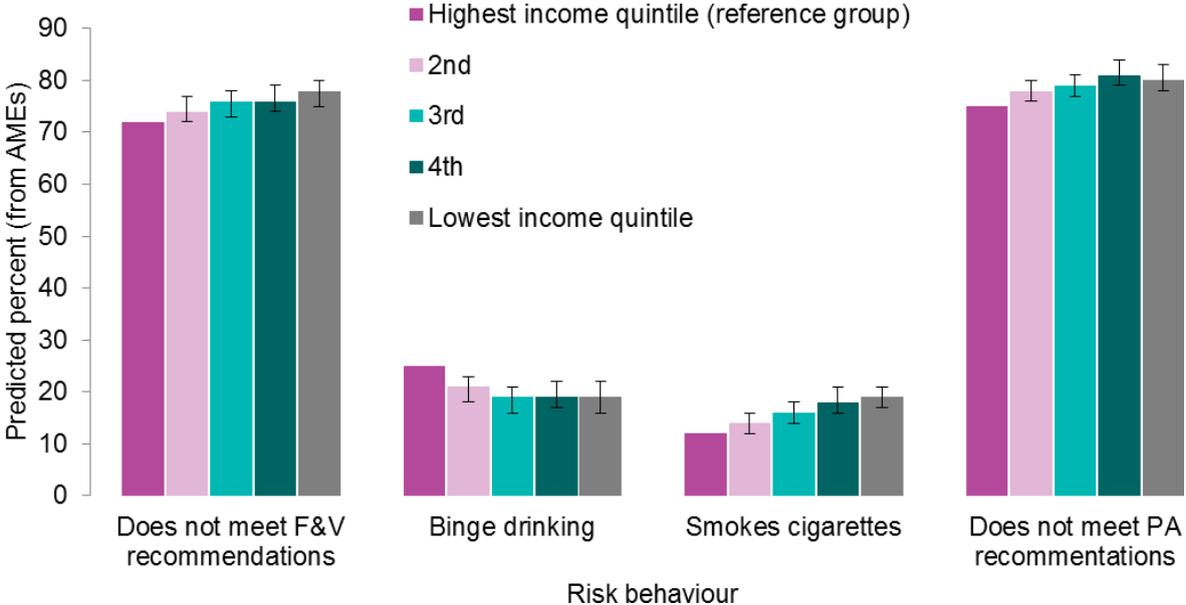
Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



(Appendix C, Tables C1, C3, C5, C7)

Figure 4.9: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, women, by equivalised household income

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



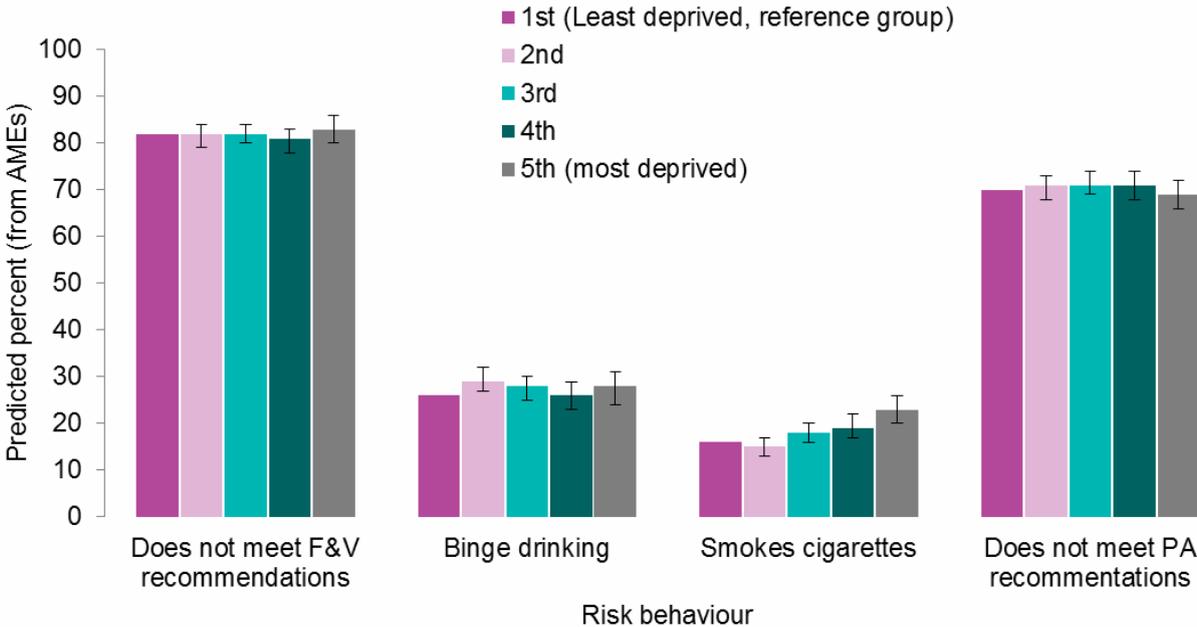
(Appendix C, Tables C2, C4, C6, C8)

Area deprivation, as measured using the Indices of Multiple Deprivation (IMD), was only associated

with smoking for both men and women and with binge drinking for women.² Looking at smoking, those who lived in the most deprived areas of England had higher predicted rates of smoking (23% men; 19% women) than those who lived in the least deprived areas (16% men; 12% women). Conversely, however, women who lived in the most deprived areas were less likely to binge drink (18%) than those who lived in the least deprived areas (21%) (see Figures 4.10 and 4.11).

Figure 4.10: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, men, by Indices of Multiple Deprivation quintile group

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account

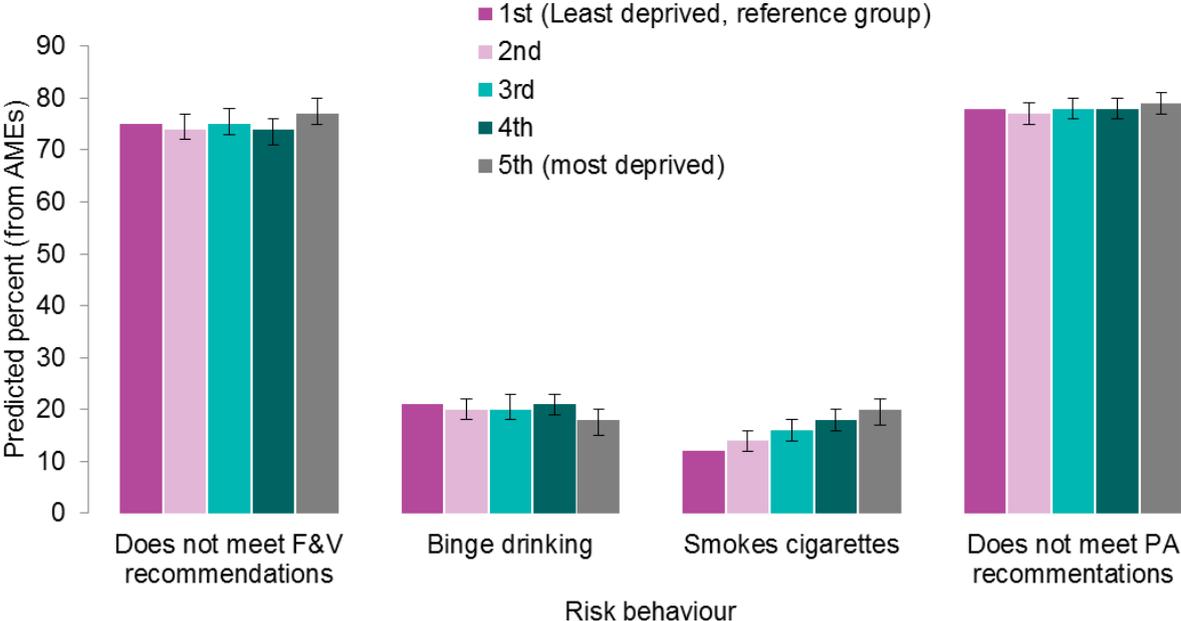


(Appendix C, Tables C1, C3, C5, C7)

² As noted on page 30, all the analyses on social patterning of risk behaviours are adjusted; Figure 4.10 therefore takes account of individual-level (educational attainment, employment status) and household-level (equivalised household income) socio-economic factors.

Figure 4.11: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, women, by Indices of Multiple Deprivation quintile group

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



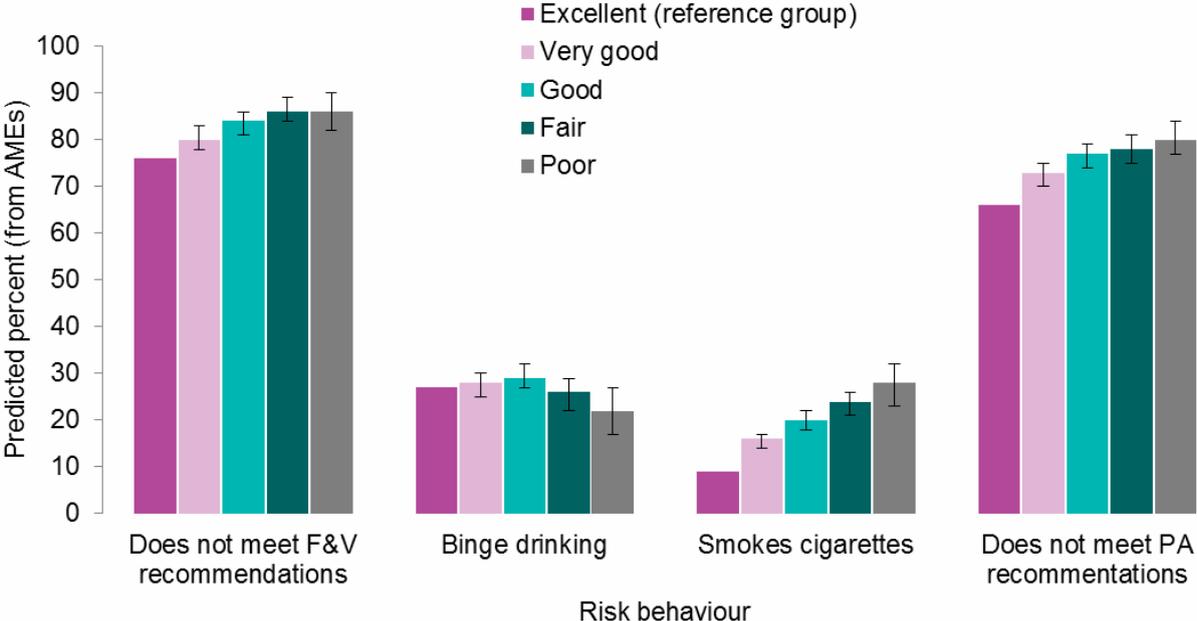
(Appendix C, Tables C2, C4, C6, C8)

4.3.3 Health behaviours by general health status

Finally, self-reported general health status was associated with all four risk behaviours. The patterns were the same for men and women. Those in poor health were more likely to smoke than those in excellent health. They were also more likely to not meet F&V or PA recommendations. However, those in poor health were less likely than those in excellent health to binge drink. See Figures 4.12 and 4.13.

Figure 4.12: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, men, by self-reported general health

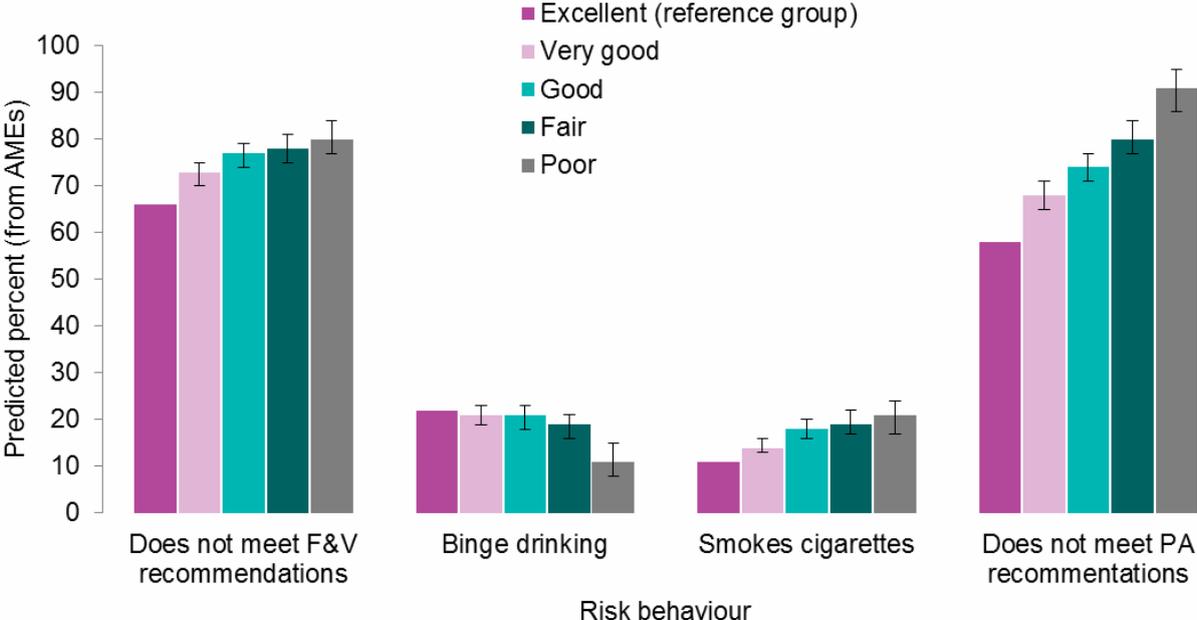
Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



(Appendix C, Tables C1, C3, C5, C7)

Figure 4.13: Predicted prevalence (with 95% confidence intervals) of each risk behaviour, women, by self-reported general health

Source: UKHLS 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



(Appendix C, Tables C2, C4, C6, C8)

4.4 Summary

Overall, engagement in risky health behaviours varied; smoking was not common with less than one in five men and women being cigarette smokers. Binge drinking too was uncommon: around 3 out of 4 men and women did not binge drink. However, most people (at least 3 out of 4) did not meet recommendations for F&V or PA.

Adherence to recommendations was socially patterned. The patterns for men and women were broadly similar; however, with the exception of PA, women were more likely to meet the recommendations than men. Age was strongly associated with all health behaviours. In broad terms, those who were older typically displayed more positive health behaviours, being less likely to smoke and binge drink and more likely to meet F&V recommendations. However, older people were less likely to meet PA recommendations, even after health status and socio-economic factors were taken into account. PA recommendations are intended to be applicable to all adults and variance in adherence by age suggests that there are barriers to participation among older people.

Along with age, health behaviours were also patterned by ethnicity, where those from non-white ethnic groups were less likely to smoke and binge drink but more likely not to meet F&V or PA recommendations. Engagement in risk behaviours was also related to people's socio-economic circumstances. In broad terms, social disadvantage was associated with smoking, and with levels of F&V consumption and PA that did not meet the recommendations, while social advantage was associated with binge drinking. Thus, those with the lowest levels of educational attainment, who were unemployed or with low incomes tended to be more likely to smoke and less likely to meet F&V recommendations. Those with lower levels of educational attainment or low incomes were also less likely to meet PA recommendations. When looking at binge drinking and income, however, the opposite pattern was true: those with low incomes were less likely to binge drink than those with higher incomes.

Area deprivation did not discriminate between those meeting F&V or PA recommendations. This is an interesting finding given that the local environment has been identified as an influence on these behaviours, for example with respect to food outlets (Fraser et al, 2010; White, 2007) and to accessible greenspace (Jones & Combes, 2009), and policies are giving increasing emphasis to locality-based approaches to promoting health (Kings Fund, 2013; PHE, 2015). It may be that area deprivation is a poor proxy for the area-level factors that may be associated with F&V or PA or that the main drivers of these health behaviours are related more to the individual than the area in which they live. However, area deprivation was strongly associated with smoking status, with those living in more deprived areas being more likely to smoke. Area deprivation has been identified as an important influence on smoking status in both quantitative and qualitative studies (Ellaway & Macintyre, 2009; Stead et al, 2001).

Overall, our analysis shows that meeting government recommendations for key health behaviours is socially patterned but that these associations do not operate in the same way for all four behaviours. In particular, binge drinking is more likely to be associated with social advantage, whereas disadvantage is a predictor of smoking and not meeting F&V or PA recommendations.

5. STABILITY AND CHANGE IN HEALTH BEHAVIOURS: 2010/11 TO 2013/14

5.1 Introduction

This chapter addresses the project's second objective, to investigate the prevalence and social patterning of changes in the four health behaviours between 2010/11 and 2013/14. To our knowledge, it provides the first analysis of health behaviour change for all four risk behaviours for England's adult population.

Section 5.2 looks at stability and change in health behaviours. In Section 5.2.1, we examine stability and change in meeting government recommendations between 2010/11 and 2013/14. The measures used to explore adherence to government recommendations at the two time points were whether or not they:

- smoked one or more cigarettes per day;
- consumed twice or more the (then) daily recommended units of alcohol in a single day in the past week (called binge drinking hereafter)
- ate five or more portions of F&V per day
- did moderate/vigorous PA on three or more days per week

Section 5.2.2 focuses on persistent smokers and binge drinkers (i.e. those who were smokers and those who were binge drinkers in both 2010/11 and 2013/14). It presents evidence on reductions and increases in cigarette and alcohol consumption. Improved health behaviour among persistent smokers was defined as smoking five or more cigarettes per day fewer than previously. Worsening health behaviour was smoking five or more cigarettes per day more than previously. For persistent binge drinkers, 'improvers' reduced their alcohol consumption on their heaviest drinking day by more than about six units of alcohol. Those whose drinking behaviour worsened increased their alcohol consumption on the heaviest drinking day by more than about six units of alcohol (see Chapter 3.3. for a summary and Appendix A for fuller details).⁸ Because of the way data were collected, it was not possible to look at improving or worsening health behaviours with respect to F&V and PA among those who failed to meet the recommendations (see Appendix A).

Section 5.3 investigates the social patterning of changes in health behaviours. It examines the social factors potentially associated with change to assess whether there was evidence of patterning in who was more or less likely to change their health behaviours and in which direction (i.e. starting or ceasing to meet recommendations).

Because changes in some health behaviours were relatively rare, we did not have the statistical power to conduct multivariate analysis separately for men and women. Therefore, in this chapter and Chapter 6, analyses are presented for all with sex entered as a co-variate in the analysis. As noted in Chapter 3, our multivariate analyses took account of a range of other factors, including age, ethnic group, health status, marital and cohabitation status, and employment status. The models also included standard measures of an individual's socio-economic circumstances: educational attainment, household income and area deprivation (see Appendix A for fuller details).

⁸ The drinking thresholds were calculated separately for men and women to take account of the different recommended levels of consumption. We used a threshold of one standard deviation from the mean to classify improvement or worsening: to one decimal place, this was 6.3 units for men and 6.6 for women.

As discussed in Appendix A, a key consideration when measuring individual behaviour change is the extent to which data reflect real behaviour change rather than differences in question wording or when data were collected. This is particularly pertinent for F&V, PA and binge drinking. For F&V, participants were asked to consider a usual week and day, and for PA, to consider an average frequency over the last 12 months for sporting activities and the last 4 weeks for walking. This makes it less likely that differences in behaviour are due to when data were collected as responses are averaged over a longer time frame. Binge drinking questions asked about alcohol consumed in the past seven days. This makes this information potentially more susceptible to differences in when data were collected (for example, if someone had a birthday in the week prior to interview in one year but not the other). However, respondents tended to be surveyed in the same month each year, and results tended to show stability in binge drinking habits for individuals, which would not be expected if data were subject to measurement error due to different times of data collection.

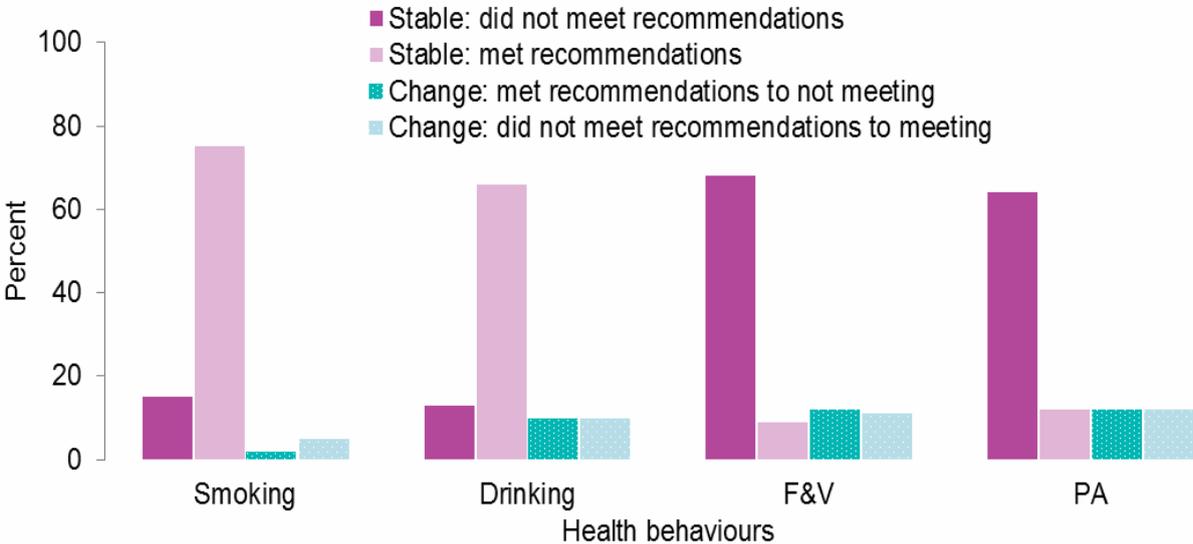
5.2 Stability and change in health behaviours

5.2.1 Stability and change in meeting recommendations

Figure 5.1 describes stability and change in the four behaviours between 2010/11 and 2013/14. It indicates that stability in health behaviour was the norm: most people had the same pattern of behaviour in 2013/4 as 2010/11. For smoking and drinking, the majority of respondents who met the recommendations in 2010/11 (by not smoking or binge drinking) continued to meet them three years later. The pattern was similar for F&V consumption and PA, though this was driven by most people failing to meet the F&V and PA recommendations over time.

Figure 5.1: Stability and change in health behaviours, 2010/11 to 2013/14

Source: UKHLS 2010/11 and 2013/14; Base: all adults



(Appendix D, Tables D1-D4)

For a minority of the adult population, improved health behaviours were evident: 2% stopped smoking, 10% stopped binge drinking, 11% started to eat 5 or more portions of F&V and 12% met PA recommendations when they had not previously (Figure 5.1; Tables D1-D4).

However, there were also some who met recommendations in 2010/11 but who, when followed up in 2013/14, no longer did so. Smoking was unique among the health behaviours with the proportion of people stopping smoking outstripping the proportion starting, though those who ‘started’ smoking

were likely to include a large proportion of relapsed ex-smokers.⁹ For all other behaviours, the proportions starting and stopping meeting recommendations were broadly similar (see Figure 5.1 and Tables D1-D4).

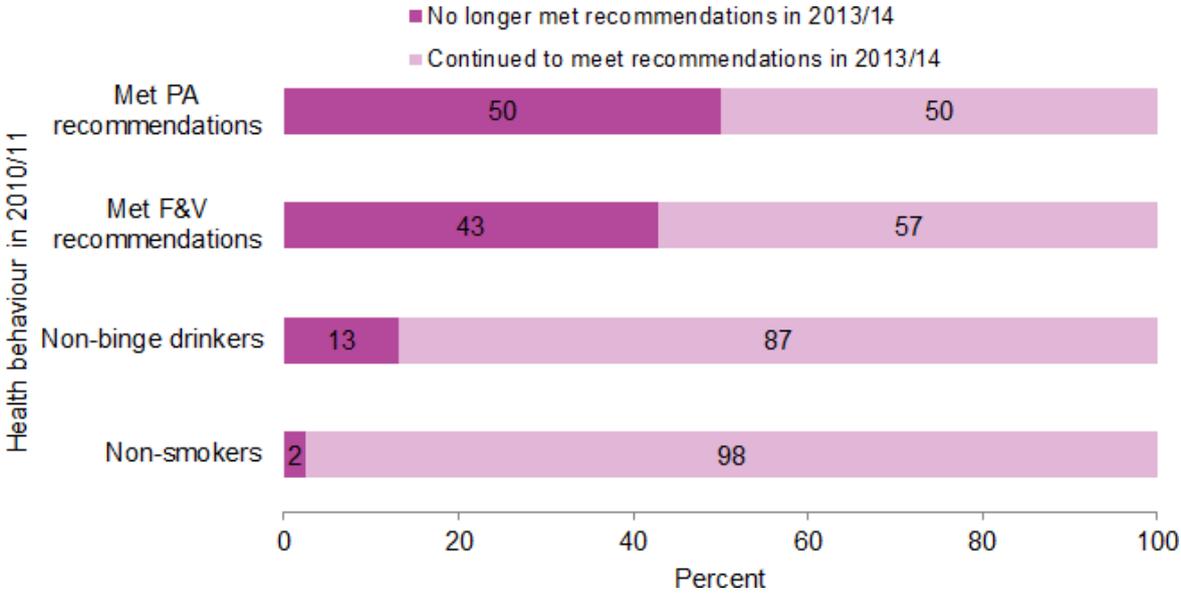
Figures 5.2a and 5.2b take a more detailed look at behaviour change among two different sub-groups: those who met recommendations in 2010/11 (Figure 5.2a) and those who did not meet recommendations in 2010/11 (Figure 5.2b). For each group, we present the proportion that maintained the same behaviour in 2013/4 or who changed.

Looking at Figure 5.2a first, there was a high degree of change in behaviours evident among the small proportion of individuals who previously met F&V and PA recommendations: 50% of those who met PA recommendations in 2010/11 no longer did so in 2013/14. The equivalent proportion of changers for F&V was 57%. As Figure 5.2a shows, such fluctuation was not apparent for smoking and drinking, where behaviours among the majority of respondents who met recommendations tended to be more stable. Thus, only 2% of those who were previously non-smokers were smokers three years later and 13% of those who had not been binge drinkers in 2010/11 reported levels of alcohol consumption in 2013/14 that classified them as binge drinkers.

Figure 5.2b focuses on those who did not meet the relevant recommendation in 2010/11 and shows whether they did so in 2013/14. For smoking, F&V and PA, there was a large degree of stability. Those who did not meet F&V or PA recommendations in 2010/11 tended not to meet them in 2013/4; only 14% and 16% started to meet recommendations respectively. The majority of smokers remained smokers (24% stopped smoking between 2010/11 and 2013/14). Patterns among binge drinkers, however, were different. Over 40% of binge drinkers in 2010/11 did not binge drink in 2013/14, displaying a greater level of change between survey years than seen for other risk behaviours.

Figure 5.2a: Stability and change among those who met the recommendation in 2010/11

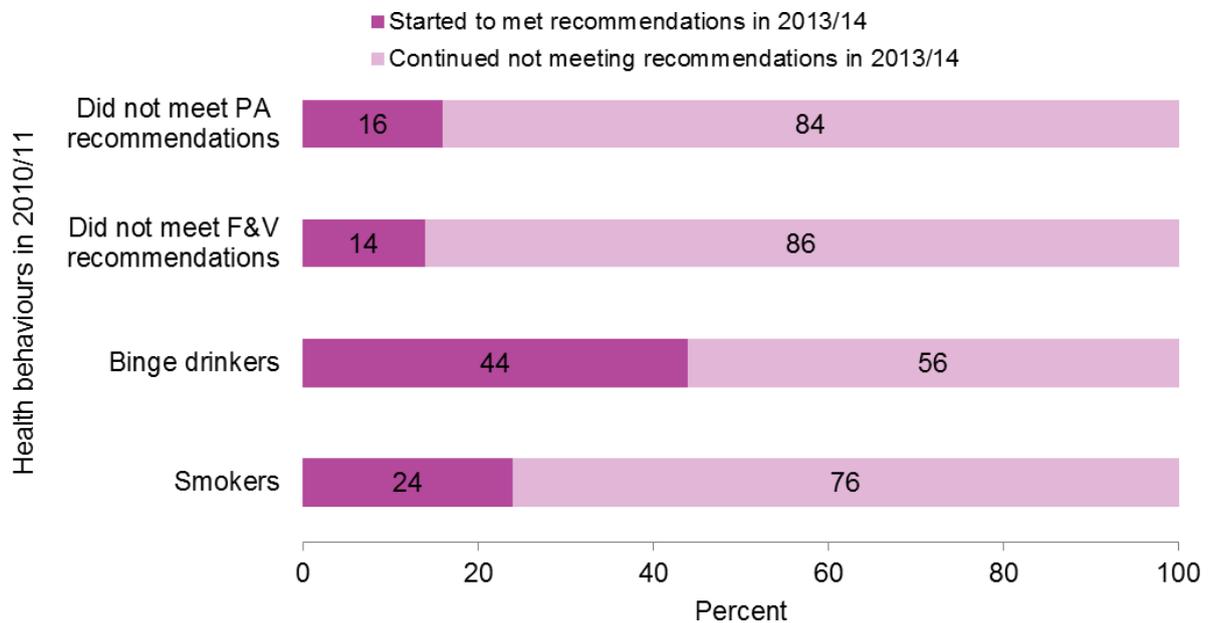
Source: UKHLS 2010/11 and 2013/14; Base: those who met recommendations in 2010/11



⁹ About 82% of those who ‘started’ smoking at wave five had at wave two responded “yes” to the question “Have you ever smoked a cigarette, a cigar or a pipe?”.

Figure 5.2b: Stability and change among those who did not meet the recommendation in 2010/11

Source: UKHLS 2010/11 and 2013/14; Base: those who did not meet recommendations in 2010/11



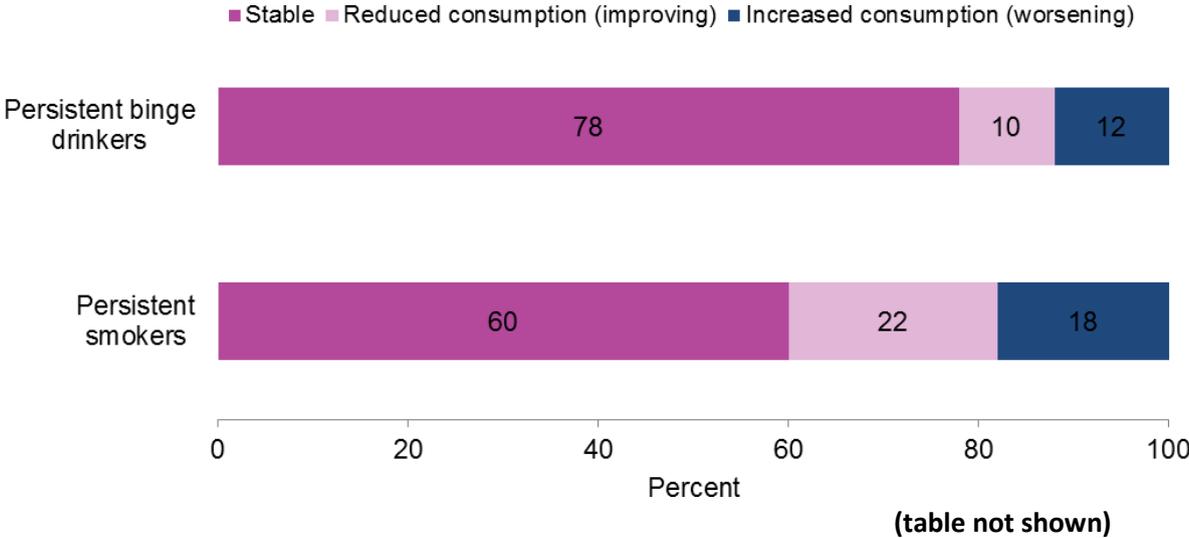
(Appendix D, Table D1-D4)

5.2.2 'Improving' and 'worsening' health behaviour: persistent smoking and binge drinking

Among persistent smokers and binge drinkers, consistency in their consumption patterns was the norm. Using our measure of change (smoking five or more cigarettes per day fewer/more than previously and reducing/increasing alcohol consumption on the heaviest drinking day by more than about six units of alcohol), we found that most people tended to smoke or binge drink in 2013/14 at levels similar to those in 2010/11. For a minority, however, behaviours did change. Among smokers, 18% increased the number of cigarettes they smoked per day and 22% decreased the number. Among binge drinkers, 10% reduced their consumption of alcohol on their heaviest drinking day whereas 12% increased it.

Figure 5.3: Changing health behaviours among persistent smokers and binge drinkers¹⁰

Source: UKHLS 2010/11 and 2013; Base: those who were either current smokers or binge drinkers in both 2010/11 and 2013/4



5.3 Social patterning of change

To explore whether changes in health behaviours were socially patterned, multivariate regression models were estimated for positive and negative behavioural change. We estimated logistic regression models looking at the factors associated with the following outcomes:

- stopping meeting recommendations for each health behaviour,
- starting to meet recommendations for each health behaviour,

and for smoking and drinking, for those who did not meet recommendations at both waves (“persistent” smokers or binge drinkers):

- improving health behaviour (smoking and drinking less than previously),
- worsening health behaviour (smoking and drinking more than previously).

We report the estimated probability of the outcome, based on average marginal effects, for each factor included in these regressions: age, sex, ethnic group, marital and cohabitation status, educational attainment, employment status, household income and area deprivation, and health status.

These covariates were based on data collected in 2010/11 with the exception of ethnic group and educational attainment where information collected in 2013/14 was used.¹¹ (For details of the measures used in our analyses, see Appendix A). We also supply the full models with both AMEs and ORs in Appendix D, Tables 17 to 24.

¹⁰ The number of persistent smokers in our sample was 3,256, and of persistent binge-drinkers was 2,535 (unweighted)

¹¹ Both ethnic group and educational attainment had a great degree of missing data in 2010/11 and therefore more complete information from 2013/4 was used instead.

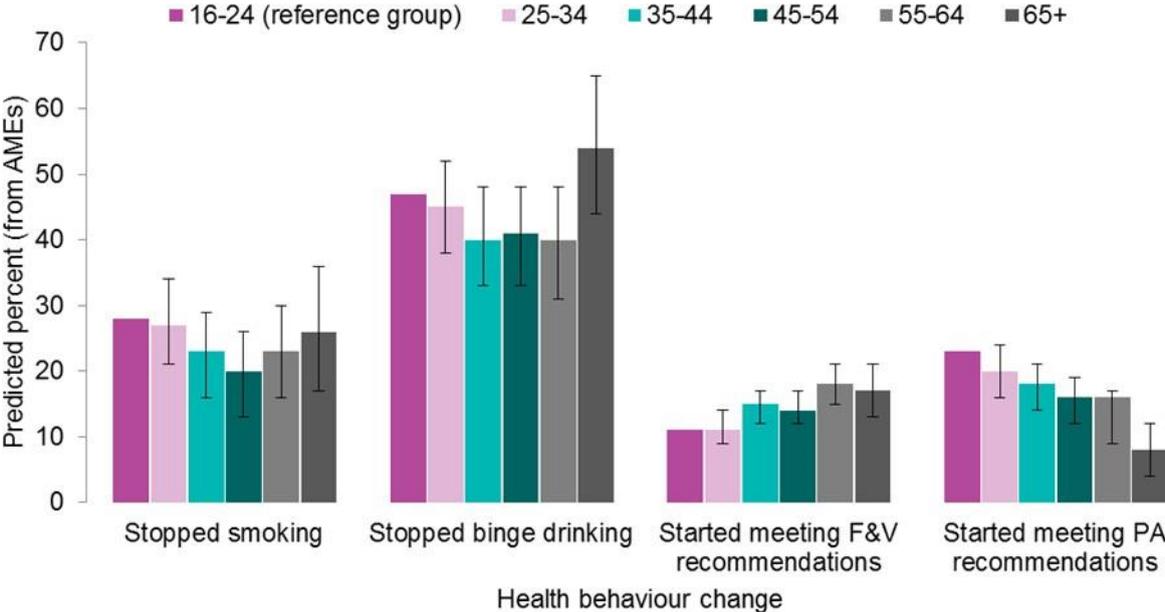
The subsections below discuss the patterning of change for each outcome according to its net association with other factors. Section 5.3.1 shows socio-demographic factors (age, sex, ethnic group, marital and cohabitation status); section 5.3.2 moves on to socio-economic factors (educational attainment, employment status, household income and area deprivation). Section 5.3.3 considers patterning of change by health status.

5.3.1 Health behaviour change by socio-demographic factors

Age: was strongly associated with changing health behaviours. Age was associated with starting and stopping meeting recommendations for all health behaviours, except stopping meeting the PA recommendations and stopping binge drinking. The patterns by age are summarised in Figures 5.4a and 5.4b and discussed in more detail below (for full details, see Appendix D, Tables D5-D12).

Figure 5.4a: Predicted prevalence (with 95% confidence intervals) of positive health behaviour changes (not meeting recommendation in 2010/11 but meeting it in 2013/14), by age group

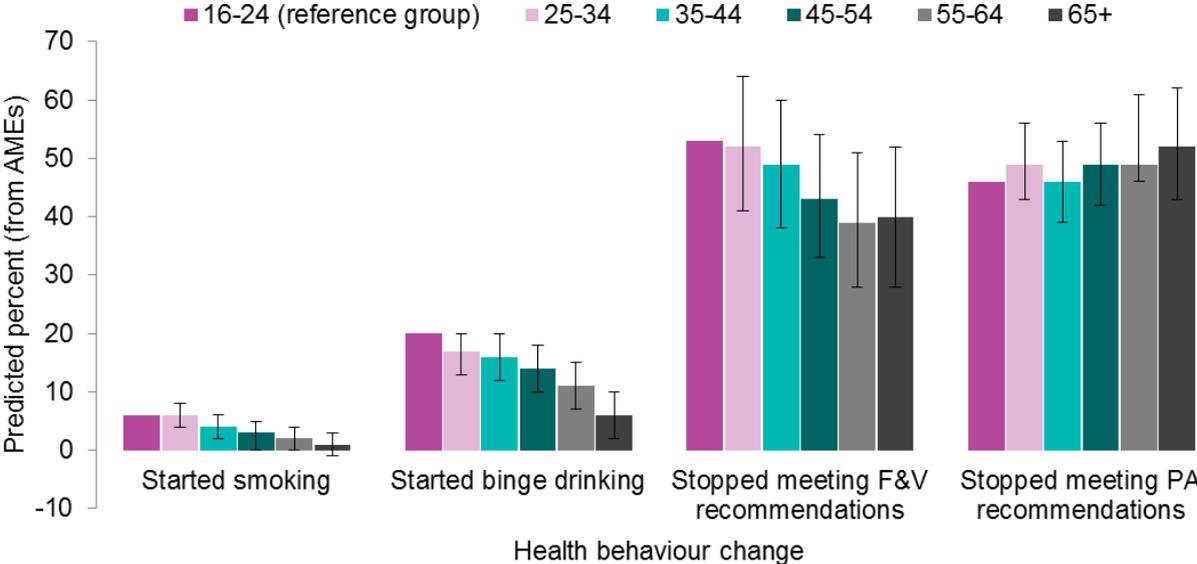
Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Tables D5-D12

Figure 5.4b: Predicted prevalence (with 95% confidence intervals) of worsening health behaviours (meeting recommendation in 2010/11 but not meeting it in 2013/14), by age group¹²

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Tables D5-D12

With respect to smoking, those aged 45 and over were less likely than those aged 16-24 (the reference group) to start smoking but those aged 45-54 who already smoked were less likely to give up smoking than those aged 16-24. Predicted prevalence of starting to smoke for those aged 16-24 was 6%, whereas it ranged between 1-3% for those aged 45 and over (see Figure 5.4b). The predicted prevalence of stopping smoking among those aged 16-24 was 28%; eight percentage points higher than those aged 44-54 (20%) (see Figure 5.4a).

With respect to the other three behaviours, those aged 35 and over were less likely to start binge drinking than those aged 16-24: the predicted prevalence was 6-14 percentage points lower than those aged 16-24 (20%). Those aged 55 and over were less likely to stop eating five portions of F&V per day. Those aged 35 and over were more likely to start meeting recommendations for F&V consumption than those aged 16-24; 11% of those aged 16-24 started meeting F&V recommendations, with rates being 3-7 percentage points higher for those aged 35 and over. For those aged 16-24, the predicted prevalence of stopping meeting F&V recommendations was 53%; equivalent rates among those aged 55 and over were 13-14 percentage points lower than this (See Figures 5.4a and 5.4b; Appendix D, Tables D5-D12). This suggests that the instability in meeting F&V recommendations noted in section 5.5.11 (see Figure 5.2a) may be driven by greater variation among younger people. Finally, those aged 35 and over were less likely to start meeting PA recommendations than those aged 16-24 (18% to 8% for those aged 35 and over vs 23% for those aged 16-24).

¹² Confidence intervals straddle zero with low prevalence behaviours for small n groups. This is because the estimate for the reference group itself has a confidence interval around it and confidence intervals for each group represent the level of change from the confidence interval of the reference estimate, which means in some cases they look as if they are lower than zero.

Sex: Like age, sex was strongly associated with changes in health behaviour. With the exception of starting and stopping smoking, it was significantly associated with starting and stopping meeting the health behaviour recommendations. The patterns are summarised in Figures 5.5a and 5.5b.

As Figures 5.5a and 5.5b indicate, women were more likely than men (the reference group) to experience positive behaviour change in relations to binge drinking and F&V recommendations; they were more likely to stop binge drinking and less likely to start than men (49% women vs 41% men for stopping; 12% women vs 15% men for starting). Women were also more likely than men to start eating 5 portions of F&V a day (16% women; 12% men) and less likely to stop (40% women; 49% men). However, men were more likely than women to experience positive behaviour change in relation to PA, being more likely to start meeting PA recommendations (14% women; 18% men) and less likely to stop meeting recommendations (52% women; 46% men) (see Figure 5.5a and 5.5b).

Figure 5.5a: Predicted prevalence (with 95% confidence intervals) of positive health behaviour changes (not meeting recommendation in 2010/11 but meeting it in 2013/14), by sex

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account

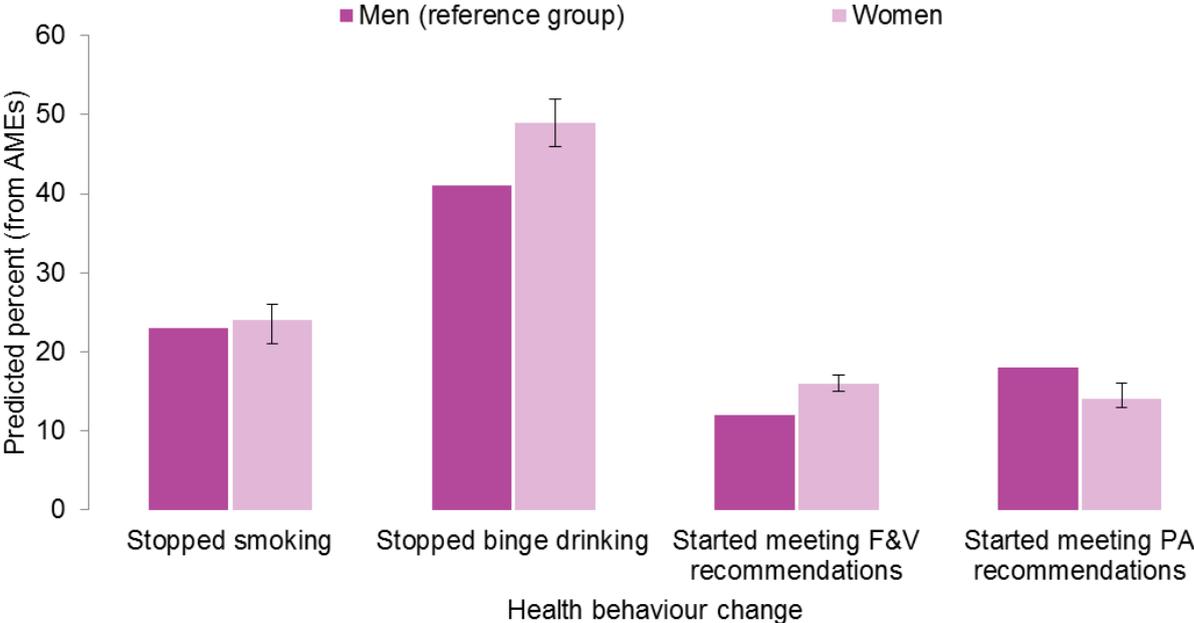
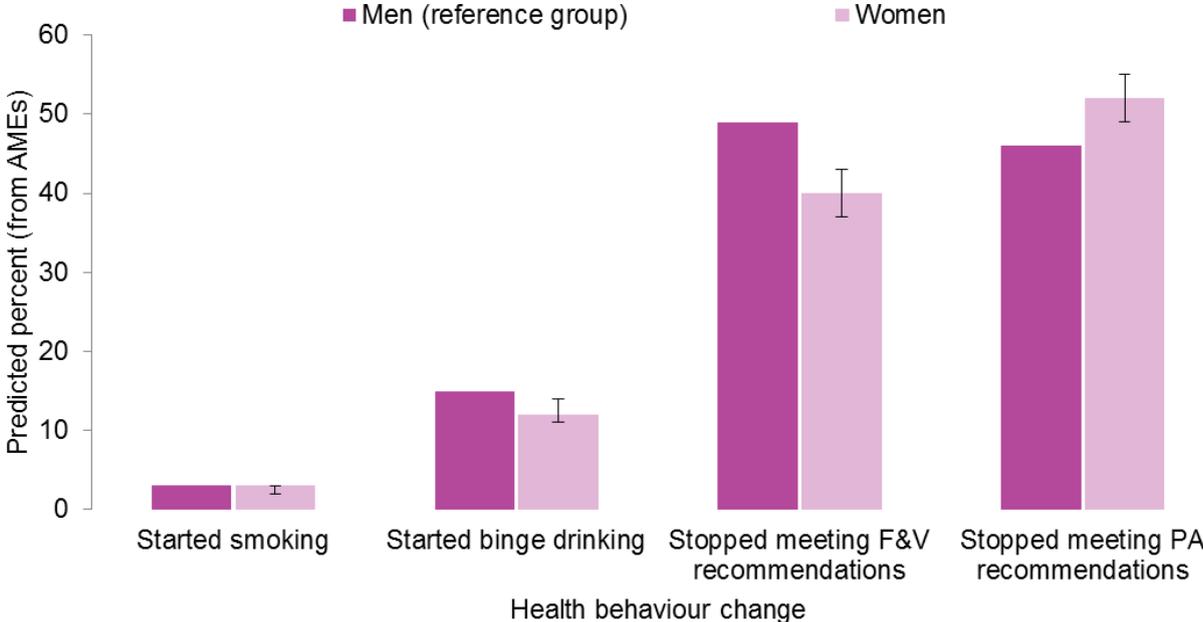


Figure 5.5b: Predicted prevalence (with 95% confidence intervals) of worsening health behaviours (meeting recommendation in 2010/11 but not meeting it in 2013/14), by sex

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Table D5-D12

Ethnic group: With the exception of smoking, ethnicity was associated with changes in meeting recommendations for all other health behaviours. Patterns are summarised in Figures 5.6a and 5.6b below.

As the Figures indicate, those from non-white backgrounds were more likely to stop binge drinking and less likely to start than White British (the reference group). Predicted prevalence of stopping binge drinking was 43% among White British but among those from South Asian groups it was 60%; among Black African or Black Caribbean groups, it was 66%. Those from South Asian groups were less likely to start meeting F&V recommendations (9%) than White British (14%) and were more likely to stop meeting them (60%) than White British (43%). Those from Black African/Caribbean backgrounds were also more likely to stop meeting the F&V recommendations. South Asians were also less likely to start meeting the PA recommendations (13%) than White British (16%). Therefore, whilst South Asians were more likely to change their alcohol consumption in a positive way, they were less likely to replicate this for F&V consumption and PA.

Figure 5.6a: Predicted prevalence (with 95% confidence intervals) of positive health behaviour changes (not meeting recommendation in 2010/11 but meeting it in 2013/14), by ethnic group

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account

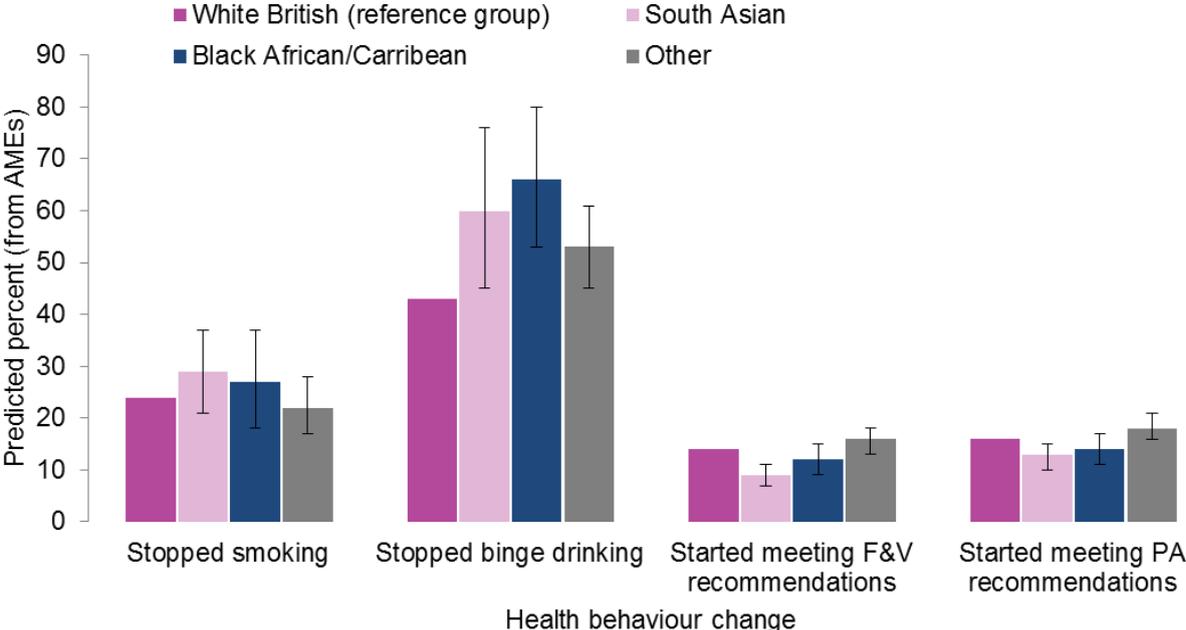
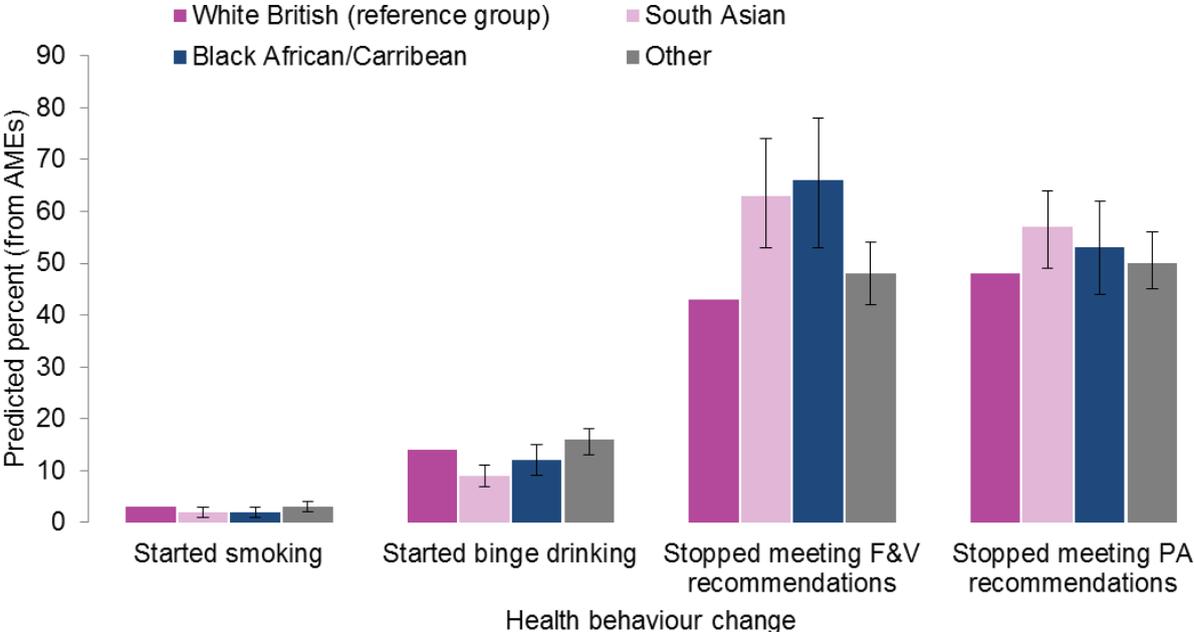


Figure 5.6b: Predicted prevalence (with 95% confidence intervals) of worsening health behaviours (meeting recommendation in 2010/11 but not meeting it in 2013/14), by ethnic group

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



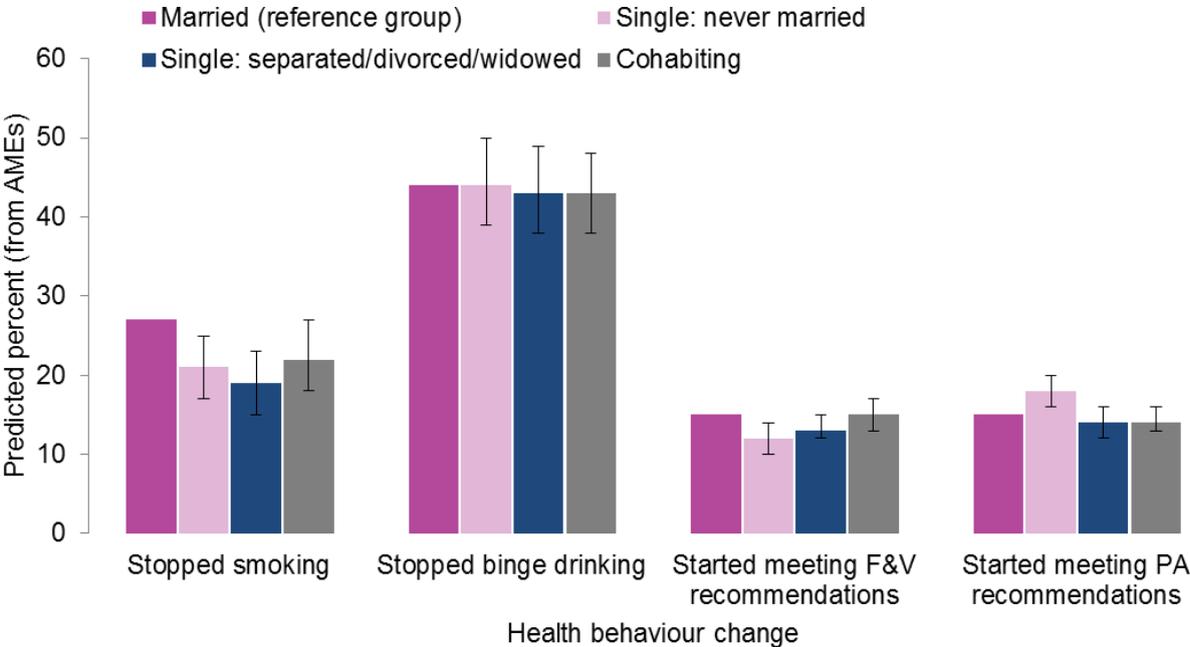
Appendix D, Tables D5-D12

Marital and cohabitation status: The patterns of behaviour change are summarised in Figures 5.7a and 5.7b. Marital and cohabitation status in 2010/11 was associated with changes in smoking behaviour and starting to meet recommendations for F&V consumption and PA. With regard to smoking, those who were not married were more likely to start smoking and those who already

smoked were less likely to stop than those who were married (the reference group). Looking at stopping smoking, predicted prevalence rates were 5 to 8 percentage points lower among those who were not married than those who were married (27%). Those who were single (never married) or single (separated, widowed or divorced) were less likely than married people to start meeting F&V recommendations. Predicted prevalence estimates were 12%, 13% and 15% respectively. Those who were single (never married) were more likely to start meeting PA recommendations (18%) than their married counterparts (15%). Marriage may confer a protective benefit in relation to changes in smoking behaviour and F&V consumption which is not evident for other risk behaviours (see Figure 5.7a and 5.7b).

Figure 5.7a: Predicted prevalence (with 95% confidence intervals) of positive health behaviour changes (not meeting recommendation in 2010/11 but meeting it in 2013/14), by marital and cohabitation status

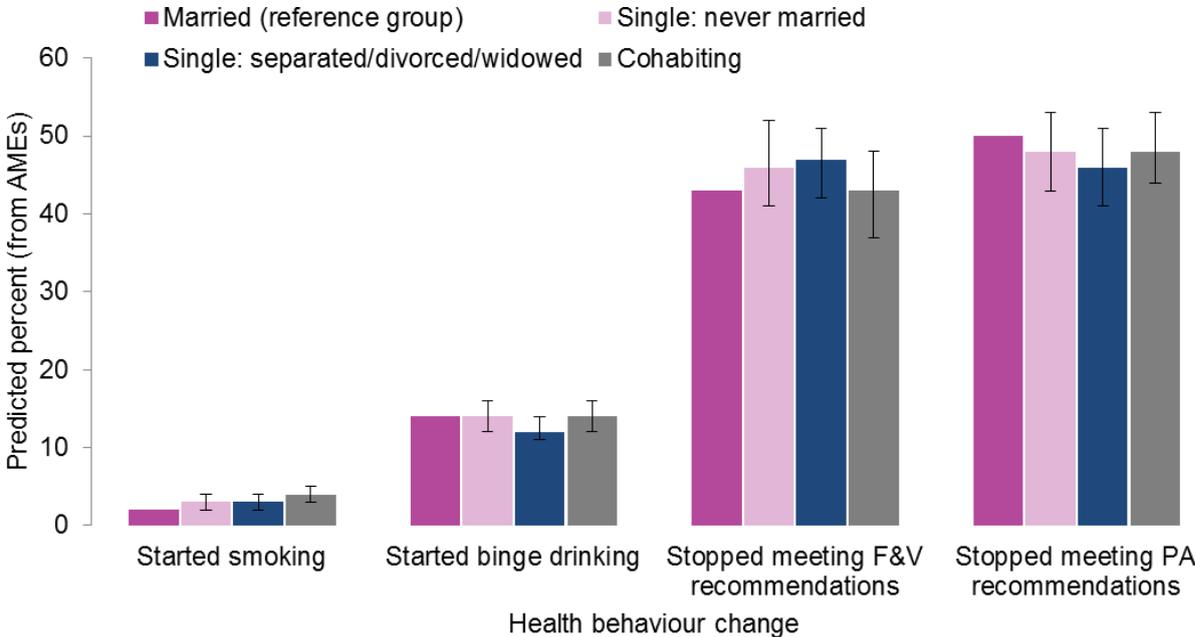
Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Tables D5-D12

Figure 5.7b: Predicted prevalence (with 95% confidence intervals) of worsening health behaviours (meeting recommendation in 2010/11 but not meeting it in 2013/14), by marital and cohabitation status

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Tables D5-D12

5.3.2 Health behaviour change by socio-economic factors

A range of measures of socio-economic circumstances (educational attainment, employment status, household income and area deprivation) were included in the multivariate models to explore whether there were social gradients in health behaviour change.

The area-based measure (IMD) of socio-economic circumstances was not significantly associated with any health behaviour change. The household measure, household income, was only associated with starting to binge drink and stopping meeting the PA recommendations. Those with lower incomes were less likely to start binge drinking than those in the highest income quintile group (the reference group) and more likely to stop meeting the PA recommendations (those in the 4th income quintile group were more likely to stop meeting the PA recommendations than those in the highest income group. (Figures not shown; further details are available Appendix D, Tables D5-D12).

Stronger associations between people’s socio-economic circumstances and changes in health behaviours were evident for the individual-level measures: education and employment status. Social patterning by education was evident for many dimensions of behaviour change (see Figures 5.8a and 5.8b). Those with lower levels of educational attainment were less likely to stop smoking (Appendix D, Table D5) and less likely to start meeting F&V or PA recommendations (Appendix D, Table D9) than those educated to degree level or higher (the reference group). This pattern was particularly pronounced for smoking. The predicted prevalence of stopping smoking was 35% among those educated to degree level or higher compared with 19% for those with no or other educational qualifications.

Similarly, as Figure 5.8b indicates, those with lower educational attainment were more likely to start smoking (see Appendix D, Table D6 for further details) and more likely to stop meeting F&V and PA recommendations (Appendix D, Table D10). For example, with respect to stopping meeting the F&V recommendations, the predicted prevalence was 34% among the highest educational group compared with 54% among the lowest educational group (Appendix D, Table D10).

For binge drinking, however, the opposite pattern was evident (Figure 5.8a). Those with no/other educational qualifications were more likely to stop binge drinking (48%) than those with a degree or higher (41%) (Appendix D, Table D7).

Figure 5.8a: Predicted prevalence (with 95% confidence intervals) of positive health behaviour changes (not meeting recommendation in 2010/11 but meeting it in 2013/14), by educational attainment

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account

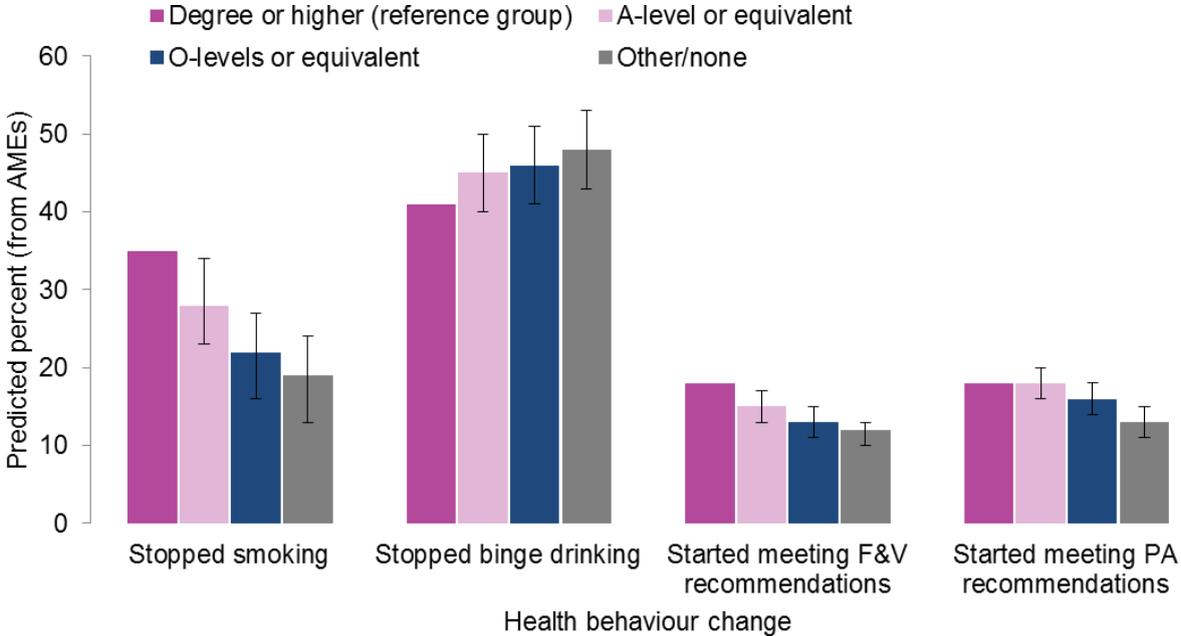
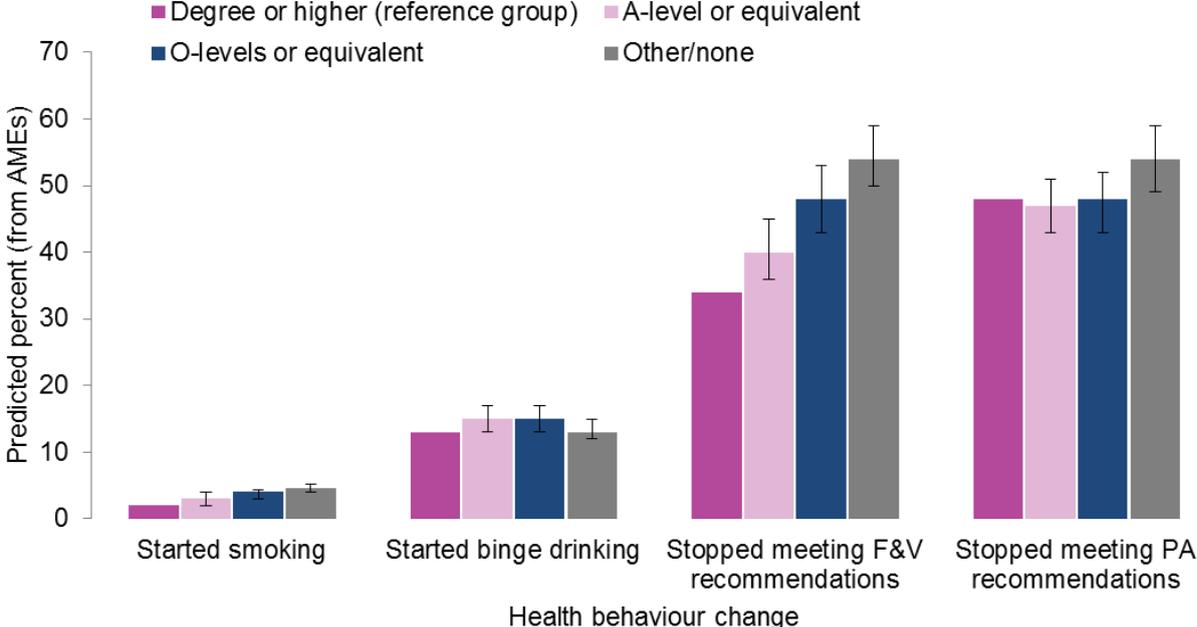


Figure 5.8b: Predicted prevalence (with 95% confidence intervals) of worsening health behaviours (meeting recommendation in 2010/11 but not meeting it in 2013/14), by educational attainment

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Tables D5-D12

The patterns for employment status, our other individual-level measure of socio-economic circumstances, are summarised in Figures 5.9a and 5.9b. Employment status was associated with stopping smoking, starting binge drinking and starting to meet F&V recommendations. Compared with people in paid employment (the reference group), those who were unemployed were less likely to stop smoking (18% compared with 26%) and less likely to start meeting F&V recommendations (10% compared with 14%). Students were more likely to start binge drinking than those in paid employment (18% vs 14% respectively).

Figure 5.9a: Predicted prevalence (with 95% confidence intervals) of positive health behaviour change (not meeting recommendation in 2010/11 but meeting it in 2013/14), by economic activity

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account

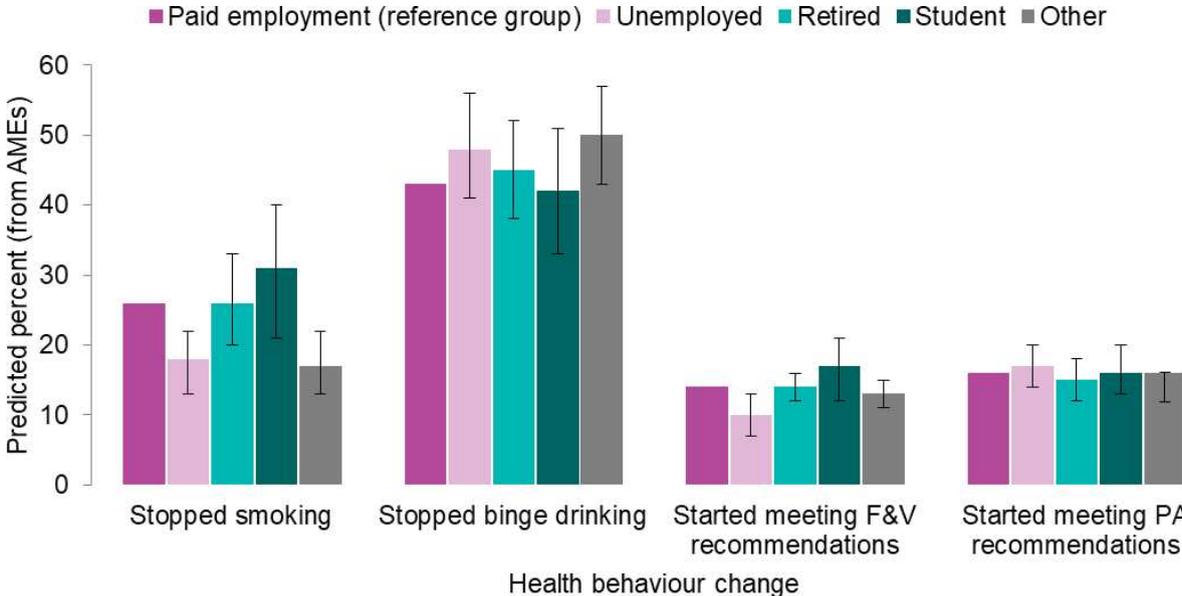
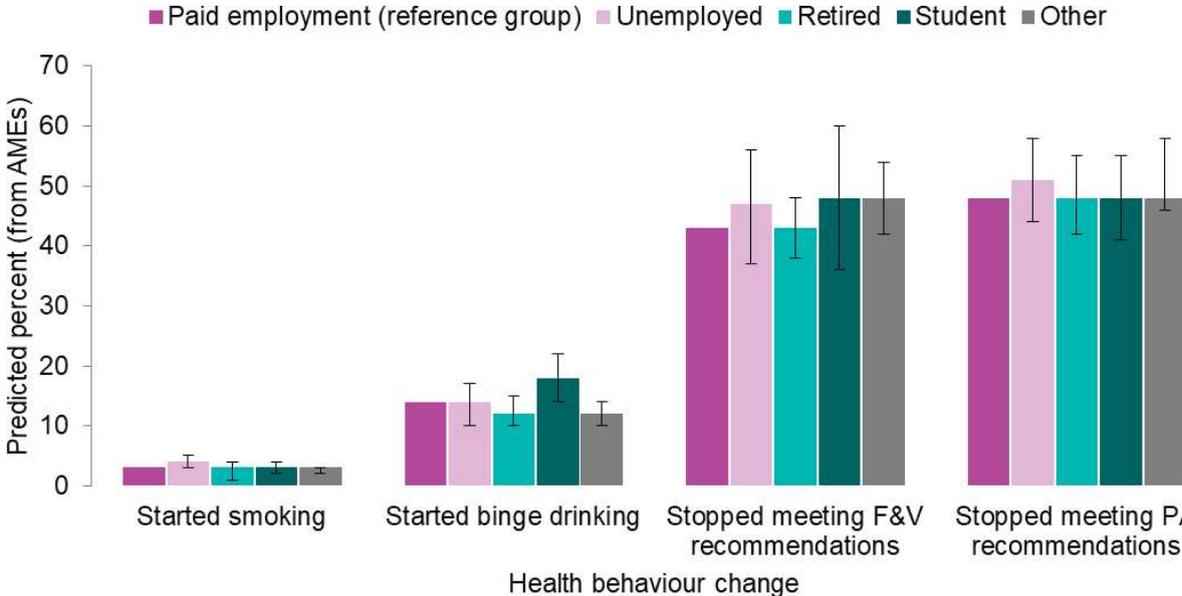


Figure 5.9b: Predicted prevalence (with 95% confidence intervals) of worsening health behaviours (meeting recommendation in 2010/11 but not meeting it in 2013/14), by economic activity

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Tables D5-D12

5.3.3 Health behaviour change by general health status

Figures 5.10a and 5.10b summarise the patterns of change in the four health behaviours by self-reported health status. As the Figures indicate, health status was associated with changes in PA. Compared to those in good health (the reference group), those in fair or poor health were more

likely to stop meeting the PA recommendations and less likely to start meeting them (starting PA: 17% for good health; 8% for poor health; stopping PA: 48% for good health, 64% for poor health). However, those with poor health were less likely to start binge drinking than those with good health (10% poor health; 14% good health). Compared with those in good health, those in fair health were more likely to start smoking and less likely to stop binge drinking (see Figures 5.10a and 5.10b). There was no relationship between self-reported health and change in meeting F&V recommendations.

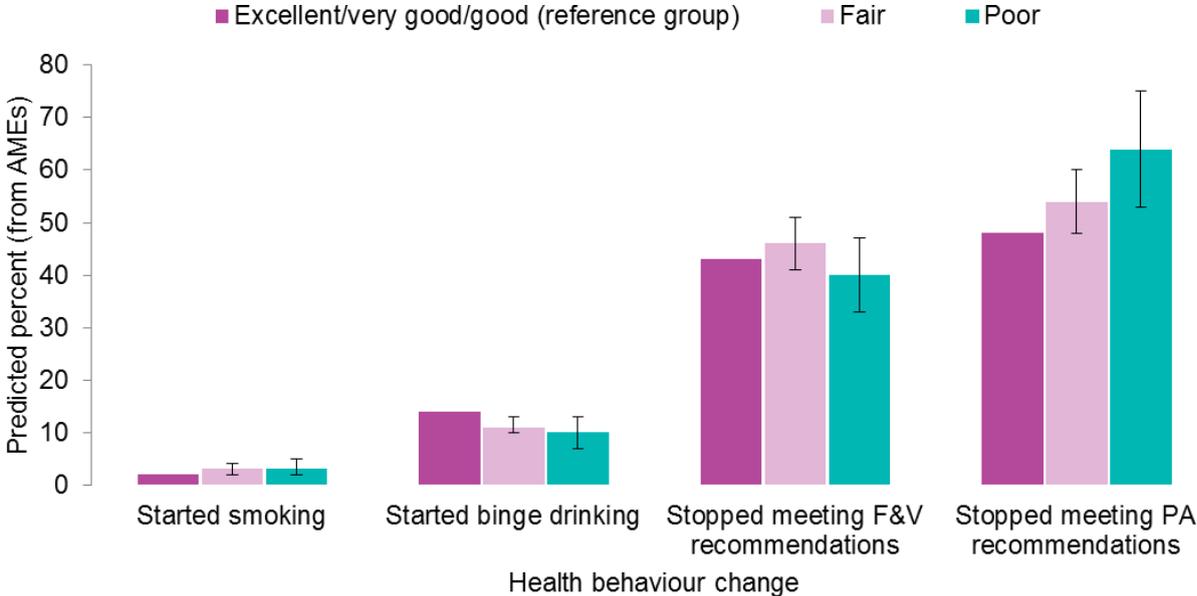
Figure 5.10a: Predicted prevalence (with 95% confidence intervals) of positive health behaviour changes (not meeting recommendation in 2010/11 but meeting it in 2013/14), by self-reported general health

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Figure 5.10b: Predicted prevalence (with 95% confidence intervals) of worsening health behaviours (meeting recommendation in 2010/11 but not meeting it in 2013/14), by self-reported general health

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Appendix D, Tables D5-D12

5.3.4 ‘Improving’ and ‘worsening’ health behaviour by socio-demographic, socio-economic factors and general health status

Among those who did not meet the recommendations for smoking and binge drinking in both 2010/11 and 2013/14), we additionally explored whether they showed any improvement (reduced consumption) or deterioration (increased consumption) in these behaviours (see section 5.2.2 above). Few factors were associated with improving and worsening health behaviour among persistent smokers and binge drinkers. Age, sex and ethnic group were the main distinguishing factors. Full details are given in Appendix D, Tables D13-16.

Among persistent smokers, those aged 25 and over were less likely than those aged 16-24 to increase the number of cigarettes they smoked. Predicted prevalence of increasing cigarette consumption was 27% for those aged 16-24 and ranged between 15 - 19% for those aged 25 and over. However, persistent binge drinkers aged 25 and over were less likely than those aged 16-24 to reduce the number of units of alcohol consumed. Estimates ranged between 5%-12% for those aged 25 and over, compared with 20% for those aged 16-24 (Appendix D, Table D15). Persistent binge drinkers aged 55 and over, however, were less likely to increase their alcohol consumption than those aged 16-25 (4% vs 14% respectively).

Female smokers were more likely than male smokers to reduce the number of cigarettes they smoked but female binge drinkers were less likely than male binge drinkers to reduce their alcohol consumption. Finally, persistent South Asian binge drinkers were more likely to reduce their alcohol consumption than those who were White British. Persistent Black Caribbean/African smokers were less likely than White British to reduce the number of cigarettes smoked.

5.4 Summary

Two broad conclusions can be drawn from our analysis: stability in adult health behaviours is the norm and, while few adults change their behaviour, for those that do there is some evidence that these changes are socially patterned.

Looking firstly at stability, it was rare that people either started or stopped smoking between 2010/11 and 2013/14. Most people did not smoke or binge drink in 2010/11 and continued not to do so in 2013/14. Similarly, most people did not meet F&V or PA recommendations in 2010/11 and continued not to do so in 2013/4. Such stable patterns of behaviour provide the context in which policies to promote healthy lifestyles are set and point to the challenge of achieving positive changes in behaviour. Particularly for behaviours which the majority of the population fail to meet, it suggests that attention should be paid to increasing positive health behaviours below the recommendation- thresholds (e.g. what is associated with moving from no/low levels of F&V consumption and PA).

With respect to F&V and PA, it should also be noted that the overall pattern of stability masks considerable variation in behaviour over time. A large proportion of those who met recommendations for F&V and PA in 2010/11 did not do so in 2013/4; a finding that points to the difficulty not only of achieving but also of maintaining these healthy behaviours, as well as difficulties in measuring these behaviours accurately.

Turning to the social patterning, there was some evidence that lifestyle changes varied in line with people's circumstances. Net of other socio-demographic and socio-economic factors, those less likely to stop smoking were adults with lower levels of educational attainment; those who were unemployed and those who were not married. Conversely, those most likely to start smoking were those with lower levels of educational attainment, those who were not married and those who were younger.

Like smoking, negative changes in F&V consumption were more likely among those who were more disadvantaged. Those with lower levels of educational qualifications were less likely to start meeting recommendations as were those who were unemployed. In addition, those who were not married (single and widowed/divorced/separated) and those from South Asian groups were also less likely to start meeting recommendations. Women and older people were more likely to start meeting recommendations than men and those who were younger. Women and older people were also less likely to stop meeting recommendations, suggesting that, on balance, women and older people were most likely to achieve positive behaviours in relation to F&V recommendations. Those with lower levels of educational attainment and those from non-White ethnic groups were more likely to stop meeting recommendations, suggesting that these groups face additional barriers in maintaining health behaviours that meet the recommendations for F&V.

With respect to PA, women, older people, those from South Asian groups, those who described their health as poor and those with lower levels of educational attainment were all less likely to start meeting PA recommendations. However, those who were single (never married) were more likely to start meeting recommendations than those who were married. Women, those in poor health, with the lowest levels of educational attainment and with lower household incomes were also more likely to stop meeting recommendations.

For binge drinking, a markedly different social pattern was evident. Those most likely to stop binge drinking were women, those with the lowest levels of educational attainment and those from non-white ethnic groups. Those less likely to start binge drinking were women, older people, those with poor health, those from non-white ethnic groups and those with the lowest household incomes. Change in binge drinking behaviour therefore does not display the same social gradients as other health behaviours.

When looking at behaviour change among persistent smokers and binge drinkers, there was also some evidence of social patterning. The factors were socio-demographic rather than socio-economic, with age, sex and ethnic group being the main net predictors.

Taken together, the patterns point to some widening of social inequalities in health behaviours over time. With the exception of binge drinking, those with lower levels of educational attainment were typically less likely to make positive improvements in behaviour and more likely to make negative changes. More disadvantaged groups were less likely to stop smoking and less likely to start meeting F&V and PA recommendations. We found particularly marked social gradients for stopping smoking; the predicted prevalence of stopping smoking was 35% among those educated to degree level or higher compared with 19% for those with no or other educational qualifications, though the populations to whom this applies are small (smoking prevalence overall is low). For binge drinking, however, the opposite pattern was evident. Those with no/other educational qualifications were more likely to stop binge drinking (48%) than those with a degree or higher (41%). However, as with smoking, we should be aware that binge drinking is a minority behaviour (unlike low PA or low F&V consumption). It is also notable that certain factors which were strongly associated with the prevalence of health behaviours (see Chapter 4), such as household income, were less important when looking at behaviour *change*. This alerts us to the fact that the factors predictive of individual behaviour at a single point in time (i.e. when viewed cross-sectionally) are not necessarily associated with change in behaviour over time.

6. RELATIONSHIP BETWEEN LIFE TRANSITIONS AND CHANGES IN HEALTH BEHAVIOURS

6.1 Introduction

This chapter addresses the third project objective, which is to explore the relationship between key life transitions and events (hereafter ‘transitions’) and changing health behaviours. As explained in Chapter 3.5, we focused on transitions that many people will experience in the course of their lives and where lifestyle changes may be anticipated; additionally, we selected transitions experienced by a sufficient number of study participants across a three-year period (2010/1 to 2013/14) to allow analyses to be undertaken. Using the large-scale and nationally representative UKHLS, we were able to explore the relationship between these transitions and changes in all four health behaviour change across the adult population.

The transitions considered are:

- Changes in relationship status (moving in or out of a relationship)
- Changes in family composition (adding at least one child to a previously childless household)¹³
- Changes in employment status (moving from employment to unemployment; unemployment to employment; being a student to employment or unemployment and employment to retirement)
- Changes in income (changes in equivalised household income of +/- 20% or more)

To support our analysis, we undertook a rapid assessment of evidence on the selected life transitions (changes in relationship status, adding a child/ren to a childless household, changes in employment status and changes in household income) and changes in the four health behaviours (Section 6.2). Then, focusing on adults in England, Section 6.3 describes the number and characteristics of people in the UKHLS who experienced each transition between 2010/11 and 2013/14. Finally, Section 6.4 presents exploratory analyses showing the relationship between the experience of each life transition and health behaviour change. Section 6.5 provides a summary and offers some conclusions.

6.2 Rapid Evidence Assessment of life transitions and health behaviour changes

Rapid Evidence Assessments (REA) were conducted to identify evidence about the relationship between each life transition and each health behaviour change (sixteen individual reviews in total). Details of the REA methods are given in Appendix F.

Overall, 54 studies were included in the review, some of which addressed more than one life transition (n=16). There was considerable diversity in the studies, including in the study populations and the measures of the four behaviours. All of the UK studies were based on analyses of its major longitudinal studies. These included:

¹³ In the literature, and theoretically, it is more usual to consider specifically the *birth* of a first child. However, the way that the UKHLS questionnaire is constructed does not allow us to do this. Calculating the addition of one or more children to a previously childless household is a close proxy. For more details, see appendix A.

- National Child Development Study (NCDS) following a cohort of children born in 1958¹⁴
- English Longitudinal Study of Ageing (ELSA) following men and women aged 50 and older at recruitment¹⁵
- EPIC-Norfolk (European Prospective Investigation of Cancer-Norfolk) following men and women aged 40 to 79 years at recruitment¹⁶
- British Household Panel Survey (BHPS) which recruited people living in households in Britain (then extended to Northern Ireland) and followed them every year; the BHPS has now been incorporated into the UKHLS¹⁷

Details of the UK-based studies are shown in Table 6.1; these are arranged by health behaviour (smoking, alcohol consumption, PA and F&V consumption). Full details of the 54 studies in the REA are given in Appendix F.

The overall finding from the REA is the paucity of evidence on life transitions and lifestyle change:

- A) *There is a paucity of UK-based evidence examining the impact of life transitions (relationship, employment and income transitions and having children) on smoking, alcohol consumption, PA and F&V.*

Six UK studies based were identified. Two of the six used the 1958 National Child Development Study to explore the relationship between a) changes in labour market categories and alcohol consumption and b) changes in family composition and alcohol consumption. Staff et al (2014) examined how within-person changes in family composition (union formation and becoming a parent) impacted on alcohol consumption; they found that consumption was lower when men and women were married and lived with children under the age of 5. Colell et al (2014) found that men who became sick or were mainly sick between the ages of 30 and 53 decreased their alcohol intake at a greater rate than others. Women who became employed after being a ‘homemaker’ (compared with those who were employed throughout) increased their alcohol intake.

A further two studies used the EPIC Norfolk study to explore a) the relationship between retirement and PA and b) marital transitions and F&V intake. Barnett et al (2013) found that retirement was associated with an increase in recreational physical activity but a decrease in occupational and travel activity, giving a net overall reduction in PA. Vinther et al (2016) found that marital transitions were associated with changes in F&V intake for men but not women. Relative to men who remained married, men who became widowed, separated or divorced reduced their consumption of F&V.

Two other studies looked at changes in smoking behaviour. Lang et al (2007) examined data from the English Longitudinal Study of Ageing to explore smoking cessation and the transition to retirement. They found that those who retired were more likely to stop smoking than those who remained employed. Giordano and Lindstrom (2010) used two waves of the British Household Panel Survey (2003 and 2005) to look at changes in social

¹⁴<http://www.cls.ioe.ac.uk/page.aspx?&sitesectionid=724&sitesectiontitle=National+Child+Development+Study>

¹⁵<https://www.elsa-project.ac.uk>

¹⁶<http://www.srl.cam.ac.uk/epic>

¹⁷<https://www.understandingsociety.ac.uk/about/bhps-in-understanding-society>

capital (trust in other people and levels of community participation) on smoking behaviours. This included looking at income change, employment change and marital status change. In multivariate analyses, they found no relationship between income change and stopping or starting smoking. Looking at marital and cohabitation status, compared with those who remained single, those who remained married were more likely to stop smoking. Conversely, compared with those who remained married, those who remained single were more likely to start smoking. Notably, those whose marital and cohabitation status changed did not vary significantly from the reference groups of those who remained single (in the smoking cessation model) and those who remained married (in the starting smoking model). A similar pattern was found for employment status, where those who were employed in both 2003 and 2005 were more likely to stop smoking than those who were unemployed in both years. Again, those whose employment status had changed did not vary significantly from the reference category of those who remained unemployed.

The REA pointed to some particular gaps in the UK-based literature. Of the studies identified through the assessment:

- The only studies which looked at drinking behaviour changes and their relationship with life transitions used data from a single birth cohort (i.e. those born in 1958) and focused on changes in mid-life. Whilst this gives useful insight for middle-aged adults born in a single year, 1958, it does not explore how this relationship might operate for those of different ages and other cohorts. Furthermore, these studies looked only at changes in family composition and employment and not at income changes.
- The only studies looking at change in PA and F&V consumption used data from EPIC Norfolk, whose results may not be generalisable to those outside of this age group and region. Changes in PA were only considered relative to retirement, and changes in F&V consumption were considered only relative to marital transitions. No UK studies were identified looking at changes in F&V consumption and employment transitions, income change or adding a child to the household. Likewise, no UK studies were identified looking at changes in PA and marital transitions, other employment changes, income change or the addition of a child to the family.
- Of the two studies which considered smoking transitions, one used data from the English Longitudinal Study of Ageing and assessed this relationship with retirement only. The other used the British Household Panel Survey (a panel study that included adults of all ages) and conducted analysis similar to that undertaken in our project and reported below. However, the BPHS analysis is based on data collected over 12 years ago and the focus of that study was restricted to changes in smoking behaviour, leaving gaps in knowledge around the relationship between life transitions and changes in drinking, F&V and PA.

B) The international literature provides some evidence about life transitions and changes in smoking behaviour, drinking behaviour and PA.

Results were mixed and often showed different patterns for men and women or older and younger age groups (see Appendix F for details). The most consistent evidence was found for:

- a. becoming unemployed and increased smoking;
- b. starting employment and a reduction in PA among younger men and women;

- c. retirement being associated with an increase in leisure time PA;
- d. becoming a parent being associated with reductions in smoking (though with resumption of smoking likely) and alcohol consumption, and;
- e. additional children being associated with lower levels of PA (see Appendix F for fuller details).

C) While the REA located little evidence around life transitions and health behaviour change, the impact of changing income on health behaviours emerged as a particular research gap.

The limited pool of studies tended to show no relationship in the case of income change and smoking behaviour (reported in three out of four studies identified). Few studies were identified which explore the relationship between income change and changes in F&V consumption and in PA.

D) There was a general paucity of evidence relating to life transitions and F&V consumption.

Only six studies in the review included F&V consumption; and none of these related to employment transitions. The evidence base appears to focus on dietary change more broadly, with fat and sugar consumption as the main outcomes rather than F&V consumption.

Overall, there is a lack of UK-based evidence on the relationship between key life transitions and changes in all four health behaviours. Internationally, evidence is also patchy and tends to paint a mixed picture about the nature of the relationships. The exploratory analysis of the UKHLS presented in Sections 6.3 and 6.4 therefore provides an important opportunity to add to this very limited evidence base, using the most recent data available for adults in England.

Table 6.1 Summary of UK studies identified in REA

Author	Data and population of focus	Life transitions considered	Health behaviour change	Life transition and health behaviour measures	Summary of findings
Giordano & Lindstrom (2010)	British Household Panel Survey 2003/2005; adults aged 16+ (n=10512)	Marital status; employment status; income	Smoking	<p>Smoking status change: coded as still a smoker; now a non-smoker; now a smoker; still a non-smoker; based on responses to the question “do you smoke cigarettes”.</p> <p>Employment change: coded as still employed; now unemployed; now employed; still unemployed. No further details provided.</p> <p>Marital status: coded still married; now unmarried; now married; still unmarried. No further details provided.</p> <p>Household income change: coded as still higher income; now lowest quartile; now higher income; still lowest quartile. Change defined in terms of movements between income quartile groups.</p>	<p>In bi-variate analysis, those who became unemployed (compared with those who remained employed), got married or became unmarried (compared with those who remained married) had higher odds of starting smoking. These relationships were not observed in the multivariate models which took into account cofounders like age, gender and psycho-social health.</p> <p>There was no relationship between household income change and smoking status change and no relationship between employment change, marital relationship change and stopping smoking.</p>
Lang et al (2007)	English Longitudinal Study of Ageing; compares data between baseline (HSE 1998-2000) and follow-up, (either 2002 or 2004). Smokers at baseline: n=1712	Employment transition - Retirement	Smoking cessation	<p>Smoking status change: coded as stopped smoking based on changes to the question “Do you smoke cigarettes at all nowadays?” between baseline and follow-up.</p> <p>Employment transition: coded as: Employed at baseline, retired at follow-up; Employed at baseline, employed at follow-up; Retired at baseline, retired at follow-up; Other (e.g. long-term sick; full-time caregiver). Based on standard economic activity question which included employment, retirement, full time education, long-term sick etc.</p>	<p>This analysis focused on those who were smokers at baseline and looked at rates of quitting by employment transition group. Those who transitioned into retirement had higher rates of stopping smoking than those who did not. These results remained significant in various multivariate models adjusting for cofounders.</p>
Colell et al (2014)	National Child Development Study (1958 cohort); uses data from waves aged 33 to 50; n=9960	Employment transition	Drinking	<p>Alcohol consumption: units of alcohol consumed in the past week.</p> <p>Employment transitions: For men were coded as (1) mainly FT employed: (FT employed in at least three sweeps); (2) mainly PT or unemployed (PT employed in at least three sweeps, or unemployed in at least three sweeps, or combinations of the two); (3) became unstable (FT employed at age 33 and 42 and PT or unemployed at age 46 and 50 or at age 50 only); (4) mainly sick or became sick (sick/disabled in at least three sweeps; or any activity at age 33 and 42 and sick/disabled at age 46 and 50); and (5) other. For women,</p>	<p>Using multi-level growth curves showed that women who became employed after being a homemaker had higher levels of alcohol consumption than those who were mainly employed and alcohol consumption increased at a marginally greater rate. Men who were mainly sick or became sick had higher levels of alcohol consumption than those mainly in FT employment but their alcohol consumption decreased rapidly over time.</p>

				<p>transitions coded as: (1) mainly employed (either FT or PT employed in at least three sweeps); (2) mainly homemaker (homemaker in at least three sweeps); (3) from employed to homemaker (either FT or PT employed at age 33 and 42 and homemaker at age 46 and 50 or at age 50 only); (4) from homemaker to employed (homemaker at age 33 or at age 33 and 42 and either FT or PT employed at age 46 and 50 only); (5) mainly sick or became sick: (sick/disabled in at least three sweeps or any activity at age 33 and 42 and sick/disabled at age 46 and 50); (6) other.</p>	
Staff et al (2014)	National Child Development Study (1958 cohort); uses data from waves at aged 16 to 50; n=14,589	Marital/relationship transitions; adding a child to a household	Drinking	<p>Alcohol consumption: measured by units of alcohol consumed in the past week and a dichotomous variable showing whether women drank more than two units and men drank more than three units per day in the 7 days prior to interview (called heavy daily drinking by authors).</p> <p>Relationship status: coded as whether single and not cohabiting; single and cohabiting; married; separated, widowed, or divorced and cohabiting; separated, widowed, or divorced and not cohabiting at each time point.</p> <p>Children status: coded as whether not residing with children; residing in household with children under age 5; from ages 5 to 16; or from ages 17 to 21 at each timepoint.</p>	<p>Results from fixed effect models showed a relationship between parenthood and alcohol consumption that was mediated by the age of the child. Parents consumed fewer units of alcohol per week when living with children under the age of 5 compared with those who had no children. Residing with older children (ages 17 to 21) had little association with women's alcohol use, whereas for men the link was positive; men had higher alcohol consumption when older children resided in the household.</p> <p>There was no association between relationship status change and alcohol consumption.</p>
Barnett et al (2013)	EPIC-Norfolk; baseline = 1997-2000 and follow up = 2006-2007; adults aged 39-78, n=3334	Employment transitions - retirement	PA	<p>PA change: measured by the EPAQ2. Total energy expenditure estimated by multiplying hours per week of activity by the metabolic cost for that activity. Change in these two values compared between baseline and follow-up.</p> <p>Retirement: coded as 'remained employed' (includes those who are retired but have a paid job) or 'employed to retired' (those who are retired and do not do any paid work). Based on whether they were currently retired from their main occupation and whether they had a paid job at present in each round.</p>	<p>Transition to retirement was associated with a decrease in occupational and travel PA and an increase in recreational and household PA, except among women from manual groups. The net effect was a decrease in overall PA.</p>
Vinther et al, 2016	EPIC-Norfolk; baseline = 1993 to 1997 and follow up = 1998 to	Marital and relationship transitions	F&V	<p>F&V change: average daily consumption estimated from questions asking about yearly consumption of 11 fruits and 26 vegetables. Differences between baseline and follow-up compared.</p> <p>Marital transitions: coded as remain</p>	<p>Fruit quantity varied by marital transition for men but not women. Relative to those who remained married, men who became widowed or separated reduced fruit intake. Similar patterns were observed for vegetable intake with</p>

2002; adults aged 39- 78, n=11,577			married (married at both time-points); remain unmarried (single, divorced or widowed at both time-points); became separated/divorced (married at baseline and separated or divorced at follow-up); became widowed (married at baseline and widowed at follow-up); and became married (single, widowed, divorced or separated at baseline and married at follow-up).	reduction in vegetable intake for men (but not women) who became widowed, became separated/divorced, or remained unmarried.
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6.3 Experience of each life transition

Before undertaking our UKHLS analyses of the relationship between life transitions and health behaviour change, it was important to establish how common these transitions were and whether the social profile of those who experienced the transition differed from those who did not. Table 6.2 shows the proportion of people who experienced each life transition between 2010/11 and 2013/14 (see Appendix A for details of how each life transition was coded).

With the exception of changes in household income, the experience of the transitions across the relatively short time period of the study was uncommon, with just 1% to 3% of adults experiencing each transition between 2010/11 and 2013/14.

Changes in household income were much more common than other changes; 18% experienced a decrease in household income of 20% or more between 2010/11 and 2013/14 whilst 36% experienced an increase in household income of 20% or more over the same time period.¹⁸

Table 6.2 Prevalence of life transition change between 2010/11 and 2013/4

Life transition	%
Moved into a relationship	2
Moved out of a relationship	3
Moved from employment to unemployment	1
Moved from unemployment to employment	2
Moved student to employment	3
Moved from student to unemployment	1
Moved from employment to retirement	3
Increased household income by 20% or more	36
Decreased household income by 20% or more	18
Added a child to the household	3
<i>Base</i>	<i>25,849</i>

Although the experience of each life transition was uncommon, there was variation in who was more likely to experience these transitions. Bi-variate analysis explored the profile of people experiencing each life transition by sex, age group, levels of educational attainment, ethnic group and general health status. These were the factors most closely associated with health behaviour change (see Chapter 5). It was therefore important to see how these factors were related to life transitions.

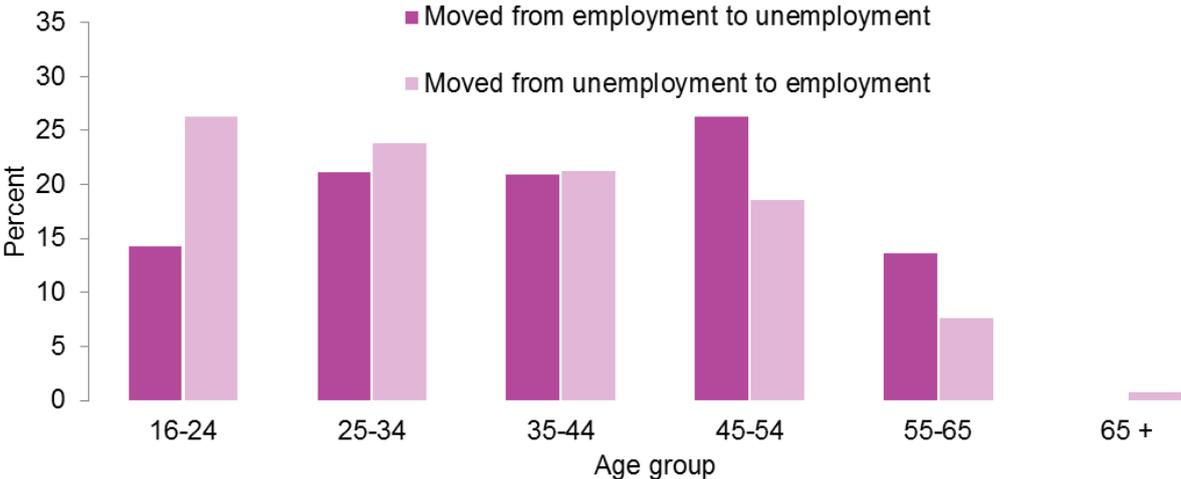
¹⁸ This threshold was chosen to represent real and meaningful change in equivalised household incomes, with income change less likely to be an artefact of measurement error in reporting of household incomes.

As expected, there was significant variation in the types of people who were more likely to experience each life transition. Looking first at marital and cohabitation status, those who moved into a relationship tended to be younger than those moving out of a relationship or for whom relationship status was stable. Those who moved into a relationship tended to have higher levels of educational attainment (82% educated to CSE equivalent or higher) than those who remained single (64%) and were less likely to have poor health in 2010/11; 3% of those moving into a relationship had poor general health compared with 8% who remained single.

Employment transitions were strongly associated with age. Those who moved from unemployment to employment tended to be younger than those who moved from employment to unemployment (see Figure 6.1). Those moving from unemployment to employment were also disproportionately male and were less likely to report poor health in 2010/11; 63% of those moving from unemployment to employment were men compared with 51% of those whose employment status was stable. Likewise 3% of those moving from unemployment to employment described their health status as poor compared with 6% for those with stable employment status.

Figure 6.1: Age profile of those who moved between employment and unemployment

Source: UKHLS 2010/11 and 2013/14; Base; those who moved from employment to unemployment and from unemployment to employment



Those who added a child to their household were younger than those who did not; 53% were aged 25-34 whereas just 14% of those who did not add a child to their household were aged 25-34. Those adding a child had higher levels of educational attainment (45% educated to degree level or higher vs 23%), and had better self-reported health in 2010/11, than those that did not. A larger proportion of those who added a child to their household came from non-white ethnic groups than those who did not: 20% vs 12%.

The profile of people experiencing an increase or decrease in their household income did not vary by age, sex, educational attainment, ethnic group or general health.

With the exception of income, this analysis highlights that the profile of people who experienced each life transition varied, particularly with respect to age, educational attainment and general health status. These are clearly interrelated with different life course stages and were also key factors associated with health behaviour change. Therefore, in the analysis that follows, age, sex, educational attainment, ethnic group and general health status are included as controls. These

factors were selected as they had the strongest and most consistent relationship with each health behaviour and health behaviour change in Chapters 4 and 5. Variables like area deprivation did not display a strong relationship in these prior analyses and therefore were not included as a control.

6.4 Patterning of life transitions and changing health behaviours

6.4.1 Overview

To explore the relationship between life transitions and changing health behaviours, the extent to which health behaviour change varied among those who did and did not experience each life transition was examined. As with our previous analysis, we focused on those whose health behaviours changed in terms of meeting or not meeting government recommendations.

For each transition, predicted prevalence estimates of health behaviour change were compared between those who experienced the life transition and those who had the same behaviour at baseline but did not experience change. For example, rates of health behaviour change among those who moved into unemployment were compared with those who were employed at both waves. Similarly, rates of health behaviour change among those who moved out of a relationship were compared with the rates of change among those who remained in a relationship (see Chapter 3.6 and Box 5 for more details).

We estimated a series of logistic regression models of behaviour change: one model each for all four positive and negative behavioural changes and for each of the transitions.¹⁹ As before, we report the results in the form of predicted prevalence derived from the average marginal effect (AME) of each independent variable on the probability of behavioural change. As noted, the models controlled for age, sex, educational attainment, ethnic group and general health status as the profile of people experiencing each transition varied. Results are summarised in Tables 6.3 and 6.4. Table 6.3 summarises significant associations between each life transition and positive health behaviour change, focusing on those who started to meet recommendations for each health behaviour in 2013/14. Table 6.4 summarises significant associations between each life transition with negative health behaviour change, that is stopping to meet recommendations for each health behaviour in 2013/14. Statistically significant results are those significant at conventional levels ($p < 0.05$). In Tables 6.3 and 6.4, 'no association' means that there was not a statistically significant association at these conventional levels.

¹⁹ In total, 80 different models were run. For example, there were five different employment transitions considered. These were: moving from employment to unemployment; moving from unemployment to employment; moving from FTE to employment; moving from FTE to unemployment and retiring. Models were estimated for each health behaviour looking at both starting and stopping meeting recommendations. This means that for smoking alone, ten models were estimated to look at the associations with changes in employment status. Tables of all models are provided in Appendix E.

Table 6.3: Summary AME analyses showing significant associations between life changes and positive health behaviour changes (started meeting recommendations)

Life transition	Positive health behaviour change			
	Stopped smoking	Stopped binge drinking	Started meeting F&V recommendations	Started meeting PA recommendations
Relationship behaviour change				
Moved out of relationship (compared with those remaining in relationship)	No association	No association	No association	Starting to meet PA recs higher among those moving out of relationship than those remaining in relationship
Moved into relationship (compared with those remaining single)	No association	No association	No association	No association
Employment transition				
Became employed (compared with those who remained unemployed)	No association	Stopping binge drinking lower among those who moved to employment than those who remained unemployed	No association	No association
Became unemployed (compared with those who remained employed)	No association	No association	Starting to meet F&V recs lower among those who became unemployed than those who remained employed	No association
Moved from full time education (FTE) to employment (compared with those who remained in FTE)	Stopping smoking lower among students who moved into employment than those still in FTE	No association	No association	No association
Moved from FTE to unemployment (compared with those who remained in FTE)	No association	No association	No association	Starting to meet PA recs lower among students who became unemployed than those still in FTE
Retired (compared with those who remained employed)	No association	No association	No association	No association
Income change				
Income increased (compared with those whose income stayed the same)	No association	No association	No association	No association
Income decreased (compared with those whose income stayed the same)	No association	No association	No association	No association
Adding children to household				
Childfree households who added at least one child to the household (compared with those that remained childfree)	No association	No association	No association	Starting to meet PA recs lower among those adding a child than those who remained child-free

Table 6.4: Summary AME analysis showing significant associations between life changes and negative health behaviour changes (stopped meeting recommendations)

Life transition	Negative health behaviour change			
	Started smoking	Started binge drinking	Stopped meeting F&V recommendations	Stopped meeting PA recommendations
Relationship behaviour change				
Moved out of relationship (compared with those remaining in relationship)	Starting smoking higher among those moving out of relationship than those remaining in relationship	Starting binge drinking higher among those moving out of relationship than those remaining in relationship	Stopping meeting F&V recs higher among those moving out of relationship than those remaining in relationship	No association
Moved into relationship (compared with those remaining single)	No association	No association	No association	Stopping meeting PA recs higher among those moving into a relationship than those who remained single
Employment transition				
Became employed (compared with those who remained unemployed)	No association	No association	No association	No association
Became unemployed (compared with those who remained employed)	Starting smoking higher among those who became unemployed than those who remained employed	Starting binge drinking lower among those who became unemployed than those who remained employed	No association	No association
Moved from full time education (FTE) to employment (compared with those who remained in FTE)	Starting smoking higher among students who moved into employment than those still in FTE	No association	No association	No association
Moved from FTE to unemployment (compared with those who remained in FTE)	Starting smoking higher among students who became unemployed than those who remained in FTE	Starting to binge drink lower among students who became unemployed than those who remained in FTE	No association	No association.
Retired (compared with those who remained employed)	No association	No association	No association	No association
Income change				
Income increased (compared with those whose income stayed the same)	No association	No association	No association	No association
Income decreased (compared with those whose income stayed the same)	No association	Starting to binge drink lower among those whose income decreased than those whose income stayed the same	No association	No association
Adding children to household				
Childfree households who added at least one child to the household (compared with those that remained child-free)	No association	Starting to binge drink lower among those who added a child than those who remained child-free	No association	Stopping meeting PA recs higher among those adding a child than those who remained child-free

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account

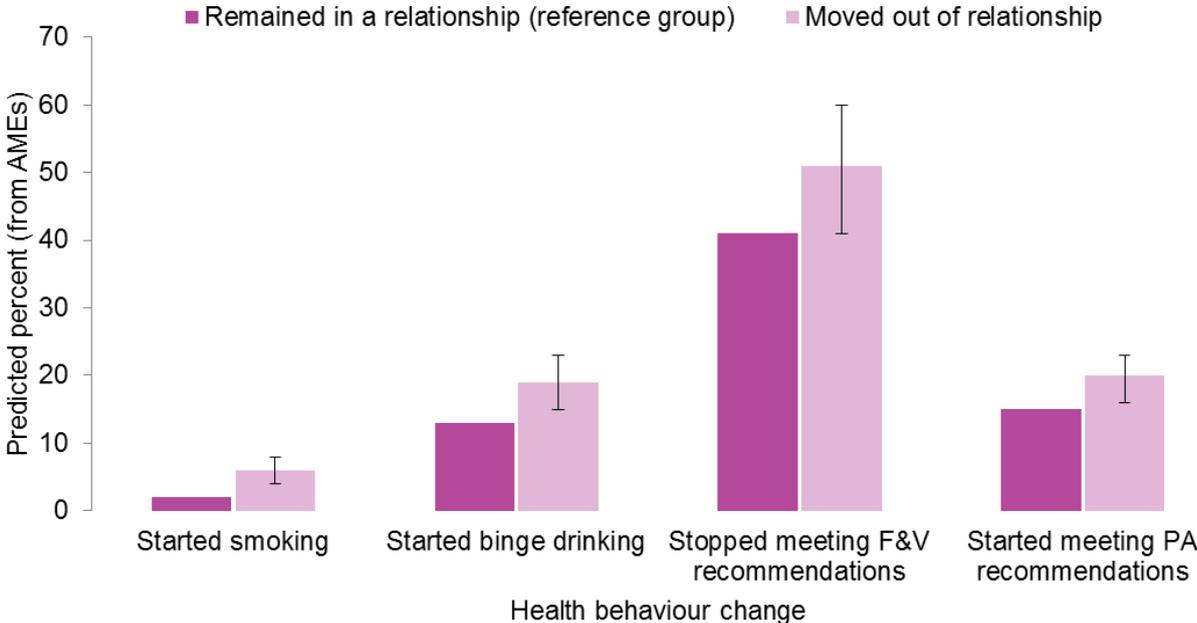
6.4.2 Relationship transitions and health behaviour change

Only one positive health behaviour change had a significant association with changes in marital and cohabitation status. Those who moved out of a relationship were more likely to start meeting

recommendations for PA (predicted prevalence 20%) than those who remained in a relationship (15%). However, on the whole, moving out of a relationship was associated with a greater range of negative health behaviour changes. Those moving out of a relationship were more likely to start smoking than those who remained in a relationship (6% vs 2%), to start binge drinking (19% vs 13%) and to stop meeting F&V recommendations (51% vs 41%). With the exception of PA, it appears that moving out of a relationship is more likely to be associated with negative than positive health behaviour changes (see Figure 6.2).

Figure 6.2: Predicted prevalence (with 95% confidence intervals) of selected changes in health behaviours by relationship transition: moving out of a relationship.²⁰

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



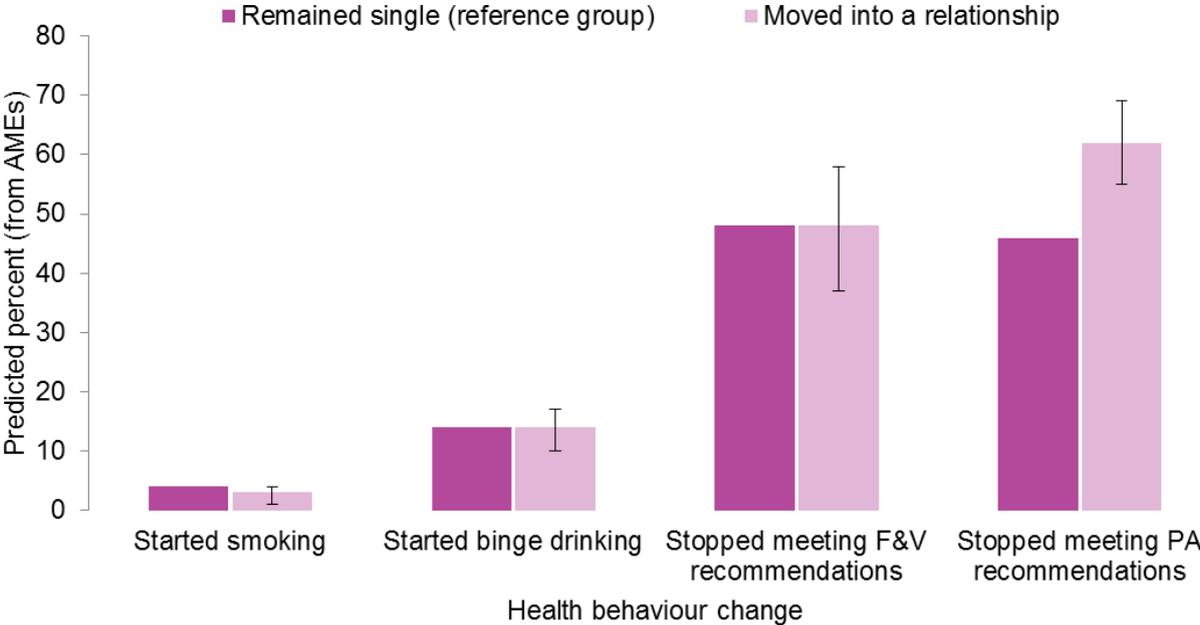
Whilst moving out of a relationship was associated with an increase in risk behaviours, the converse was not true for those moving into a relationship. Those who moved into a relationship were not more likely than those who remained single to show improved health behaviour change. Those moving into a relationship were no more likely than their single counterparts to stop smoking, stop binge drinking or start meeting F&V recommendations. The exception to this was PA; those who moved into a relationship were more likely to stop meeting PA recommendations than those who remained single (62% vs 46%, see Figure 6.3). With respect to PA, it appears that moving out of a relationship was associated with a positive effect on health behaviour change whilst moving into a relationship was associated with a negative effect. For other health behaviour changes, moving out of a relationship was associated with a negative impact but moving into a relationship did not appear to confer any health behaviour benefit.

(Appendix Tables E1 – E8)

²⁰ The relationships shown are those where there was a significant association between moving out of a relationship and health behaviour change.

Figure 6.3: Predicted prevalence (with 95% confidence intervals) of selected changes in health behaviours by relationship transition: moving into a relationship.

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



6.4.3 Employment transitions and health behaviour change

Employment transitions were considered firstly for all adults. A second group of transitions were then considered among the sub-group of those who were moving out of full-time education (called students hereafter). This is a transition undertaken by a large proportion of young adults (see Chapter 3.5).

Moving in and out of employment – all adults

Becoming employed was associated with only one health behaviour change. However, as Table 6.1 shows, this was not a positive relationship. Those who became employed were less likely to stop binge drinking (predicted prevalence 46%) than those who remained unemployed (63%). No other associations with health behaviour change, either positive or negative, were evident among those who became employed.

Those who became unemployed were more likely to start smoking (predicted prevalence 6%) and less likely to start meeting F&V recommendations (9%) than those who remained in employment (3% and 15% respectively). While moving into unemployment is associated with a negative behaviour change for these two health behaviours, those who became unemployed were less likely to start binge drinking (9%) than those who remained employed (17%).

Taken together, these patterns suggest that, while becoming unemployed is associated with negative changes in smoking and F&V consumption, moving into employment is not associated with positive changes in these behaviours. Further, transitions into employment were associated with a lower propensity to stop binge drinking whilst transitions into unemployment were associated with a lower propensity to start binge drinking.

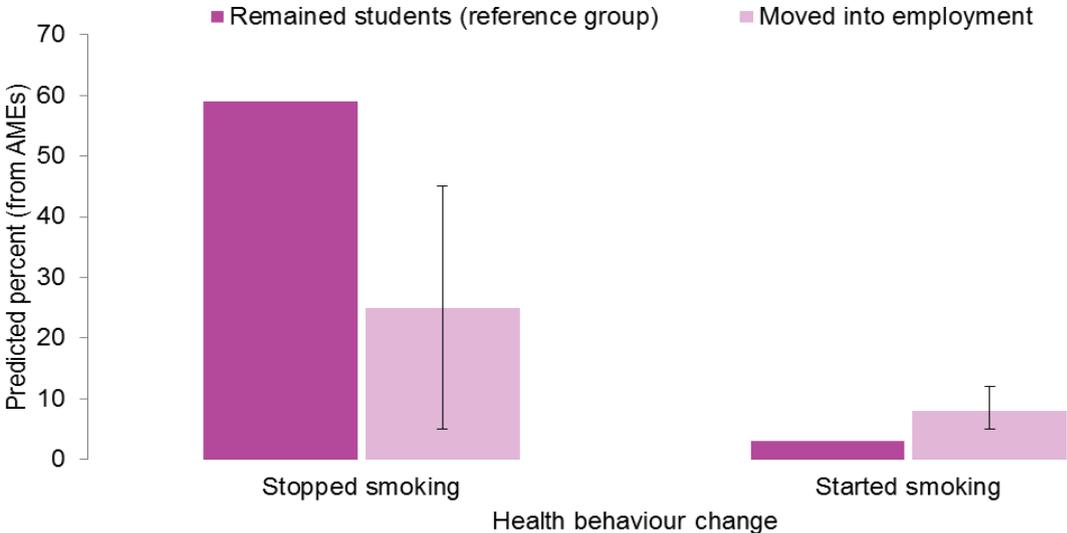
Moving in and out of employment – students

Analyses were also conducted looking at transitions among those moving out of full-time education (FTE) compared with those remaining in FTE.

Only changes in smoking status were associated with movements from FTE to employment. The pattern was symmetrical; those who moved into employment were less likely to stop smoking (predicted prevalence 25%) than those who remained in FTE (the reference group) (59%), whilst those who moved into employment were more likely also to start smoking (5%) than those who remained in FTE (3%) (see Figure 6.4).

Figure 6.4: Predicted prevalence (with 95% confidence intervals) of changing smoking status, by employment transition: moved from student to employment

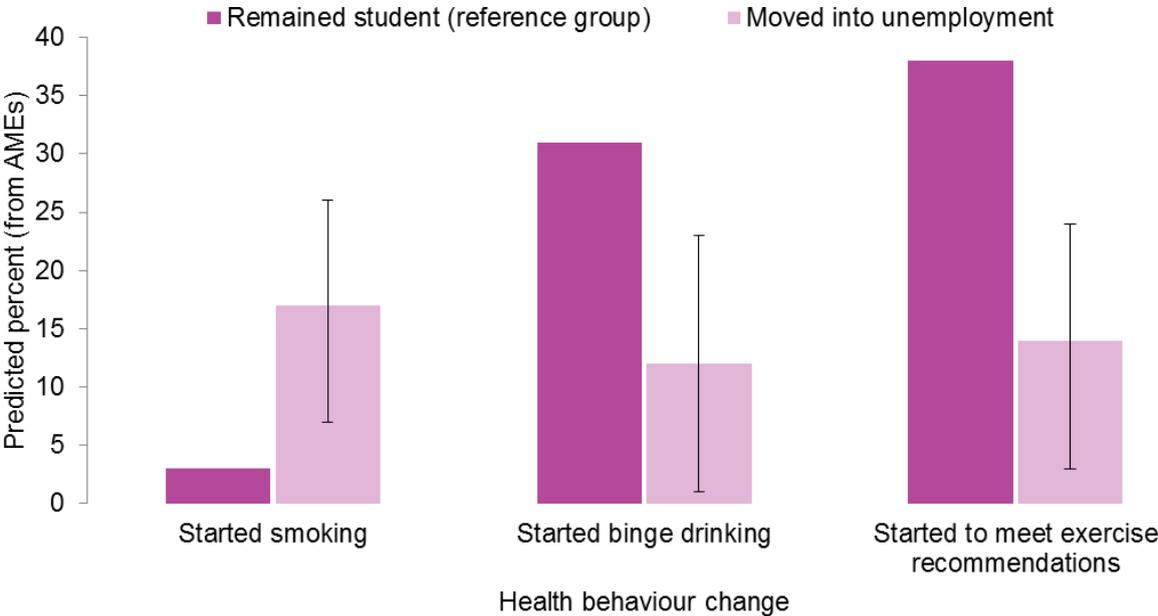
Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Those who left FTE and who moved into unemployment were more likely to start smoking (14%) and less likely to start meeting PA recommendations (14%) than those who remained in FTE (the reference group) (3% started smoking; 38% started meeting PA recommendations). However, those who left FTE and became unemployed were less likely to start binge drinking (12%) than those who remained in FTE (31%) (See Figure 6.5).

Figure 6.5: Predicted prevalence (with 95% confidence intervals) of health behaviour change, by employment transition: moved from student to unemployed.

Source: UKHLS 2010/11 and 2013/4; predicted prevalence derived from logistic regression models taking all other variables into account



Retirement

Interestingly, given the REA findings noted in Section 6.2, the transition into retirement from employment was not associated with any health behaviour change.

(Appendix E, Tables E9-E16)

6.4.4 Income change and health behaviour changes

Changes in household income were generally not associated with health behaviour change. There was one exception to this; those whose household income decreased by 20% or more were slightly less likely to start binge drinking than those whose income was stable (estimates were 12% vs 14% respectively).

(Appendix E, Tables E17-E24)

6.4.5 Adding a child to the household and health behaviour change

Adding a child to a previously childless household was associated with changes in binge drinking and PA. Those who added a child to the household were less likely to start binge drinking (predicted prevalence 9%) than those who continued to live in child-free households (13%). Those who added a child to the household were less likely to start meeting PA recommendations (10%) than those who did not (15%) and were also more likely to stop meeting PA recommendations (56% to 48%).

(Appendix E, Tables E25-E32)

6.5 Summary

To our knowledge, our exploratory analysis of the UKHLS represents the first attempt to examine the relationship between a range of key life transitions and positive and negative changes in four key health behaviours for the adult population in England. Focusing on a set of common transitions (relating to changes in relationship status, family composition, employment status and household income), we examined whether they were associated with changes in meeting/not meeting recommendations.

A number of key themes emerge from our analysis. First, the associations evident with each life transition do not operate in a uniform direction for all health behaviours. For example, moving out of a relationship brought with it a greater likelihood of starting smoking, binge drinking and stopping meeting F&V recommendations but also a greater likelihood of meeting the PA recommendations. A greater proportion of people who moved out of a relationship met the PA recommendations than those who remained in a relationship. Likewise, moving from employment to unemployment was associated with negative behaviour change for smoking and F&V consumption but more positive behaviour change for binge drinking, with those moving into unemployment being less likely to start binge drinking. Adding a child to a household meant being less likely to start binge drinking but also being less likely to start to meet, and more likely to stop meeting, the PA recommendations.

Second, whilst some life changes were associated with negative health behaviour change, it was not always evident that the reverse transition was associated with positive health behaviour change. For example, moving out of a relationship was associated with a greater likelihood of starting smoking and binge drinking but moving into a relationship did not reduce the likelihood of experiencing these negative changes in behaviour. Similarly, becoming unemployed meant a greater likelihood of starting smoking but becoming employed was not associated with any changes in smoking behaviour.

Third, any move from full-time education (FTE) seem to be associated with greater risk for smoking behaviour; this is regardless of whether people become employed or unemployed, both of which saw higher rates of starting smoking than those who remained in FTE.

Fourth, of the life transitions considered, very few displayed an association with changing F&V consumption. Only moving out of a relationship and becoming unemployed were associated with changes in whether people met F&V recommendations. The vast majority of people do not meet F&V recommendations and it may be there was behaviour change at lower levels of consumption. As the REA indicated, there is a paucity of studies examining life transitions and F&V consumption; these null findings therefore add to a limited evidence base.

Fifth, some of the null findings may be considered to be surprising. For example, adding a child to the household had no association with changing smoking status. Studies have found that pregnancy, particularly first pregnancy, is associated with smoking cessation (Crozier et al, 2009; Graham et al, 2010); however, post-partum resumption rates are high (Bauld et al, 2017). There were no significant associations between moving into retirement and changing health behaviours. Other studies have found a relationship between retirement and changes in PA (Barnett et al, 2013; Engberg et al, 2013). The lack of association in our study may be related to how PA is measured in the UKHLS, which excludes occupational activity; however, changes in recreational activity should have been detected. It may be that there are increases in recreational activity that nevertheless do not move people above the recommended threshold and are thus not detected in this analysis.

Finally, whilst the UKHLS has a very large sample size (over 25,000 people in this analysis), few people experience each life transition over a three-year period. This, combined with general stasis in health behaviours between 2010/11 and 2013/4, means that the sample sizes for analysis were often small. It may be that some of the non-associations shown in Tables 6.1 and 6.2 are because the study is underpowered to detect these differences.²¹ This should be borne in mind when reviewing results from this exploratory analysis.

²¹ At the same time, given the number of models estimated, it is possible that some associations will appear as significant when they are not actually observed in the population.

7. CONTRIBUTION TO CONSORTIUM THEMES

The PHRC's programme of research is structured around a set of inter-related themes. These include individual health behaviours (focused on smoking, diet and alcohol use) and multiple risk behaviours (in which smoking, diet, alcohol use and physical activity are all included). The behavioural themes are complemented by consortium themes related to living and working conditions. Information on themes and their related projects can be found at http://phrc.lshtm.ac.uk/projects_by_theme.html.

Our project's main contribution is to the behavioural themes. It advances these themes by providing in-depth analysis of the health behaviours that contribute most to the burden of ill-health and premature mortality among adults in England.

It uses measures of smoking, diet, physical activity and alcohol consumption based on government recommendations, together with measures of consumption for smoking and hazardous alcohol intake, to describe the prevalence of risk behaviours among the adult population in 2013/14 and changes in risk behaviours since 2010/11. It uses the UKHLS' rich measures of social circumstances and identity to analyse the social patterning of prevalence and of stability and change in risk behaviours. In so doing, it points to inequalities in risk behaviour and behaviour change, thus providing a link to the consortium theme around living and working conditions. The project's contribution to consortium evidence on living and working conditions is further strengthened by its analyses of associations between life events and transitions, on the one hand, and health behaviour change, on the other. These analyses included employment transitions (from full-time education into employment and unemployment, from employment into unemployment and from unemployment to employment, and from employment to retirement). The project also investigated the impact of changes in household income on the four health behaviours. To our knowledge, our project is the first UK study to provide evidence on the social patterning of changes in health behaviour and on the impact of life events and transitions on health behaviour.

8. CONCLUSIONS

The project has focused on four behavioural risk factors - cigarette smoking, harmful alcohol intake, poor diet and physical inactivity – that contribute to ill-health and premature mortality in England. Estimates suggest that eliminating these risk factors could prevent up to 80% of heart disease, stroke and type 2 diabetes and over a third of cancers (WHO, 2008). The four risk factors are also associated with high healthcare costs (Scarborough et al, 2011; NHS, 2014).

We used measures of the four behaviours aligned to government recommendations; three of these measures – not smoking, consuming a minimum of 5 portions of F&V a day and undertaking a minimum of 150 minutes of moderate to vigorous activity a week - are also used to track progress at local and national level in promoting healthy lifestyles and reducing social inequalities in key risk factors for ill-health (DoH, 2013c).

Using a large representative study of the adult population, the project sheds light on the patterning of the four health behaviours. Most adults met the recommendations for smoking (they did not smoke) and drinking (they did not binge drink) in 2010/11 and continued to meet the recommendations in 2013/14. But the majority of those who smoke and binge drank in 2010/11 were also smokers and binge drinkers three years later. For F&V consumption and PA, the majority did not meet the recommendations in 2010/11 and also failed to do so three years later. For both health behaviours, a larger proportion of those who had previously met the recommendations no longer did so three years later. This was true for 1 in 2 (50%) of adults who had previously met PA recommendations and over 4 in 10 (43%) of those who had previously met the F&V recommendations. Such patterns of physical activity and diet point to the challenge of achieving and maintaining positive changes in these behaviours.

In our analyses of change in health behaviours, we took account of a wide range of dimensions of people's lives, including socio-demographic factors (like age and ethnic group), socio-economic factors and health status. We found that positive changes in three of the four behaviours (smoking, F&V consumption and PA) were less likely to be made by those in disadvantaged circumstances; social disadvantage also increased the likelihood of making negative changes in these behaviours. For example, those with lower levels of educational attainment were less likely to stop, and more likely to start, smoking. The same patterns were evident for F&V consumption and for PA; study participants with low levels of educational attainment were less likely to start meeting the F&V and the PA recommendations - and were more likely to stop. Binge drinking was the exception to this pattern. Social disadvantage was associated with an increased likelihood of stopping binge drinking and a reduced likelihood of starting.

Ethnic group was also an important predictor of health behaviour and health behaviour change. For example, those from non-white groups were less likely to smoke and binge drink but more likely not to meet the recommendations for F&V consumption and PA. Those from South Asian groups were also less likely to start meeting the F&V and the PA recommendations. Our evidence lends weight to policies grounded in an understanding of cultural diversity, and supports Public Health England's emphasis on 'people and community-centred approaches to health and wellbeing' (PHE, 2015).

Our analyses took account of individual-level, household-level and area-level measures of people's socio-economic circumstances. In the cross-sectional analyses, area deprivation (measured by IMD

quintile group) did not discriminate between those meeting F&V and PA recommendations; however, it was strongly associated with smoking status, with men and women in more deprived areas more likely to smoke. In the analyses of changes in meeting the recommendations, area deprivation was not significantly associated with any change, positive or negative, in any of the four health behaviours. This finding is of interest given the increasing policy emphasis on locality-based approaches to promoting health (Kings Fund, 2013). It suggests that area-level factors may not be the key drivers of lifestyle change but that multi-component approaches addressing individual-level disadvantage may also be required.

The UKHLS also enabled us to explore whether the transitions that many people experience as they move through adulthood were springboards for positive changes in health behaviour. In broad terms, our analysis suggests that this is not the case. Only one of the transitions we examined was associated with a positive change: those moving out of a cohabiting relationship were more likely to start meeting the PA recommendations than those remaining in a relationship. Additionally, some employment transitions – specifically, moving from full-time education or employment to unemployment – reduced the likelihood of starting to binge drink, as did the addition of a child to the household and a decrease in household income. We recognise that our analysis is exploratory; even with a sample the size of the UKHLS (over 25000 for England), relatively few people experienced the transitions of interest over the 3 year period for which we had health behaviour data. Extending the analysis to subsequent years would provide capacity to investigate associations between life course processes and health behaviour change.

9. DISSEMINATION/OUTPUTS

Presentations given

H Graham and H Wardle (2017) "Are we creatures of habit? Persistence and change in adult health behaviours in England", plenary lecture, *2017 Understanding Society conference*, University of Essex, <https://www.understandingsociety.ac.uk/scientific-conference-2017/papers/212>

Bespoke reports for the Department of Health (Health Improvement Analytical Team)

- *Multiple risk behaviours among adults in England, 2013-14* (short report for DoH Health Improvement team on health behaviours in 2013/14), June 2016
- *Multiple risk behaviours among adults in England, 2013-14 including IMD analysis* (short report for DoH Health Improvement team on health behaviours in 2013/14), Aug 2016

Manuscripts planned

- "Persistence and change in adult health behaviours in England", to be submitted to JECH
- "Life transitions and changes in health behaviour: insights from a study of English adults", to be submitted to *Social Science and Medicine: Population Health*

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Appendix A: Method details

About the UKHLS

Understanding Society: the UK Household Longitudinal Study (UKHLS) has conducted annual surveys since 2009 of participants from a representative sample of around 28,000 UK households, and an ethnic minority boost sample of around 4,000 households, who are followed over time.²² Health behaviour data were gathered in the second (2010/11) and fifth (2013/14) waves. In English households, data were collected from around 38,000 adults at wave two, and from around 31,000 at wave five. Nearly 26,000 adults in English households participated at both waves. Participants included in these analyses are from English households, had fully productive face-to-face interviews and were aged 16 or over at wave two.

More information about the UKHLS is available at <https://www.understandingsociety.ac.uk/>

Health behaviour measures

We used government recommendations available at the time of data collection for the four health behaviours (Box 1 in Chapter 1) to categorise responses to the health behaviour questions. For most of the analysis included in this report, the measures are therefore simple binary ones (meeting/not meeting the relevant recommendation); we classified 'not meeting the recommendation' as a risk behaviour. These binary measures were used in Chapters 4, 5 and 6.

For UKHLS adults, smoking, fruit and vegetable consumption and physical activity participation were collected by a main CAPI questionnaire (Computer Assisted Personal Interview, administered face-to-face by an interviewer), whereas alcohol consumption was collected by a separate confidential self-completion questionnaire.

Smoking

Smoking one or more cigarettes per day was classed as not meeting government guidelines and was categorised as a risk behaviour (DoH, 2013a). Other patterns of smoking behaviour, including occasional smoking of cigarettes, were categorised as non-risk in this analysis. Regular cigar and/or pipe smoking were not measured in the UKHLS questionnaire but these are very low prevalence behaviours (Booth et al, 2013) and their exclusion will have made minimal difference to the analysis.

The UKHLS questions are as follows:

Have you ever smoked a cigarette, a cigar or a pipe?
Yes/No. If Yes:
Do you smoke cigarettes at all nowadays?
Yes/No. If Yes to both:
Approximately how many cigarettes a day do you usually smoke, including those you roll yourself?
(If less than 1 per day on average, zero is entered)
If Yes to first question and No to second:
Have you ever smoked cigarettes regularly, that is at least one cigarette a day, or did you smoke them only occasionally?
Smoked regularly, at least one per day; smoke them only occasionally; Spontaneous (e.g. never really smoked, just tried them once or twice).

Alcohol intake

In the UKHLS, adults were asked separate questions for different groups of alcohol consumed:

²² The household structure of the UKHLS means that children are also included in the survey. Our analysis focuses on adults only

‘...in the last seven days, on the day you drank the most, how many....’

- 1) *pints of beer, lager, stout or cider*
- 2) *measures of spirits or liqueurs, such as gin, whisky, rum, brandy, vodka or cocktails*
- 3) *glass of wine including sherry, port*
- 4) *alcopops*

For our analyses, these were converted into units of alcohol intake using values of 2 units per pint (based on normal strength beer, lager, stout and cider); 1 unit per single spirit measure; 2 units per glass of wine (assuming an average glass size of 175ml); and 1.5 units per alcopop. Although previous research based on the General Household Survey (Goddard, 2007) has shown that men are more likely to drink strong beers and lagers than women (which are about 6%+ alcohol by volume and, on average, equivalent to 3 units per pint), these accounted for a very small proportion of total alcohol consumed (6% of total units for men and 2% for women (Goddard, 2007)). Therefore, even though we did not know the proportion of strong beers and lagers consumed in the UKHLS, the underestimation of the total units drunk by UKHLS men due to this is likely to be modest.

Government guidelines on alcohol consumption were revised in 2015. It was not possible with UKHLS questions to produce measures for the now-current lower-risk guidelines for alcohol (men should not regularly drink more than 3 to 4 units per day and women should not regularly drink more than 2 to 3 units per day). We used the recommendations in place at the time of data collection pertaining to binge drinking: individuals who drank more than twice the daily recommended units of alcohol on their heaviest drinking day in the past week (for women more than 6 units and for men more than 8 units) were classed as binge drinkers and therefore engaging in a ‘risk behaviour’.

Unlike the other three health behaviours, the UKHLS alcohol data were gathered by self-completion questionnaire. Other studies suggest that interviewer-led questionnaires are more likely to produce socially desirable answers: for alcohol intake, lower consumption is more likely to be reported than in self-completed questionnaires (Tipping et al, 2010; Graham et al, 2016a). For example, in Tipping et al’s analysis, 44% of women in a self-completion sample who reported that they had drunk alcohol in the previous week had exceeded the thresholds for binge drinking, compared with 33% of women in an interviewer-led sample.

Fruit and vegetable intake

The UKHLS interview questions asked for the total number of portions and the number of days that fruit and vegetables were consumed; it did not specifically mention fruit juice though interviewers were instructed “IF QUERIED, FRUIT JUICE IS NOT TO BE INCLUDED”

- 1) *Including tinned, frozen, dried and fresh fruit, on how many days in a **usual** week do you eat fruit?*
- 2) *Including tinned, frozen and fresh vegetables, on how many days in a **usual** week do you eat vegetables? Do not include potatoes, crisps or chips*
Never,
1 - 3 Days,
4 - 6 Days,
Every day
- 3) *On a day when you eat fruit or vegetables, how many portions of fruit and vegetables in total do you usually eat? The showcard has some pictures that may give you an idea of what a portion looks like.*
0 through high



Individuals who did not report consuming five portions of fruit and vegetables a day for seven days in a usual week in the UKHLS were classed as not meeting government recommendations (DoH, 2003) i.e. as having a risk behaviour.

Physical activity:

In the UKHLS, questions on duration and intensity were asked in relation to walking, but not for other physical activities. Data were gathered on how many days individuals had walked fast or briskly for 30 or more minutes in the last four weeks. Walking briskly, which can cause adults to get warmer, breathe harder and their hearts to beat faster, can be classed as moderate activity (DoH 2011a); therefore, minutes of walking fast or briskly were used to estimate whether adults had done at least the recommended 150 minutes of moderate intensity exercise per week. Questions on other physical activity and its duration were limited; only questions on sporting activity were asked and the highest frequency category was three or more days a week. Therefore, an approximation to meeting government guidelines had to be used for the analyses as follows:

- 30 minutes or more of brisk or fast walking in a day 20 times in the past four weeks, or 3 days or more a week moderate to vigorous sporting activity, or 1-2 times a week moderate to vigorous sporting activity and 4 days a week brisk or fast walking for 30 minutes or more.

The UKHLS questions on moderate to vigorous intensity sports activities were as follows:

Here is a list of sporting activities. Please tell me which ones, if any, you have done in the last 12 months? Health, fitness, gym or conditioning activities; gymnastics; swimming or diving; cycling, BMX or mountain biking; football; rugby; track and field athletics; jogging, cross-country, road-running; hill trekking, backpacking, climbing or mountaineering; golf; boxing; martial arts; water sports (including sailing types); horse riding; nothing of this kind.

And have you done any of these sporting activities in the last 12 months? Please include ALL sports activities you have done. If there are any other sport activities you want to mention, just let me know which ones. Basketball; netball; volleyball; cricket; hockey; baseball, softball or rounders; racquet sports; ice-skating; skiing; motor sports; angling or fishing; archery (64 < only); yoga or pilates (64 < only); bowls (64 < only); croquet (64 < only); Other sporting activity such as triathlon, fencing, lacrosse, orienteering, curling, Gaelic sports, skate boarding, parachuting, scuba diving; nothing of this kind.

How often in the last 12 months have you done this/these sport(s)? If there is a 'peak season' for some of these sports then please bear this in mind when thinking of your answer.

Three or more times a week;
at least once a week but less than 3 times;
less than once a week but at least once a month;
less than once a month but at least 3 or 4 times a year;
twice in the last 12 months;
once in the last 12 months.

The UKHLS questions relating to walking were as follows:

I'd like you to think about all the walking you have done in the past four weeks either locally or away from home. Please include any country walks, walking to and from work or college and any other walks that you have done. In the past four weeks, have you done a continuous walk that lasted at least 10 minutes?

During the past four weeks, on how many days did you do a walk of at least 10 minutes?

On how many days in the last four weeks did you spend 30 minutes or more walking? This could be made up of more than one walk.

Which of the following best describes your usual walking pace?

A slow pace; a steady average pace; a fairly brisk pace; a fast pace – at least 4 miles per hour; Spontaneous (e.g.. None of these).

UKHLS does include a question about physical activity in the workplace but this is a broad and subjective measure which did not allow us to include it in our measure of PA:

Thinking about the type of work that you do, in general would you say that you are...

Very physically active

Fairly physically active

Not very physically active

Or not at all physically active in your job?

Therefore our measure of PA excludes workplace activity, which may under-represent the activity levels of certain groups, for example manual labourers.

Health behaviour change over time

For objective 2 and 3, we looked at stability and change in each health behaviour over time. To be included in analysis for objective 2 and 3, individuals had to have valid health behaviour data in both 2010/11 and 2013/4. For each health behaviour, the following groups were identified:

- Stable: did not meet health behaviour recommendations in both 2010/11 and 2013/4
- Stable: met health behaviour recommendations in both 2010/11 and 2013/4
- Change: Met health behaviour recommendations in 2013/4 but not 2010/11
- Change: Met health behaviour recommendations in 2010/11 but no longer did so in 2013/4

No survey is without measurement error, but the measures we have used to look at change over time are likely to be reflective of real change. Overall, we measure a simple dichotomy – whether the individual is meeting or not meeting each health behaviour recommendation. For the longitudinal analysis, these are categorised into simple groups of stability or change. Such groupings are clear-cut and likely to be more robust than if we were attempting to measure finer degrees of change.

The questions themselves are designed to measure typical behaviour and change. F&V and physical activity questions refer to “usual” amounts consumed, and “usual” intensities for walking; and the sports frequency question asks respondents to consider ‘peak season’ when answering. Walking questions refer to the last four weeks, which is a period likely to be well-recalled by respondents. Similarly, drinking questions refer to the last seven days. The measure of smoking is based on whether the individual regularly smokes at least one cigarette per day.

For objective 2 an additional four groups were created to examine worsening and improving health behaviour among persistent smokers and binge drinkers. These were:

- Improving smokers: persistent smokers who improved their smoking behaviour by smoking fewer cigarettes than previously;

- Worsening smokers: persistent smokers whose smoking behaviour worsened by smoking more cigarettes than previously;
- Improving drinkers: persistent binge drinkers who improved their drinking behaviour by consuming fewer units of alcohol on their heaviest drinking day than previously;
- Worsening drinkers: persistent binge drinkers whose drinking behaviour worsened by consuming more units of alcohol on their heaviest drinking day than previously.

There were 3256 persistent smokers in our sample and 2535 persistent binge-drinkers (unweighted numbers). For those who were smokers at both waves we calculated the change in number of cigarettes smoked each day; and likewise for persistent drinkers using number of units consumed. To set boundaries for 'improving' and 'worsening' that were likely to capture real change, we based our analyses on a change of five cigarettes per day for smoking and one standard deviation from the mean change in units drunk for drinking. For both persistent smokers and binge-drinkers, the distribution of change approximated a normal distribution closely, and had a mean very close to zero.

The level of change for cigarettes was set as there was of 'heaping' of reported numbers of cigarettes smoked at multiples of five in the distribution – i.e. spikes in number of people at five, and then especially ten, fifteen, twenty and above cigarettes smoked per day – as respondents appeared to round to the nearest five when reporting. A change of five cigarettes therefore seemed to be a plausible threshold to set for real change – if, for example, a respondent reported smoking 15 cigarettes in 2010/11 and 10 in 2013/14. There is an established dose response relationship between cigarette consumption and health, so it was deemed less important whether a change was from a higher or lower starting point e.g. whether a reduction from 10 to 5 cigarettes is equivalent to a reduction from 25 to 20. The +/-5 cigarettes threshold gave us 704 respondents whose smoking behaviour 'improved' and 541 whose behaviour 'worsened'.

There was no evidence of heaping in the distribution of reported units drunk to help inform a threshold for change in binge drinking behaviour, and there is no established threshold to help guide this. The change in units drunk for persistent binge drinkers between 2010/11 and 2013/4 could be modelled very well by a normal distribution and the mean change was close to 0 for both men and women. Therefore the level for alcohol consumption was set at one standard deviation from the mean change in units consumed by persistent binge drinkers, calculated separately for men and women. This figure was 6.3 units for men, and 6.6 for women. This may seem like a large number but this is among persistent binge drinkers who have higher levels of alcohol consumption and this equates to reducing/increasing alcohol consumption by approximately 3 glasses of wine or 3 pints on the heaviest drinking day. This gave us 254 respondents whose drinking behaviour 'improved' and 293 whose behaviour 'worsened'.

It was not possible to create robust measures for improvement or worsening for F&V and PA due to the way the UKHLS questions are constructed. There are two dimensions to F&V recommendations – eating five or more portions and eating this number every day. Improvement/worsening in behaviour could be achieved either through a change in: number of portions eaten; number of days on which f&v eaten; or both. Creating a count of weekly portions eaten would be one way to take this into account to measure improving/worsening behaviour. However, the structure of the UKHLS questions does not lend itself to this relatively fine calculation.

As indicated in the box on F&V consumption above, the UKHLS questions ask about number of days eaten for fruit and vegetables separately in categories of 0, 1-3 days, 4-6 days and every day; the number of portions is then asked in a single question, combining responses for F&V together, and this is recorded in whole numbers, range 0 to maximum. Because of this, we cannot calculate the number of portions of fruit consumed per week and then the number of portions of vegetables consumed per week as the data do not specify what the portions were – fruit or vegetables. To create a weekly portion index, this information would need to be captured separately and multiplied by frequency of consumption; using the existing data to attempt this risks significant over-counting. It is also not clear what types of behaviour would count as improvement. For example, someone may increase the number of days that they consumed fruit but not vegetables (or vice versa) whilst reducing their portions on the average day. Depending on the relative size of these values, someone may actually be consuming more F&V than previously or might be consuming less. This is very difficult to determine using the UKHLS data.

Similarly, changing levels of PA are difficult to measure finely using the UKHLS questions. There are several dimensions to our measure – frequency of sports participation, and walking frequency as well as pace. The categorical frequency measure used in the questions on sport especially makes it problematic to even approximate fine change (as the response options are very blunt, ranging from once in the last 12 months to 3 or more times a week) and no information is captured about duration or intensity of PA. It is very difficult to use this information to determine mutually exclusive groups of people who have increased or decreased their PA, once their combination of activities are taken into account. It is also not clear what thresholds would constitute an improvement or vice versa. Therefore, analyses looking at improving and worsening health behaviours were restricted to persistent smokers and binge drinkers only where we could be more confident that changes in the data represent real behaviour change.

Analysis techniques

For each objective, bi-variate and multivariate analyses were performed to explore associations between each health behaviour (and change thereof) and a standard set of explanatory covariates (see below for further information about covariates). Simple cross tabulations were produced to describe the basic relationships between each health behaviour and each covariate, and multivariate logistic regressions run to explore the relationships once other factors were taken into account. Results of these analyses are reported as Average Marginal Effects and Odds Ratios and are shown in Appendices C to E. All analyses were produced using Stata v14.

Average Marginal Effects

Average Marginal Effects (AMEs) are predicted values from non-linear multivariate analysis (i.e. from multiple logistic regression). They can be interpreted in a similar way to odds ratios from multiple logistic regression.

AMEs take all variables entered into the model into account to derive the predicted proportion of a given behaviour (in the example below, cigarette smoking) for each variable. Table A1 below shows the predicted prevalence of smoking among men of different ages. Like odds ratios, AMEs are presented relative to a reference category and show how much (if at all) the predicted prevalence varies from the reference group.

For example, taking a number of other factors into account (in this case educational attainment, ethnic group, employment, general health status, area deprivation, marital and cohabitation status and income), the predicted prevalence of smoking among men aged 16-24 was 21%. Current smoking

varied by age and was lower among those aged 55 and over than those aged 16-24. For those aged 55-64, the predicted prevalence was 5 percentage points lower than those aged 16-24 (i.e., 16%; calculated as 0.21 – 0.05). Among those aged 65 and over, the predicted prevalence was 11 percentage points lower than those aged 16-24 (i.e., 10%, calculated as 0.21 – 0.11).

As with odds ratios, the confidence intervals indicate whether the differences are statistically significant. If the confidence intervals include the value of 0, the difference from the reference category is not significant at conventional levels. In this example, those aged 55 and over had significantly different predicted smoking prevalence than those aged 16-24.

AMEs have advantages over odds ratios as results represent a predicted prevalence of behaviour which can be easier to interpret and understand than odds ratios. This predicted prevalence rate helps to highlight the magnitude of differences from the reference group in a meaningful way. For example, we can see that predicted smoking rates among those aged 65 and over were broadly half that of those aged 16-24 (21% vs 11%).

TABLE A1: Prevalence of cigarette smoking and average marginal effects of being a current cigarette smoker: Men

	Unadjusted prevalence of cigarette smoking	Bases		Average Marginal Effect* (change in proportion from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age^{a,b}						
16-24	20	2271	1704	REF: 0.21		
25-34	24	2087	1537	+0.03	-0.00	+0.07
35-44	20	2339	2048	+0.02	-0.02	+0.05
45-54	22	2563	2267	+0.01	-0.03	+0.05
55-64	18	2262	1965	-0.05	-0.08	-0.01
65+	10	3316	2969	-0.11	-0.15	-0.06

^a Unadjusted prevalence varies significantly by this characteristic, $p < 0.05$

^b Characteristic significant in regression model, $p < 0.05$

*Average Marginal Effects take into account other characteristics entered into the model, in this case educational attainment, ethnic group, employment, general health, area deprivation, marital status and income (data not shown).

Multivariate logistic regression

Logistic regression models were produced for all objectives. For each model, a standard set of covariates was entered into the model, using the enter method. The set of covariates used were carefully selected by the team, representing individual, household and area characteristics and were initially chosen because they were important dimensions of an individual's identity and everyday circumstances and/or had a known relationship with health behaviours. All covariates were carefully checked for collinearity. Unless noted below, the covariate measure was based on data collected in 2010/11.

The covariates included in the models were²³:

Age: grouped in 10-year age bands, starting with 16-24 year-olds and with the oldest category as aged 65 and above

Sex: Men and women

Ethnic group: This was derived from the UKHLS variable and categories combined to create useable analysis groups. For chapters 5 and 6, responses were grouped into the following categories: White British; South Asian (any Indian, Bangladeshi or Pakistani groups); Black Caribbean/Black African; other (all other ethnicities, including mixed and White - other).

Marital and cohabitation status: The 10-category UKHLS derived variable *De facto marital status* was recoded into four categories, but still reflecting living arrangements: "married or civil partner" (from "married" and "civil partnership" categories); "single, never married" (retained as a one category); "separated, divorced, widowed" (from six original categories covering these statuses with respect to marriage or civil partnership); and "cohabiting" (from "living as a couple").

Educational attainment: This was derived from the highest level of educational attainment variable. This was recoded as: degree or higher, A-levels or equivalent; O-levels or equivalent; other educational qualifications; none. Because of high levels of missing data in 2010/11, data for this covariate was taken from 2013/14.

Equivalised household income: quintiles were calculated with weighted data: the UKHLS derived variable for gross household income in the month before interview (which includes imputed values) and the variable for the modified OECD equivalence scale.

Economic activity in past 7 days: The 11-category UKHLS variable *current economic activity* was recoded into four categories: "self-employed" and "paid employment (ft/pt)" were coded into "employed"; "unemployed", "retired" and full-time student" were retained as single categories; all other activities (including "on maternity leave", "family care or home" and "long-term sick or disabled") were coded as "other".

Area deprivation: Area deprivation data in the form of IMD quintiles was matched to the respondent data.

General health status: The 5-category UKHLS question on self-assessed general health, which was adapted from the SF1 questionnaire, was collapsed into a three-category variable: "excellent/very good/good", "fair", and "poor".

Life events and transitions

Chapter 6 of this report focuses on exploring the relationship between changing health behaviours and four main life transitions. These are:

- Changing relationship status
- Changing employment
- Changing income
- Adding children to the household.

These were created as follows.

Changing relationship status: The transitions were moving into or out of a relationship. Using our marital/cohabitation status variable, those who were single (never married) or single (separated/widowed/divorced) in 2010/11 and then married or cohabiting in 2013/4 were classed as

²³ The AMEs presented in Chapter 4 use fuller versions of these covariates as there were larger base sizes for these analyses.

having moved into a relationship; those who were married or cohabiting in 2010/11 and single (either never married, separated, widowed or divorced) in 2013/4 were classed as having moved out of a relationship.

Changing employment: calculated from the economic activity status variable at each wave, binary variables were created for key employment pathways: moved into employment (including part time and self-employment) from unemployment; moved into unemployment from full time, part time or self-employment; moved from full time education to employment (full time, part time or self-employment); moved from full time education to unemployment; moved from employment (full time, part time or self-employment) to retirement.

Changing income: The percentage increase or decrease in income was calculated from equivalised income at each wave. The small number of households (n=86) that recorded zero or negative equivalised income at either wave were excluded from the variable. An “increase or decrease” was classified as more than a 20% difference between waves, and differences less than this were classified as having stable household income between 2010/11 and 2013/14.

Adding children to the household: Those households where the number of children recorded in the household was zero at 2010/11 and was greater than 0 in 2013/14 were coded as “1 or more children added to household”. This is deliberately termed “adding a child to the household” rather than “having children” as the data include those who may have added a child through adoption or through cohabiting with someone who already had a child.

Weighting

Analyses were adjusted for the complex survey design of the survey and all values presented in the tables are weighted. Weighting takes into account non-response and over-sampling to produce nationally representative results. The UKHLS collects data from all four countries within the UK, and additionally it oversamples individuals from ethnic minority groups who are resident in areas of high ethnic density.

The UKHLS general population sample from Great Britain (England, Scotland and Wales) is an equal probability clustered sample drawn from the Postcode Address File. The ethnic minority boost sample specifically targeted areas of high ethnic density to recruit ethnic minority individuals, and in particular to achieve a sample of 1,000 each of Indian, Pakistani, Bangladeshi, Caribbean and African individuals. Given this, the data were weighted to reflect the population in England using weights provided by the Understanding Society team (Knies, 2017). Additionally, data on drinking behaviours was gathered by self-completion questionnaire; fewer respondents answered this than the UKHLS interviewer-led questionnaire and a separate self-completion weight was used for this analysis.

For objective 1, all analyses were conducted using the 2013/4 cross-sectional weights (main weight, e_indinub_xw, for smoking, fruit and vegetable consumption and physical activity; self-completion weight, e_indscub_xw, for drinking).

For objectives 2 and 3 (changing health behaviour over time), the following issues were considered:

- Whether use of the longitudinal weights was appropriate: it was agreed that these weights were not appropriate as these weights are for respondents present in all waves of data collection (not just 2010/11 and 2013/5, the focus of our study). Using these weights would have meant we would have lost cases, which was not optimum when we already had relatively small base sizes for some of our analysis;
- Whether we should use the design weight only: this would correct for unequal probability of selection at a number of levels and arguably control for the relevant covariates that effect non-response – but would not account for attrition between waves and therefore was not the preferred option;
- Whether to use the wave 5 cross-sectional weights: these adjust for sampling error and non-response; this is appropriate since people are only included in the analysis if they are present in wave 5, and we take into account non-response at wave 5. In this way, we treated the analysis as cross-sectional even though we are looking a behaviour change. As there is no specific non-response weight for those who responded specifically in 2010/11 and 2013/4, we determined that using the 2013/4 cross-sectional weight was the best option.

We explored the impact of using cross-sectional weights compared with the other options available for some key tables/regressions. Minimal differences in the results were found.

Appendix B: Summary of strengths and limitations of the analysis

The main strength of this project was its focus on a gap in longitudinal research on changing health behaviours among the general population, exploring the extent to which these behaviours are socially patterned and their relationship with key life transitions. A further strength is the use of the UKHLS as a large nationally representative survey. However it should be noted that the numbers available for our analysis were of modest size and power.

Like the majority of previous research on health behaviours, the analyses in this report rely on self-reporting of behaviours; these are generally less reliable than objective measures which are either not available for these health behaviours or require large resources to employ (Gorber et al, 2009). In addition, the responses were given to interviewers (except for alcohol intake) and interview-led questions are more susceptible to response bias, producing an increased reporting of healthier behaviours and a decreased reporting of unhealthy behaviours (Tipping et al, 2010). In contrast, the alcohol intake by UKHLS adults is given on the confidential self-completion questionnaire. In a previous project of parental health behaviours undertaken by the team, we compared responses to questions on alcohol consumption in the UKHLS and the HSE. We found that consumption in the UKHLS self-completed questionnaire was, on average, higher than the HSE interview-led responses suggesting that the UKHLS answers were possibly less subject to social desirability bias (Graham et al, 2016a et al, see also Graham et al 2016b);²⁴

A further limitation is that we only measure behaviour change at two specific time points – in 2010/11 and 2013/4. If people met recommendations at both time periods, they were classed as having stable health behaviours. However, this masks a variety of potential changes in the intervening period which is not captured in our analysis. The likelihood of this is minimised for F&V and PA, which ask about usual behaviour. Being a smoker is more tightly defined; the individual is asked whether they regularly smoke one or more cigarettes a day. Nonetheless, we acknowledge that people can have variable and transient smoking behaviours. The greatest potential fluctuation of behaviour between time points may be for alcohol consumption as our measures are based on alcohol consumed on the heaviest drinking day in the past 7 days. This may mask a range of other alcohol behaviour change in the intervening three years.

The same limitation applies to our measures of life transitions. We compare status at two time points only, which may conceal a range of other key events within the three year period. For example, someone may have been married in 2010/11, got divorced and remarried by 2013/4. In our exploratory analyses, these people would be classified as being stably married throughout. It is possible that using intervening waves of data from UKHLS could help to explore these patterns further. This was beyond this scope of this study as our aim was to produce the first exploratory analysis of the relationship between life transitions and health behaviours. Furthermore, the relative stasis in health behaviours and the low numbers of people experiencing each life transition within the three year time period means it is unlikely that sufficient number of people would have experienced these multiple and more complex transitions to allow analysis to be undertaken.

²⁴ A more detailed comparison of the HSE and UKHLS measures of alcohol consumption has been undertaken by NatCen to examine factors that may explain the higher levels of binge drinking in the UKHLS. See Connolly, 2016

Appendix C: Tables for Chapter 4 – prevalence and social patterning of individual risk behaviours in 2013/14

Table C1: Prevalence of cigarette smoking and average marginal effects of being a current cigarette smoker: Men						
	Unadjusted prevalence of cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweight-ed			
	%	<i>n</i>	<i>n</i>			
Age*						
16-24	20	2271	1704	Ref. 0.21		
25-34	24	2087	1537	+0.03	-0.00	+0.07
35-44	20	2339	2048	+0.02	-0.02	+0.05
45-54	22	2563	2267	+0.01	-0.03	+0.05
55-64	18	2262	1965	-0.05	-0.08	-0.01
65+	10	3316	2969	-0.11	-0.15	-0.06
Educational attainment*						
Degree or higher	8	3489	2954	Ref. 0.10		
A-levels or equivalent	16	2701	2214	+0.06	+0.04	+0.08
O-levels or equivalent	24	3266	2633	+0.10	+0.08	+0.12
Other	23	934	789	+0.11	+0.08	+0.14
None	25	3206	2754	+0.14	+0.12	+0.17
Missing	N/A			+0.07	+0.04	+0.10
Employment*						
Paid employment	18	7313	6014	Ref. 0.19		
Self employed	18	1606	1366	+0.01	-0.02	+0.04
Unemployed	44	804	649	+0.09	+0.06	+0.13
Retired	10	3375	3017	-0.05	-0.08	-0.01
Looking after family/home	36	107	97	+0.05	-0.03	+0.13
Student	11	1037	867	-0.10	-0.13	-0.07
Long-term sick	46	481	390	+0.04	-0.01	+0.08
Other	31	110	87	+0.05	-0.04	+0.14
Ethnic group*						
White British	18	12737	9996	Ref. 0.18		
White other	22	548	372	+0.05	-0.00	+0.09
Mixed	21	166	213	+0.00	-0.05	+0.04
Indian	10	370	478	-0.07	-0.10	-0.03
Pakistani	18	202	348	-0.04	-0.08	-0.00
Bangladeshi	26	81	218	+0.01	-0.06	+0.08
Black Caribbean	26	107	191	-0.02	-0.06	+0.03
Black African	11	175	240	-0.07	-0.11	-0.03
Other	12	259	309	-0.06	-0.10	-0.01
Missing	N/A			+0.06	-0.02	+0.14
Marital and cohabitation status*						
Married, civil partner	23	4066	2874	Ref. 0.14		
Single: never married	12	7845	6953	+0.07	+0.05	+0.09
Single: widowed, divorced, separated	25	1309	1157	+0.10	+0.07	+0.12

Cohabiting	29	1584	1482	+0.09	+0.06	+0.11
Area deprivation*						
Lowest quintile (least deprived)	12	3007	2515	Ref. 0.16		
2 nd	13	3046	2486	-0.01	-0.03	+0.01
3 rd	17	3039	2512	+0.02	-0.00	+0.04
4 th	22	2859	2341	+0.03	+0.01	+0.06
Highest quintile (most deprived)	31	2474	2249	+0.07	+0.04	+0.10
Missing	N/A			+0.02	-0.03	+0.06
General health*						
Excellent	9	3489	2954	Ref. 0.09		
Very good	15	2701	2214	+0.07	+0.05	+0.08
Good	21	3266	2633	+0.11	+0.09	+0.13
Fair	25	934	789	+0.15	+0.12	+0.17
Poor	34	3206	2754	+0.19	+0.14	+0.23
Equivalised household income quintile*						
Highest	11	3535	2962	Ref. 0.15		
2 nd	16	3401	2822	+0.03	+0.00	+0.05
3 rd	20	3056	2535	+0.04	+0.02	+0.06
4 th	23	2252	2207	+0.06	+0.03	+0.09
Lowest	26	2592	1964	+0.07	+0.04	+0.09

*Denotes variable significant in the regression model; P<0.05

Table C2: Prevalence of cigarette smoking and average marginal effects of being a current cigarette smoker: Women

	Unadjusted prevalence of cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweight-ed			
		%	n			
Age*						
16-24	17	1931	1849	Ref. 0.18		
25-34	22	2310	2132	+0.03	-0.00	+0.06
35-44	19	2507	2683	+0.03	-0.00	+0.06
45-54	19	2858	2893	+0.01	-0.02	+0.04
55-64	15	2348	2371	-0.04	-0.07	-0.00
65+	9	3798	3433	-0.10	-0.14	-0.06
Educational attainment*						
Degree or higher	7	3311	3336	Ref. 0.08		
A-levels or equivalent	13	3279	3266	+0.05	+0.04	+0.07
O-levels or equivalent	22	3325	3182	+0.10	+0.09	+0.12
Other	19	944	890	+0.10	+0.07	+0.13
None	22	3396	3220	+0.15	+0.12	+0.17
Missing	N/A			+0.08	+0.05	+0.10
Employment*						
Paid employment	17	7276	7111	Ref. 0.17		
Self employed	13	784	775	-0.01	-0.04	+0.02
Unemployed	37	579	557	+0.06	0.02	+0.10
Retired	9	4154	3819	-0.05	-0.08	-0.02
Looking after family/home	24	1278	1427	+0.02	-0.01	0.04
Student	8	950	968	-0.11	-0.13	-0.08
Long-term sick	38	477	451	+0.04	+0.00	+0.08
Other	22	100	104	-0.02	-0.07	+0.03
Ethnic group*						
White British	17	13522	12143	Ref. 0.17		
White other	16	678	523	+0.02	-0.02	+0.06
Mixed	19	205	312	-0.02	-0.06	+0.03
Indian	3	311	510	-0.14	-0.16	-0.13
Pakistani	4	191	410	-0.15	-0.16	-0.13
Bangladeshi	6	75	276	-0.14	-0.16	-0.11
Black Caribbean	19	159	337	-0.05	-0.08	-0.01
Black African	4	202	335	-0.14	-0.16	-0.12
Other	10	263	388	-0.08	-0.11	-0.04
Missing	N/A			-0.05	-0.11	+0.01
Marital and cohabitation status*						
Married, civil partner	11	7551	7690	Ref. 0.12		
Single: never married	21	3501	3092	+0.08	+0.06	+0.10
Single: widowed, divorced, separated	19	3080	2865	+0.07	+0.05	+0.09
Cohabiting	27	1584	1679	+0.09	+0.07	+0.11
Area deprivation*						
Lowest quintile (least deprived)	9	3153	2980	Ref. 0.12		

2 nd	12	3226	3042	+0.02	-0.00	+0.04
3 rd	15	3244	3061	+0.04	+0.02	+0.06
4 th	21	2961	2883	+0.06	+0.04	+0.08
Highest quintile (most deprived)	26	2703	2900	+0.08	+0.05	+0.10
Missing	N/A			+0.06	+0.02	+0.10
General health*						
Excellent	9	3311	3336	Ref. 0.11		
Very good	14	3279	3266	+0.03	+0.02	+0.05
Good	18	3325	3182	+0.07	+0.05	+0.09
Fair	21	944	890	+0.08	+0.06	+0.11
Poor	25	3396	3220	+0.10	+0.06	+0.13
Equivalised household income quintile*						
Highest	9	3245	3196	Ref. 0.12		
2 nd	13	3274	3201	+0.02	-0.00	+0.04
3 rd	17	3277	3176	+0.04	+0.02	+0.06
4 th	21	3143	3046	+0.06	+0.04	+0.09
Lowest	22	2813	2742	+0.07	+0.05	+0.09

*Denotes variable significant in the regression model; P<0.05

Table C3: Prevalence of binge drinking and average marginal effects of being a binge drinker: Men

	Unadjusted prevalence of binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweight-ed			
		%	<i>n</i>			
Age*						
16-24	30	1944	1506	Ref. 0.31		
25-34	34	1840	1391	+0.02	-0.03	+0.07
35-44	32	2093	1821	+0.01	-0.04	+0.06
45-54	32	2235	1996	-0.01	-0.06	+0.04
55-64	28	2028	1757	-0.03	-0.08	+0.02
65+	16	2985	2508	-0.13	-0.19	-0.08
Educational attainment						
Degree or higher	30	3142	2670	Ref. 0.28		
A-levels or equivalent	31	2378	1994	+0.01	-0.01	+0.04
O-levels or equivalent	30	2885	2345	+0.01	-0.02	+0.03
Other	26	831	678	+0.00	-0.05	+0.04
None	20	2785	2263	-0.03	-0.06	-0.00
Missing	N/A			+0.00	-0.03	+0.04
Employment*						
Paid employment	33	6442	5438	Ref. 0.29		
Self employed	31	1380	1191	+0.01	-0.03	+0.04
Unemployed	25	722	543	-0.04	-0.08	+0.01
Retired	17	3056	2573	-0.02	-0.06	+0.03
Looking after family/home	21	97	84	-0.08	-0.17	+0.02
Student	26	914	761	-0.04	-0.09	+0.01
Long-term sick	14	413	311	-0.11	-0.17	-0.05
Other	28	99	75	-0.02	-0.13	+0.10
Ethnic group*						
White British	30	11276	8971	Ref. 0.30		
White other	22	487	325	-0.09	-0.15	-0.04
Mixed	18	151	184	-0.13	-0.21	-0.06
Indian	10	325	382	-0.21	-0.24	-0.17
Pakistani	2	180	257	-0.28	-0.30	-0.26
Bangladeshi	3	78	154	-0.27	-0.31	-0.23
Black Caribbean	12	90	157	-0.17	-0.23	-0.10
Black African	5	164	199	-0.25	-0.28	-0.22
Other	12	222	250	-0.19	-0.23	-0.15
Missing	N/A			+0.02	-0.08	+0.11
Marital and cohabitation status						
Married, civil partner	26	6977	6069	Ref. 0.27		
Single: never married	29	3546	2549	+0.01	-0.02	+0.04
Single: widowed, divorced, separated	21	1193	997	+0.00	-0.03	+0.04
Cohabiting	35	1377	1342	+0.04	+0.01	+0.07
Area deprivation						
Lowest quintile (least deprived)	28	2594	2264	Ref. 0.26		

2 nd	31	2708	2236	+0.03	+0.01	+0.06
3 rd	28	2705	2245	+0.02	-0.01	+0.04
4 th	25	2535	2042	+0.00	-0.03	+0.03
Highest quintile (most deprived)	24	2221	1843	+0.02	-0.02	+0.05
Missing	N/A			+0.00	-0.06	+0.05
General health*						
Excellent	30	2185	1827	Ref. 0.27		
Very good	30	4588	3864	+0.01	-0.02	+0.03
Good	29	3848	3264	+0.02	-0.00	+0.05
Fair	22	1802	1470	-0.01	-0.05	+0.02
Poor	15	702	554	-0.05	-0.10	-0.00
Equivalised household income quintile*						
Highest	36	3113	2713	Ref. 0.32		
2 nd	31	2957	2534	-0.03	-0.06	-0.01
3 rd	23	2721	2228	-0.09	-0.12	-0.06
4 th	23	2293	1876	-0.07	-0.10	-0.04
Lowest	21	2041	1628	-0.08	-0.11	-0.04

*Denotes variable significant in the regression model; P<0.05

Table C4: Prevalence of binge drinking and average marginal effects of being a binge drinker: women

	Unadjusted prevalence of binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweigh- ted			
		%	<i>n</i>			
Age*						
16-24	29	1738	1666	Ref. 0.29		
25-34	24	2062	1938	-0.05	-0.09	-0.01
35-44	26	2254	2428	-0.03	-0.07	+0.01
45-54	24	2500	2581	-0.06	-0.10	-0.02
55-64	18	2065	2144	-0.11	-0.15	-0.06
65+	7	3185	2834	-0.20	-0.25	-0.16
Educational attainment						
Degree or higher	24	2939	3058	Ref. 0.19		
A-levels or equivalent	24	2922	2969	+0.02	0.00	+0.04
O-levels or equivalent	23	2993	2885	+0.02	-0.01	+0.04
Other	16	826	773	+0.00	-0.04	+0.03
None	12	2841	2589	-0.01	-0.03	+0.02
Missing	N/A			+0.02	-0.01	+0.05
Employment*						
Paid employment	27	6397	6518	Ref. 0.22		
Self employed	28	704	728	+0.03	+0.00	+0.06
Unemployed	19	526	473	-0.04	-0.08	+0.00
Retired	9	3535	3215	-0.02	-0.06	+0.01
Looking after family/home	15	1139	1172	-0.07	-0.09	-0.04
Student	26	874	877	-0.05	-0.09	-0.02
Long-term sick	13	406	384	-0.04	-0.09	0.02
Other	21	86	90	-0.07	-0.12	-0.03
Ethnic group*						
White British	21	11885	10984	Ref. 0.22		
White other	20	599	468	-0.03	-0.07	+0.01
Mixed	20	191	284	-0.05	-0.11	-0.00
Indian	4	267	403	-0.18	-0.20	-0.15
Pakistani	1	162	309	-0.21	-0.23	-0.19
Bangladeshi	1	62	178	-0.21	-0.23	-0.19
Black Caribbean	13	130	281	-0.10	-0.14	-0.06
Black African	6	179	273	-0.16	-0.19	-0.13
Other	7	214	310	-0.16	-0.19	-0.12
Missing				-0.02	-0.09	0.06
Marital and cohabitation status						
Married, civil partner	19	6606	6791	Ref. 0.20		
Single: never married	26	3117	2775	+0.03	+0.00	+0.05
Single: widowed, divorced	13	2645	2451	+0.00	-0.02	+0.02
Cohabiting	24	1404	1541	+0.00	-0.02	+0.02
Area deprivation*						

Lowest quintile (least deprived)	23	2764	2722	Ref. 0.21		
2 nd	21	2843	2762	-0.01	-0.03	+0.01
3 rd	21	2847	2748	-0.01	-0.03	+0.02
4 th	20	2596	2528	+0.00	-0.02	+0.02
Highest quintile (most deprived)	16	2357	2397	-0.03	-0.06	-0.01
Missing				0.04	-0.01	0.09
General health*						
Excellent	26	2175	2178	Ref. 0.22		
Very good	23	4830	4804	-0.01	-0.03	+0.01
Good	19	4045	3983	-0.01	-0.04	+0.01
Fair	15	1919	1849	-0.03	-0.06	-0.01
Poor	8	832	774	-0.11	-0.14	-0.07
Equivalised household income quintile*						
Highest	29	2854	2945	Ref. 0.25		
2 nd	22	2846	2894	-0.04	-0.07	-0.02
3 rd	18	2898	2824	-0.06	-0.09	-0.04
4 th	16	2795	2647	-0.06	-0.08	-0.03
Lowest	15	2412	2281	-0.06	-0.09	-0.03

*Denotes variable significant in the regression model; P<0.05

Table C5: Prevalence of not meeting F&V recommendations and average marginal effects of not meeting F&V recommendations: Men

	Unadjusted prevalence of not meeting F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweigh- -ted			
	%	<i>n</i>	<i>n</i>			
Age*						
16-24	89	2266	1699	Ref. 0.88		
25-34	87	2083	1535	+0.00	-0.03	+0.03
35-44	82	2335	2043	-0.04	-0.08	-0.01
45-54	83	2554	2259	-0.04	-0.08	-0.01
55-64	78	2255	1958	-0.10	-0.14	-0.07
65+	76	3303	2959	-0.13	-0.18	-0.09
Educational attainment*						
Degree or higher	73	3480	2945	Ref. 0.74		
A-levels or equivalent	84	2697	2209	+0.08	+0.05	+0.11
O-levels or equivalent	86	3255	2625	+0.10	+0.07	+0.12
Other	84	931	787	+0.10	+0.07	+0.13
None	85	3195	2743	+0.13	+0.10	+0.15
Missing				+0.09	+0.06	+0.12
Employment						
Paid employment	82	7300	6000	Ref. 0.82		
Self employed	81	1598	1358	+0.00	-0.03	+0.02
Unemployed	92	803	648	+0.06	+0.02	+0.09
Retired	76	3359	3005	-0.02	-0.06	+0.01
Looking after family/home	82	107	97	-0.05	-0.15	+0.06
Student	89	1036	866	+0.00	-0.04	+0.05
Long-term sick	88	481	389	-0.01	-0.06	+0.05
Other	89	110	87	+0.05	-0.02	+0.11
Ethnic group*						
White British	81	12706	9973	Ref. 0.81		
White other	80	548	372	+0.00	-0.05	+0.04
Mixed	85	166	213	+0.00	-0.06	+0.07
Indian	87	368	474	+0.06	+0.02	+0.09
Pakistani	93	200	344	+0.10	+0.06	+0.14
Bangladeshi	93	80	217	+0.09	+0.01	+0.17
Black Caribbean	89	107	190	+0.05	-0.01	+0.10
Black African	89	174	239	+0.07	+0.01	+0.12
Other	84	256	306	+0.02	-0.03	+0.08
Missing				+0.01	-0.07	+0.09
Marital and cohabitation status						
Married, civil partner	78	7819	6930	Ref. 0.81		
Single: never married	88	4061	2868	+0.02	-0.00	+0.05
Single: widowed, divorced, separated	82	1305	1154	+0.03	+0.00	+0.05
Cohabiting	84	1579	1477	+0.01	-0.01	+0.04
Area deprivation						

Lowest quintile (least deprived)	79	3002	2511	Ref. 0.82		
2 nd	80	3041	2482	+0.00	-0.03	+0.02
3 rd	82	3027	2500	+0.00	-0.02	+0.02
4 th	83	2849	2334	-0.01	-0.04	+0.01
Highest quintile (most deprived)	87	2467	2239	+0.01	-0.02	+0.04
Missing				+0.01	-0.04	+0.05
General health*						
Excellent	77	2481	2035	Ref. 0.76		
Very good	80	5149	4291	+0.04	+0.02	+0.07
Good	84	4332	3707	+0.08	+0.05	+0.10
Fair	86	2017	1723	+0.10	+0.08	+0.13
Poor	86	818	697	+0.10	+0.06	+0.14
Equivalised household income quintile						
Highest	78	3531	2958	Ref. 0.81		
2 nd	81	3393	2814	+0.01	-0.01	+0.03
3 rd	84	3048	2528	+0.02	-0.01	+0.04
4 th	84	2580	2196	+0.02	-0.01	+0.04
Lowest	85	2245	1957	+0.02	-0.01	+0.05

*Denotes variable significant in the regression; P<0.05

Table C6: Prevalence of not meeting F&V recommendations and average marginal effects of not meeting F&V recommendations: women

	Unadjusted prevalence of not meeting F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Age*						
16-24	88	1932	1850	Ref. 0.89		
25-34	81	2304	2127	-0.06	-0.09	-0.03
35-44	75	2505	2679	-0.12	-0.15	-0.09
45-54	73	2856	2890	-0.16	-0.19	-0.12
55-64	68	2344	2367	-0.22	-0.25	-0.18
65+	69	3783	3421	-0.23	-0.28	-0.19
Educational attainment*						
Degree or higher	65	3306	3331	Ref. 0.66		
A-levels or equivalent	73	3279	3265	+0.05	+0.02	+0.07
O-levels or equivalent	80	3321	3177	+0.11	+0.08	+0.13
Other	78	942	889	+0.13	+0.10	+0.17
None	79	3382	3206	+0.15	+0.12	+0.17
Missing	N/A			+0.11	+0.07	+0.14
Employment*						
Paid employment	74	7267	7100	Ref. 0.76		
Self employed	66	783	774	-0.04	-0.07	-0.01
Unemployed	88	579	557	+0.05	+0.01	+0.10
Retired	69	4137	3805	-0.03	-0.06	-0.00
Looking after family/home	79	1279	1428	-0.02	-0.05	+0.01
Student	86	951	969	-0.04	-0.10	+0.02
Long-term sick	86	475	448	+0.04	-0.01	+0.09
Other	78	100	104	+0.02	-0.04	+0.08
Ethnic group*						
White British	74	13502	12128	Ref. 0.74		
White other	69	678	523	-0.02	-0.06	+0.02
Mixed	80	205	311	+0.02	-0.04	+0.08
Indian	86	310	507	+0.10	+0.06	+0.15
Pakistani	91	191	409	+0.13	+0.08	+0.18
Bangladeshi	91	74	274	+0.11	+0.05	+0.17
Black Caribbean	83	158	336	+0.06	+0.01	+0.11
Black African	87	200	333	+0.11	+0.06	+0.16
Other	76	261	386	+0.01	-0.04	+0.07
Missing				-0.05	-0.15	+0.05
Marital and cohabitation status*						
Married, civil partner	70	7542	7679	Ref. 0.73		
Single: never married	83	3497	3087	+0.03	-0.00	+0.05
Single: widowed, divorced, separated	75	3070	2857	+0.03	+0.01	+0.06
Cohabiting	78	1581	1676	+0.02	-0.00	+0.05
Area deprivation						

Lowest quintile (least deprived)	70	3152	2979	Ref. 0.75		
2 nd	71	3222	3040	-0.01	-0.03	+0.02
3 rd	74	3233	3051	+0.00	-0.02	+0.03
4 th	76	2955	2878	-0.01	-0.04	+0.01
Highest quintile (most deprived)	83	2699	2892	+0.02	-0.00	+0.05
Missing				-0.02	-0.07	+0.02
General health*						
Excellent	66	2405	2359	Ref. 0.66		
Very good	73	5441	5286	+0.07	+0.04	+0.09
Good	78	4596	4509	+0.11	+0.08	+0.13
Fair	79	2277	2219	+0.12	+0.09	+0.15
Poor	82	1002	957	+0.14	+0.11	+0.18
Equivalised household income quintile*						
Highest	67	3241	3192	Ref. 0.72		
2 nd	73	3268	3195	+0.02	-0.00	+0.05
3 rd	76	3276	3174	+0.04	+0.01	+0.06
4 th	78	3136	3039	+0.04	+0.02	+0.07
Lowest	80	2803	2734	+0.06	+0.03	+0.08

*Denotes variable significant in the regression model; P<0.05

Table C7: Prevalence of not meeting PA recommendations and average marginal effects of not meeting PA recommendations: Men

	Unadjusted prevalence of not meeting PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweight-ed			
	%	<i>n</i>	<i>n</i>			
Age*						
16-24	52	2251	1694	Ref. 0.61		
25-34	60	2081	1533	+0.03	-0.02	+0.08
35-44	67	2332	2041	+0.07	+0.02	+0.12
45-54	73	2557	2261	+0.11	+0.06	+0.16
55-64	78	2254	1958	+0.14	+0.09	+0.19
65+	83	3307	2961	+0.19	+0.13	+0.24
Educational attainment*						
Degree or higher	64	3475	2944	Ref. 0.67		
A-levels or equivalent	62	2694	2209	+0.01	-0.02	+0.04
O-levels or equivalent	67	3248	2621	+0.03	+0.01	+0.06
Other	79	933	788	+0.07	+0.03	+0.11
None	82	3195	2744	+0.08	+0.05	+0.11
Missing	N/A			+0.04	+0.01	+0.08
Employment						
Paid employment	66	7296	6000	Ref. 0.71		
Self employed	71	1600	1360	+0.01	-0.02	+0.03
Unemployed	72	799	646	+0.02	-0.02	+0.06
Retired	83	3366	3008	-0.03	-0.07	+0.02
Looking after family/home	66	103	95	-0.10	-0.20	+0.01
Student	49	1027	861	-0.04	-0.08	+0.01
Long-term sick	88	478	388	+0.03	-0.04	+0.11
Other	62	110	87	-0.04	-0.16	+0.07
Ethnic group*						
White British	70	12701	9972	Ref. 0.70		
White other	70	547	371	+0.00	-0.05	+0.06
Mixed	53	166	212	-0.09	-0.17	-0.01
Indian	73	368	475	+0.07	+0.02	+0.11
Pakistani	76	198	344	+0.09	+0.04	+0.14
Bangladeshi	71	81	218	+0.03	-0.04	+0.10
Black Caribbean	68	107	190	-0.02	-0.10	+0.05
Black African	66	175	240	+0.06	+0.00	+0.12
Other	69	259	309	+0.03	-0.02	+0.09
Missing	N/A			+0.05	-0.02	+0.13
Marital and cohabitation status						
Married, civil partner	75	7822	6930	Ref. 0.67		
Single: never married	59	4040	2860	-0.05	-0.08	-0.02
Single: widowed, divorced, separated	81	1307	1156	-0.01	-0.04	+0.02
Cohabiting	68	1581	1479	-0.02	-0.05	+0.01
Area deprivation						

Lowest quintile (least deprived)	68	2996	2506	Ref. 0.70		
2 nd	70	3039	2481	+0.01	-0.02	+0.03
3 rd	71	3023	2501	+0.01	-0.01	+0.04
4 th	71	2843	2329	+0.01	-0.02	+0.04
Highest quintile (most deprived)	71	2471	2245	-0.01	-0.04	+0.02
Missing	N/A			-0.03	-0.08	+0.03
General health*						
Excellent	52	2473	2029	Ref. 0.58		
Very good	66	5143	4289	+0.10	+0.07	+0.13
Good	75	4336	3713	+0.16	+0.13	+0.19
Fair	84	2016	1722	+0.22	+0.19	+0.26
Poor	94	813	695	+0.33	+0.28	+0.37
Equivalised household income quintile*						
Highest	64	3520	2952	Ref. 0.69		
2 nd	66	3393	2816	-0.01	-0.04	+0.01
3 rd	73	3050	2530	+0.03	-0.00	+0.06
4 th	74	2581	2201	+0.02	-0.01	+0.05
Lowest	77	2237	1949	+0.05	+0.02	+0.08

*Denotes variable significant in the regression model; P<0.05

Table C8: Prevalence of not meeting PA recommendations and average marginal effects of not meeting PA recommendations: women

	Unadjusted prevalence of not meeting PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Age*						
16-24	69	1922	1841	Ref. 0.76		
25-34	73	2305	2124	-0.01	-0.05	+0.03
35-44	73	2505	2679	-0.03	-0.06	+0.01
45-54	75	2852	2887	-0.02	-0.06	+0.02
55-64	81	2344	2367	+0.04	-0.00	+0.08
65+	89	3783	3420	+0.11	+0.07	+0.16
Educational attainment*						
Degree or higher	70	3308	3334	Ref. 0.76		
A-levels or equivalent	73	3272	3257	+0.00	-0.02	+0.02
O-levels or equivalent	78	3314	3172	+0.03	+0.01	+0.05
Other	83	944	888	+0.04	+0.00	+0.07
None	88	3382	3205	+0.05	+0.03	+0.08
Missing	N/A			+0.04	+0.02	+0.07
Employment*						
Paid employment	73	7260	7092	Ref. 0.78		
Self employed	72	783	774	-0.01	-0.04	+0.02
Unemployed	80	578	556	+0.02	-0.02	+0.06
Retired	88	4140	3807	-0.02	-0.06	+0.01
Looking after family/home	87	152	147	+0.00	-0.03	+0.03
Student	79	1274	1423	-0.02	-0.06	+0.01
Long-term sick	66	946	965	+0.12	+0.08	+0.16
Other	96	476	449	+0.10	+0.06	+0.14
Ethnic group*						
White British	78	13491	12116	Ref. 0.78		
White other	71	678	523	-0.04	-0.08	+0.00
Mixed	76	205	311	+0.02	-0.03	+0.07
Indian	81	311	510	+0.04	+0.01	+0.08
Pakistani	85	188	405	+0.06	+0.02	+0.11
Bangladeshi	87	75	276	+0.09	+0.04	+0.14
Black Caribbean	79	159	336	+0.01	-0.04	+0.06
Black African	82	202	335	+0.07	+0.02	+0.11
Other	81	263	388	+0.05	+0.01	+0.09
Missing	N/A			-0.06	-0.14	+0.02
Marital and cohabitation status*						
Married, civil partner	79	7530	7668	Ref. 0.79		
Single: never married	71	3490	3082	-0.04	-0.07	-0.02
Single: widowed, divorced, separated	86	3075	2861	-0.01	-0.03	+0.01
Cohabiting	77	1580	1672	+0.00	-0.02	+0.03

Area deprivation						
Lowest quintile (least deprived)	76	3152	2979	Ref. 0.78		
2 nd	76	3215	3033	-0.01	-0.03	+0.01
3 rd	78	3234	3053	+0.00	-0.02	+0.02
4 th	79	2954	2874	+0.00	-0.02	+0.02
Highest quintile (most deprived)	82	2694	2886	+0.01	-0.01	+0.03
Missing	N/A			-0.05	-0.09	-0.00
General health*						
Excellent	64	2401	2354	Ref. 0.69		
Very good	74	5432	5278	+0.07	+0.05	+0.09
Good	82	4589	4501	+0.12	+0.10	+0.15
Fair	89	2279	2221	+0.17	+0.14	+0.20
Poor	95	1007	961	+0.22	+0.19	+0.26
Equivalised household income quintile*						
Highest	69	3236	3189	Ref. 0.75		
2 nd	76	3272	3197	+0.03	+0.01	+0.05
3 rd	79	3271	3168	+0.04	+0.02	+0.06
4 th	84	3133	3036	+0.06	+0.04	+0.09
Lowest	84	2798	2728	+0.05	+0.03	+0.08

*Denotes variable significant in the regression model; P<0.05

Tables for Chapter 4 – Odds ratios for social patterning of individual risk behaviours in 2013/14

Table C9: Odds of being a current cigarette smoker: Men			
	Odds ratios	95% CI lower	95% CI Higher
Age*			
16-24	1		
25-34	1.25	0.97	1.61
35-44	1.12	0.86	1.45
45-54	1.08	0.83	1.40
55-64	0.70	0.53	0.93
65+	0.37	0.25	0.56
Educational attainment*			
Degree or higher	1		
A-levels or equivalent	1.82	1.48	2.23
O-levels or equivalent	2.48	2.04	3.00
Other	2.60	2.01	3.37
None	3.28	2.69	4.01
Missing	1.95	1.52	2.51
Employment*			
Paid employment	1		
Self employed	1.07	0.88	1.29
Unemployed	1.83	1.47	2.28
Retired	0.69	0.51	0.95
Looking after family/home	1.41	0.85	2.34
Student	0.39	0.28	0.55
Long-term sick	1.29	0.97	1.73
Other	1.39	0.78	2.46
Ethnic group*			
White British	1		
White other	1.39	1.00	1.93
Mixed	0.96	0.65	1.42
Indian	0.55	0.37	0.80
Pakistani	0.70	0.48	1.01
Bangladeshi	1.06	0.63	1.79
Black Caribbean	0.88	0.59	1.30
Black African	0.53	0.33	0.85
Other	0.59	0.38	0.93
Missing	1.51	0.89	2.56
Marital status*			
Married, civil partner	1		
Single: never married	1.74	1.46	2.07
Single: widowed, divorced	2.06	1.72	2.48
Cohabiting	1.94	1.64	2.29
Area deprivation*			
Lowest quintile (least deprived)	1		
2 nd	0.90	0.74	1.10

3 rd	1.17	0.97	1.42
4 th	1.29	1.06	1.57
Highest quintile (most deprived)	1.66	1.36	2.03
Missing	1.14	0.81	1.61
General health*			
Excellent	1		
Very good	1.94	1.58	2.38
Good	2.82	2.30	3.45
Fair	3.46	2.74	4.37
Poor	4.43	3.29	5.95
Equivalised household income quintile*			
Highest	1		
2 nd	1.25	1.04	1.51
3 rd	1.37	1.13	1.67
4 th	1.61	1.32	1.98
Lowest	1.69	1.37	2.08

*Denotes variable significant in the regression model; P<0.05

Table C10: Odds of being a current cigarette smoker: women

	Odds ratios	95% CI lower	95% CI Higher
Age*			
16-24	1		
25-34	1.25	0.99	1.57
35-44	1.22	0.96	1.55
45-54	1.05	0.83	1.33
55-64	0.74	0.56	0.97
65+	0.37	0.26	0.54
Educational attainment*			
Degree or higher	1		
A-levels or equivalent	1.86	1.52	2.26
O-levels or equivalent	2.81	2.32	3.40
Other	2.70	2.08	3.50
None	3.75	3.06	4.61
Missing	2.28	1.78	2.92
Employment*			
Paid employment	1		
Self employed	0.93	0.72	1.18
Unemployed	1.50	1.17	1.92
Retired	0.63	0.48	0.83
Looking after family/home	1.14	0.94	1.38
Student	0.31	0.22	0.44
Long-term sick	1.34	1.03	1.75
Other	0.87	0.58	1.30
Ethnic group*			
White British	1		
White other	1.14	0.84	1.54
Mixed	0.86	0.58	1.28
Indian	0.11	0.06	0.20
Pakistani	0.11	0.06	0.21
Bangladeshi	0.15	0.08	0.28
Black Caribbean	0.65	0.45	0.93
Black African	0.14	0.08	0.27
Other	0.45	0.29	0.70
Missing	0.62	0.32	1.20
Marital status*			
Married, civil partner	1		
Single: never married	1.95	1.64	2.31
Single: widowed, divorced, separated	1.90	1.62	2.21
Cohabiting	2.14	1.83	2.51
Area deprivation*			
Lowest quintile (least deprived)	1		
2 nd	1.21	1.00	1.46
3 rd	1.43	1.18	1.72
4 th	1.75	1.45	2.12
Highest quintile (most deprived)	1.95	1.60	2.37

Missing	1.72	1.25	2.38
General health*			
Excellent	1		
Very good	1.42	1.18	1.72
Good	1.85	1.53	2.25
Fair	2.14	1.72	2.67
Poor	2.32	1.77	3.04
Equivalised household income quintile*			
Highest	1		
2 nd	1.18	0.97	1.43
3 rd	1.46	1.21	1.77
4 th	1.77	1.45	2.15
Lowest	1.81	1.48	2.22

*Denotes variable significant in the regression model; P<0.05

Table C11 Odds of being a binge drinker: Men			
	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	1.09	0.86	1.40
35-44	1.04	0.81	1.33
45-54	0.95	0.75	1.22
55-64	0.85	0.66	1.10
65+	0.46	0.33	0.64
Educational attainment			
Degree or higher	1		
A-levels or equivalent	1.08	0.93	1.26
O-levels or equivalent	1.04	0.90	1.20
Other	0.98	0.78	1.22
None	0.85	0.72	1.00
Missing	1.02	0.85	1.24
Employment*			
Paid employment	1		
Self employed	1.03	0.88	1.20
Unemployed	0.81	0.63	1.04
Retired	0.92	0.73	1.15
Looking after family/home	0.64	0.35	1.18
Student	0.80	0.62	1.04
Long-term sick	0.51	0.34	0.79
Other	0.92	0.50	1.68
Ethnic group**			
White British	1		
White other	0.60	0.43	0.84
Mixed	0.45	0.25	0.79
Indian	0.23	0.16	0.33
Pakistani	0.03	0.01	0.11
Bangladeshi	0.06	0.01	0.25
Black Caribbean	0.35	0.20	0.59
Black African	0.11	0.06	0.20
Other	0.28	0.19	0.42
Missing	1.08	0.68	1.71
Marital status			
Married, civil partner	1		
Single: never married	1.08	0.92	1.27
Single: widowed, divorced, separated	1.01	0.85	1.21
Cohabiting	1.21	1.05	1.41
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	1.20	1.04	1.39
3 rd	1.09	0.94	1.26
4 th	1.01	0.86	1.19
Highest quintile (most deprived)	1.09	0.91	1.30

Missing	0.97	0.73	1.29
General health*			
Excellent	1		
Very good	1.03	0.90	1.19
Good	1.14	0.98	1.32
Fair	0.94	0.78	1.13
Poor	0.74	0.55	1.01
Equivalised household income quintile**			
Highest	1		
2 nd	0.84	0.74	0.96
3 rd	0.63	0.54	0.73
4 th	0.69	0.59	0.82
Lowest	0.67	0.55	0.81

*Denotes variable significant in the regression model; P<0.05

**P<0.01

Table C12: Odds of being a binge drinker: women

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.76	0.61	0.95
35-44	0.87	0.70	1.08
45-54	0.71	0.57	0.89
55-64	0.53	0.41	0.68
65+	0.22	0.16	0.31
Educational attainment			
Degree or higher	1		
A-levels or equivalent	1.16	1.00	1.33
O-levels or equivalent	1.11	0.96	1.27
Other	0.97	0.77	1.23
None	0.95	0.79	1.13
Missing	1.15	0.95	1.40
Employment**			
Paid employment	1		
Self employed	1.19	0.98	1.45
Unemployed	0.77	0.58	1.02
Retired	0.86	0.68	1.09
Looking after family/home	0.62	0.50	0.76
Student	0.69	0.53	0.89
Long-term sick	0.79	0.54	1.16
Other	0.59	0.40	0.88
Ethnic group**			
White British	1		
White other	0.81	0.62	1.06
Mixed	0.69	0.46	1.04
Indian	0.14	0.08	0.26
Pakistani	0.03	0.01	0.14
Bangladeshi	0.04	0.01	0.20
Black Caribbean	0.47	0.31	0.70
Black African	0.20	0.11	0.35
Other	0.23	0.13	0.38
Missing	0.90	0.55	1.49
Marital status			
Married, civil partner	1		
Single: never married	1.19	1.01	1.39
Single: widowed, divorced, separated	1.01	0.86	1.18
Cohabiting	1.01	0.87	1.18
Area deprivation*			
Lowest quintile (least deprived)	1		
2 nd	0.93	0.80	1.07
3 rd	0.95	0.81	1.11
4 th	1.00	0.85	1.17
Highest quintile (most deprived)	0.80	0.67	0.96

Missing	1.26	0.95	1.68
General health**			
Excellent	1		
Very good	0.95	0.83	1.08
Good	0.92	0.79	1.06
Fair	0.79	0.66	0.96
Poor	0.43	0.31	0.60
Equivalised household income quintile**			
Highest	1		
2 nd	0.76	0.67	0.88
3 rd	0.67	0.58	0.78
4 th	0.70	0.60	0.83
Lowest	0.68	0.56	0.81

*Denotes variable significant in the regression model; P<0.05

**P<0.01

Table C13: Odds of not meeting fruit and vegetable recommendations: Men

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.98	0.72	1.34
35-44	0.69	0.51	0.93
45-54	0.69	0.51	0.93
55-64	0.47	0.34	0.63
65+	0.39	0.27	0.55
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	1.63	1.37	1.93
O-levels or equivalent	1.85	1.57	2.18
Other	1.94	1.54	2.44
None	2.36	2.00	2.77
Missing	1.75	1.42	2.16
Employment			
Paid employment	1		
Self employed	0.98	0.82	1.16
Unemployed	1.58	1.13	2.21
Retired	0.85	0.68	1.05
Looking after family/home	0.73	0.39	1.38
Student	1.03	0.73	1.46
Long-term sick	0.96	0.66	1.42
Other	1.46	0.81	2.63
Ethnic group**			
White British	1		
White other	0.98	0.73	1.31
Mixed	1.02	0.66	1.59
Indian	1.57	1.10	2.22
Pakistani	2.53	1.50	4.25
Bangladeshi	2.15	0.86	5.33
Black Caribbean	1.44	0.87	2.37
Black African	1.71	1.04	2.83
Other	1.19	0.78	1.81
Missing	1.07	0.59	1.95
Marital status			
Married, civil partner	1		
Single: never married	1.18	0.98	1.42
Single: widowed, divorced, separated	1.21	1.01	1.45
Cohabiting	1.08	0.90	1.29
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.97	0.83	1.13
3 rd	1.02	0.87	1.19
4 th	0.92	0.78	1.10
Highest quintile (most deprived)	1.07	0.87	1.32

Missing	1.05	0.76	1.44
General health**			
Excellent	1		
Very good	1.30	1.12	1.50
Good	1.66	1.42	1.94
Fair	2.07	1.70	2.53
Poor	2.05	1.52	2.76
Equivalised household income quintile			
Highest	1		
2 nd	1.05	0.90	1.22
3 rd	1.13	0.96	1.34
4 th	1.11	0.93	1.34
Lowest	1.14	0.94	1.39

*Denotes variable significant in the regression model; P<0.05

**P<0.01

Table C14: Odds of not meeting fruit and vegetable recommendations: women

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.58	0.44	0.76
35-44	0.41	0.31	0.54
45-54	0.33	0.25	0.44
55-64	0.24	0.18	0.32
65+	0.22	0.16	0.31
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	1.26	1.11	1.42
O-levels or equivalent	1.78	1.56	2.04
Other	2.06	1.67	2.55
None	2.27	1.96	2.63
Missing	1.74	1.48	2.06
Employment**			
Paid employment	1		
Self employed	0.81	0.67	0.96
Unemployed	1.40	1.05	1.88
Retired	0.84	0.71	1.00
Looking after family/home	0.91	0.77	1.08
Student	0.80	0.58	1.11
Long-term sick	1.29	0.94	1.76
Other	1.11	0.78	1.58
Ethnic group**			
White British	1		
White other	0.90	0.73	1.12
Mixed	1.12	0.77	1.60
Indian	1.96	1.38	2.77
Pakistani	2.41	1.56	3.73
Bangladeshi	2.06	1.23	3.45
Black Caribbean	1.48	1.06	2.07
Black African	2.00	1.35	2.98
Other	1.09	0.79	1.49
Missing	0.77	0.47	1.26
Marital status**			
Married, civil partner	1		
Single: never married	1.16	0.99	1.36
Single: widowed, divorced, separated	1.21	1.07	1.37
Cohabiting	1.13	0.98	1.31
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.96	0.85	1.09
3 rd	1.01	0.89	1.16
4 th	0.94	0.82	1.08
Highest quintile (most deprived)	1.14	0.97	1.34

Missing	0.87	0.68	1.12
General health**			
Excellent	1		
Very good	1.41	1.25	1.58
Good	1.79	1.58	2.04
Fair	1.95	1.66	2.28
Poor	2.25	1.78	2.83
Equivalised household income quintile**			
Highest	1		
2 nd	1.14	1.00	1.29
3 rd	1.22	1.06	1.39
4 th	1.27	1.10	1.47
Lowest	1.38	1.18	1.61

*Denotes variable significant in the regression model; P<0.05

**P<0.01

Table C15: Odds of not meeting exercise recommendations: Men

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	1.14	0.92	1.41
35-44	1.37	1.09	1.72
45-54	1.68	1.34	2.10
55-64	2.04	1.60	2.61
65+	2.63	1.94	3.56
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	1.07	0.92	1.23
O-levels or equivalent	1.19	1.04	1.37
Other	1.44	1.15	1.80
None	1.55	1.33	1.81
Missing	1.25	1.04	1.51
Employment			
Paid employment	1		
Self employed	1.03	0.89	1.20
Unemployed	1.13	0.89	1.43
Retired	0.87	0.70	1.09
Looking after family/home	0.62	0.37	1.03
Student	0.81	0.65	1.02
Long-term sick	1.20	0.77	1.87
Other	0.79	0.44	1.44
Ethnic group**			
White British	1		
White other	1.02	0.78	1.35
Mixed	0.63	0.44	0.91
Indian	1.46	1.12	1.92
Pakistani	1.67	1.19	2.34
Bangladeshi	1.16	0.80	1.69
Black Caribbean	0.88	0.59	1.31
Black African	1.39	0.98	1.98
Other	1.19	0.87	1.62
Missing	1.33	0.86	2.06
Marital status**			
Married, civil partner	1		
Single: never married	0.77	0.66	0.89
Single: widowed, divorced, separated	0.94	0.79	1.12
Cohabiting	0.91	0.79	1.06
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	1.04	0.91	1.19
3 rd	1.08	0.93	1.24
4 th	1.05	0.90	1.22
Highest quintile (most deprived)	0.96	0.81	1.13

Missing	0.87	0.66	1.15
General health**			
Excellent	1		
Very good	1.60	1.41	1.82
Good	2.13	1.85	2.44
Fair	3.12	2.59	3.77
Poor	7.55	4.88	11.69
Equivalised household income quintile**			
Highest	1		
2 nd	0.94	0.83	1.07
3 rd	1.17	1.01	1.34
4 th	1.13	0.96	1.32
Lowest	1.31	1.10	1.57

*Denotes variable significant in the regression model; P<0.05

**P<0.01

Table C16: Odds of not meeting exercise recommendations: women

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.94	0.76	1.18
35-44	0.86	0.69	1.08
45-54	0.89	0.71	1.11
55-64	1.27	0.99	1.63
65+	2.23	1.63	3.05
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	1.00	0.87	1.14
O-levels or equivalent	1.20	1.04	1.38
Other	1.27	1.02	1.58
None	1.40	1.18	1.65
Missing	1.32	1.10	1.59
Employment**			
Paid employment	1		
Self employed	0.92	0.77	1.12
Unemployed	1.11	0.86	1.44
Retired	0.86	0.69	1.07
Looking after family/home	1.00	0.84	1.19
Student	0.86	0.69	1.08
Long-term sick	2.85	1.74	4.65
Other	2.25	1.47	3.44
Ethnic group**			
White British	1		
White other	0.79	0.62	1.00
Mixed	1.13	0.80	1.61
Indian	1.34	1.02	1.76
Pakistani	1.56	1.11	2.20
Bangladeshi	1.99	1.28	3.10
Black Caribbean	1.09	0.77	1.53
Black African	1.61	1.10	2.35
Other	1.45	1.06	1.98
Missing	0.69	0.45	1.08
Marital status**			
Married, civil partner	1		
Single: never married	0.76	0.65	0.89
Single: widowed, divorced, separated	0.96	0.83	1.10
Cohabiting	1.03	0.88	1.19
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.93	0.81	1.06
3 rd	1.02	0.89	1.17
4 th	0.99	0.86	1.15
Highest quintile (most deprived)	1.07	0.91	1.25

Missing	0.76	0.59	0.99
General health**			
Excellent	1		
Very good	1.44	1.29	1.62
Good	2.01	1.76	2.28
Fair	2.87	2.40	3.44
Poor	5.03	3.59	7.05
Equivalised household income quintile**			
Highest	1		
2 nd	1.22	1.07	1.38
3 rd	1.28	1.12	1.47
4 th	1.47	1.27	1.70
Lowest	1.38	1.17	1.63

*Denotes variable significant in the regression model; P<0.05

**P<0.01

Appendix D: Tables for Chapter 5 – changing and stability in health behaviours between 2010/11 and 2013/4

Table D1: Change in cigarette smoking status, by sex			
	Men	Women	All
	%	%	%
All			
Stable – current cigarette smoker in 2010/11 and 2013/4	15	14	15
Stable – non-smoker in 2010/11 and 2013/4	78	79	79
Change – non-smoker to smoker	2	2	2
Change - smoker to non-smoker	5	4	5
<i>% of smokers in 2010/11 who were non-smokers in 2013/4</i>	24	23	24
Bases			
<i>Weighted - all</i>	12608	14219	26827
<i>Unweighted - all</i>	10470	13608	24078

Table D2: Change in drinking, by sex			
	Men	Women	All
	%	%	%
All			
Stable – binge drinker in 2010/11 and 2013/4	17	10	13
Stable – non-binge drinker in 2010/11 and 2013/4	61	70	66
Change – non-binge drinker to binge drinker**	11	10	10
Change - binge drinker in 2010/11 to non-binge drinker 2013/4**	11	10	10
<i>% of binge drinkers in 2010/11 who were not binge drinkers in 2013/4**</i>	41	49	44
Bases			
<i>Weighted - all</i>	10121	11263	21384
<i>Unweighted - all</i>	8330	10874	19204

*p<0.05 **p<0.01

Table D3: Change in meeting F&V recommendations by sex			
	Men	Women	All
	%	%	%
All			
Stable – did not meet F&V recommendations in 2010/11 and 2013/4	73	64	68
Stable – did meet F&V recommendations in 2010/11 and 2013/4	9	14	12
Change – met F&V recommendations in 2010/11 but not in 2013/4**	8	10	9
Change - did not meet F&V recommendations in 2010/11 but met recommendations in 2013/4**	10	12	11
<i>% of those not meeting F&V recommendations in 2010/11 meeting them in 2013/4**</i>	13	16	14
Bases			
<i>Weighted – all</i>	12564	14182	26746
<i>Unweighted – men</i>	10430	13568	23998

*p<0.05 **p<0.01

Table D4: Change in meeting PA recommendations, by sex			
	Men	Women	All
	%	%	%
All			
Stable – did not meet PA recommendations in 2010/11 and 2013/4	60	68	64
Stable – did meet PA recommendations in 2010/11 and 2013/4	15	10	12
Change – met PA recommendations in 2010/11 but not in 2013/4**	12	11	12
Change - did not meet PA recommendations in 2010/11 but met recommendations in 2013/4**	13	11	12
<i>% of those not meeting PA recommendations in 2010/11 meeting them in 2013/4**</i>	18	14	16
Bases			
<i>Weighted - all</i>	12532	14136	26668
<i>Unweighted - all</i>	10406	13535	23941

*p<0.05 **p<0.01

Table D5: Prevalence and average marginal effects of stopping smoking cigarettes

	Unadjusted prevalence of stopping cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Age*						
16-24	27	663	464	Ref. 0.28		
25-34	28	1033	823	-0.01	-0.07	+0.06
35-44	23	1083	976	-0.05	-0.12	+0.01
45-54	19	1068	930	-0.08	-0.15	-0.02
55-64	21	803	715	-0.05	-0.12	+0.02
65+	25	500	417	-0.02	-0.11	+0.08
Sex						
Male	24	12608	10470	Ref. 0.23		
Female	23	14219	13608	+0.01	-0.02	+0.03
Educational attainment**						
Degree or higher	38	550	476	Ref. 0.35		
A-levels or equivalent	31	782	690	-0.07	-0.12	-0.01
O-levels or equivalent	22	1344	1072	-0.13	-0.19	-0.08
Other/none	17	1919	1554	-0.16	-0.22	-0.11
Missing	N/A			-0.12	-0.19	-0.06
Employment**						
Paid employment/self employed	28	2821	2432	Ref. 0.26		
Unemployed	14	608	477	-0.08	-0.13	-0.04
Retired	24	659	563	+0.00	-0.06	+0.07
Student	34	194	156	+0.05	-0.05	+0.14
Other	14	867	697	-0.09	-0.13	-0.04
Ethnic group						
White British	23	4572	3651	Ref. 0.24		
South Asian (Indian, Pakistani, Bangladeshi)	33	105	189	+0.05	-0.03	+0.13
Black African/Caribbean	25	76	132	+0.03	-0.06	+0.13
Other (includes mixed and White other)	24	359	328	-0.02	-0.07	+0.04
Marital and cohabitation status**						
Married, civil partner	27	1921	1702	Ref. 0.27		
Single: never married	23	1425	1080	-0.06	-0.10	-0.02
Single: widowed, divorced, separated	17	885	792	-0.08	-0.12	-0.04
Cohabiting	24	918	751	-0.05	-0.09	-0.00
Area deprivation						
Lowest quintile (least deprived)	30	630	541	Ref. 0.26		
2 nd	27	745	637	-0.01	-0.06	+0.05

3 rd	25	1009	850	-0.03	-0.08	+0.02
4 th	22	1152	946	-0.04	-0.09	+0.01
Highest quintile (most deprived)	19	1449	1202	-0.05	-0.10	+0.00
Missing	N/A			-0.02	-0.11	+0.07
General health						
Excellent/very good/good	26	3656	3095	Ref. 0.24		
Fair	20	1042	850	-0.02	-0.05	+0.02
Poor	15	452	380	-0.02	-0.07	+0.04
Equivalised household income quintile						
Highest	32	705	622	Ref. 0.25		
2 nd	28	929	823	-0.00	-0.05	+0.05
3 rd	24	1126	933	-0.02	-0.07	+0.03
4 th	21	1222	1000	-0.02	-0.08	+0.03
Lowest	17	1167	947	-0.03	-0.09	+0.02

* Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D6: Prevalence and average marginal effects of starting smoking cigarettes

	Unadjusted prevalence of starting cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age**						
16-24	7	2406	1848	Ref. 0.06		
25-34	5	3083	2719	-0.00	-0.02	+0.02
35-44	3	3743	3715	-0.02	-0.04	+0.00
45-54	2	3885	3667	-0.03	-0.06	-0.01
55-64	2	3633	3487	-0.04	-0.06	-0.02
65+	1	4927	4317	-0.05	-0.07	-0.03
Sex						
Male	3	10094	8468	Ref. 0.03		
Female	3	11583	11285	-0.00	-0.01	+0.00
Educational attainment**						
Degree or higher	2	5018	4609	Ref. 0.02		
A-levels or equivalent	3	4008	3657	+0.01	+0.00	+0.02
O-levels or equivalent	4	4068	3587	+0.02	+0.01	+0.02
Other/none	3	5804	5275	+0.03	+0.02	+0.03
Missing	N/A			+0.01	+0.00	+0.02
Employment						
Paid employment/self employed	3	12190	11054	Ref. 0.03		
Unemployed	8	793	725	+0.01	-0.00	+0.02
Retired	1	5528	4966	-0.00	-0.02	+0.01
Student	7	1282	1066	+0.00	-0.01	+0.01
Other	3	1884	1941	-0.00	-0.01	+0.00
Ethnic group						
White British	3	18636	15792	Ref. 0.03		
South Asian (Indian, Pakistani, Bangladeshi)	3	886	1558	-0.01	-0.02	-0.00
Black African/Caribbean	4	448	777	-0.01	-0.02	+0.00
Other (includes mixed and White other)	3	1451	1443	+0.00	-0.01	+0.01
Marital and cohabitation status**						
Married, civil partner	2	12272	11660	Ref. 0.02		
Single: never married	6	4160	3303	+0.01	+0.00	+0.02
Single: widowed, divorced, separated	2	2989	2801	+0.01	+0.00	+0.02
Cohabiting	5	2255	1987	+0.02	+0.01	+0.03
Area deprivation						
Lowest quintile (least deprived)	2	4707	4241	Ref. 0.02		
2 nd	2	4730	4168	-0.00	-0.01	+0.01
3 rd	2	4508	3978	+0.00	-0.01	+0.01

4 th	3	3920	3506	+0.00	-0.01	+0.01
Highest quintile (most deprived)	5	3200	3264	+0.01	+0.00	+0.02
Missing	N/A			-0.00	-0.02	+0.01
General health**						
Excellent/very good/good	3	17729	16120	Ref. 0.02		
Fair	3	2877	2649	+0.01	+0.00	+0.02
Poor	3	1064	977	+0.01	-0.00	+0.03
Equivalent household income quintile						
Highest	2	5019	4549	Ref. 0.02		
2 nd	2	4929	4444	+0.00	-0.01	+0.01
3 rd	3	4416	3993	+0.01	-0.00	+0.01
4 th	3	4027	3696	+0.00	-0.01	+0.01
Lowest	4	3280	3067	+0.01	-0.00	+0.02

*Denotes variable significant in regression model: p<0.05 ** Denotes variable significant in regression model: p<0.01

Table D7: Prevalence and average marginal effects of stopping binge drinking

	Unadjusted prevalence of stopping binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Age**						
16-24	48	692	526	Ref. 0.47		
25-34	45	1033	855	-0.02	-0.09	+0.05
35-44	40	1065	1011	-0.07	-0.14	+0.01
45-54	41	1029	948	-0.06	-0.14	+0.01
55-64	40	769	725	-0.07	-0.16	+0.01
65+	57	485	428	+0.07	-0.03	+0.18
Sex**						
Male	41	10121	8330	Ref. 0.41		
Female	49	11263	10874	+0.08	+0.05	+0.11
Educational attainment*						
Degree or higher	38	1084	964	Ref. 0.41		
A-levels or equivalent	44	1003	882	+0.04	-0.01	+0.09
O-levels or equivalent	45	1250	1044	+0.05	-0.00	+0.10
Other/none	51	1108	943	+0.07	+0.02	+0.12
Missing	N/A			-0.01	-0.06	+0.04
Employment						
Paid employment/self employed	40	3423	3089	Ref. 0.43		
Unemployed	53	350	270	+0.05	-0.02	+0.13
Retired	52	627	577	+0.02	-0.05	+0.09
Student	46	294	234	-0.01	-0.10	+0.08
Other	56	380	323	+0.07	+0.00	+0.14
Ethnic group**						
White British	43	4670	4087	Ref. 0.43		
South Asian (Indian, Pakistani, Bangladeshi)	60	38	53	+0.17	+0.02	+0.33
Black African/Caribbean	69	30	53	+0.23	+0.10	+0.37
Other (includes mixed and White other)	53	300	275	+0.10	+0.02	+0.18
Marital and cohabitation status						
Married, civil partner	42	2502	2277	Ref. 0.44		
Single: never married	47	1244	985	+0.00	-0.05	+0.06
Single: widowed, divorced, separated	49	500	490	-0.01	-0.06	+0.05
Cohabiting	42	827	741	-0.01	-0.06	+0.04
Area deprivation						
Lowest quintile (least deprived)	41	1050	1005	Ref. 0.44		
2 nd	43	1074	959	-0.00	-0.05	+0.04
3 rd	43	1076	959	-0.01	-0.05	+0.04

4 th	43	927	779	-0.02	-0.07	+0.04
Highest quintile (most deprived)	53	777	628	+0.05	-0.01	+0.10
Missing	N/A			+0.05	-0.04	+0.14
General health*						
Excellent/very good/good	42	4331	3864	Ref. 0.43		
Fair	52	592	501	+0.06	+0.00	+0.11
Poor	58	149	126	+0.09	-0.01	+0.19
Equivalent household income quintile						
Highest	38	1391	1307	Ref. 0.42		
2 nd	41	1238	1125	+0.00	-0.04	+0.05
3 rd	45	953	828	+0.02	-0.03	+0.07
4 th	49	833	687	+0.03	-0.02	+0.09
Lowest	56	658	545	+0.08	+0.02	+0.15

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D8: Prevalence and average marginal effects of starting binge drinking

	Unadjusted prevalence of starting binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Age**						
16-24	24	1714	1334	Ref. 0.20		
25-34	17	2206	1964	-0.03	-0.07	+0.00
35-44	17	2786	2751	-0.04	-0.08	-0.00
45-54	15	2930	2778	-0.06	-0.10	-0.02
55-64	12	2965	2784	-0.09	-0.13	-0.05
65+	5	3709	3100	-0.14	-0.18	-0.10
Sex**						
Male	15	7279	6008	Ref. 0.15		
Female	12	9031	8703	-0.03	-0.04	-0.01
Educational attainment						
Degree or higher	14	3472	3253	Ref. 0.13		
A-levels or equivalent	16	2889	2706	+0.02	-0.00	+0.04
O-levels or equivalent	17	3105	2738	+0.02	+0.00	+0.04
Other/none	10	4747	4006	+0.00	-0.01	+0.02
Missing	N/A			+0.01	-0.01	+0.03
Employment*						
Paid employment/self employed	17	8730	8118	Ref. 0.14		
Unemployed	14	761	624	-0.00	-0.04	+0.03
Retired	6	4267	3660	-0.02	-0.04	+0.01
Student	26	842	720	+0.04	+0.00	+0.08
Other	11	1709	1588	-0.02	-0.04	+0.00
Ethnic group**						
White British	14	14102	12089	Ref. 0.15		
South Asian (Indian, Pakistani, Bangladeshi)	3	617	922	-0.12	-0.13	-0.11
Black African/Caribbean	8	300	508	-0.07	-0.10	-0.04
Other (includes mixed and White other)	10	1093	1047	-0.06	-0.08	-0.04
Marital and cohabitation status						
Married, civil partner	13	8996	8446	Ref. 0.14		
Single: never married	18	3107	2487	+0.00	-0.02	+0.02
Single: widowed, divorced, separated	8	2519	2254	-0.02	-0.03	+0.00
Cohabiting	17	1687	1523	+0.00	-0.02	+0.02
Area deprivation						
Lowest quintile (least deprived)	15	3316	3063	Ref. 0.14		
2 nd	15	3416	3079	+0.01	-0.01	+0.03
3 rd	13	3365	2999	-0.01	-0.03	+0.01
4 th	14	3085	2706	-0.00	-0.02	+0.02

Highest quintile (most deprived)	11	2717	2452	-0.02	-0.04	-0.00
Missing	N/A			-0.02	-0.05	+0.02
General health**						
Excellent/very good/good	15	12931	11786	Ref. 0.14		
Fair	9	2434	2121	-0.03	-0.04	-0.01
Poor	7	942	801	-0.04	-0.07	-0.01
Equivalised household income quintile**						
Highest	18	3311	3109	Ref. 0.16		
2 nd	16	3488	3271	-0.01	-0.03	+0.01
3 rd	12	3523	3142	-0.03	-0.05	-0.01
4 th	11	3261	2849	-0.03	-0.05	-0.00
Lowest	9	2729	2340	-0.04	-0.07	-0.02

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D9: Prevalence and average marginal effects of starting to eat 5 or more portions of fruit and vegetables per day

	Unadjusted prevalence of starting to eat 5 or more portions per day	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age**						
16-24	10	2785	2105	Ref. 0.11		
25-34	12	3505	3014	+0.00	-0.02	+0.03
35-44	15	3903	3809	+0.04	+0.01	+0.06
45-54	14	3922	3635	+0.03	+0.01	+0.06
55-64	18	3200	3017	+0.07	+0.04	+0.10
65+	15	3879	3344	+0.06	+0.02	+0.10
Sex**						
Male	13	12564	10430	Ref. 0.12		
Female	16	14182	13568	+0.04	+0.03	+0.05
Educational attainment**						
Degree or higher	19	3971	3636	Ref. 0.18		
A-levels or equivalent	15	3770	3387	-0.03	-0.05	-0.01
O-levels or equivalent	13	4520	3862	-0.05	-0.07	-0.03
Other/none	12	6335	5584	-0.06	-0.08	-0.05
Missing	N/A			-0.06	-0.08	-0.03
Employment*						
Paid employment/self employed	15	11946	10686	Ref. 0.14		
Unemployed	8	1265	1074	-0.04	-0.07	-0.01
Retired	16	4404	3893	+0.00	-0.02	+0.02
Student	11	1309	1088	+0.03	-0.02	+0.07
Other	13	2269	2182	-0.01	-0.03	+0.01
Ethnic group**						
White British	14	18196	15021	Ref. 0.14		
South Asian (Indian, Pakistani, Bangladeshi)	9	883	1559	-0.05	-0.07	-0.03
Black African/Caribbean	11	467	804	-0.02	-0.05	+0.01
Other (includes mixed and White other)	16	1399	1363	+0.02	-0.01	+0.04
Marital and cohabitation status**						
Married, civil partner	16	10694	10100	Ref. 0.15		
Single: never married	10	4850	3802	-0.03	-0.05	-0.01
Single: widowed, divorced, separated	14	2997	2758	-0.02	-0.03	-0.00
Cohabiting	14	2651	2263	+0.00	-0.02	+0.02
Area deprivation						
Lowest quintile (least deprived)	16	3955	3498	Ref. 0.14		

2 nd	15	4125	3589	-0.00	-0.02	+0.01
3 rd	15	4333	3754	+0.00	-0.02	+0.02
4 th	14	4127	3621	+0.01	-0.01	+0.03
Highest quintile (most deprived)	11	4027	3859	-0.02	-0.04	+0.00
Missing	N/A			+0.01	-0.03	+0.04
General health						
Excellent/very good/good	15	16730	14952	Ref. 0.14		
Fair	13	3210	2852	-0.01	-0.02	+0.01
Poor	12	1247	1114	-0.02	-0.04	+0.00
Equivalised household income quintile						
Highest	17	4202	3774	Ref. 0.15		
2 nd	15	4597	4117	-0.01	-0.02	+0.01
3 rd	14	4430	3918	-0.01	-0.03	+0.01
4 th	12	4293	3818	-0.03	-0.05	-0.01
Lowest	12	3666	3294	-0.01	-0.04	+0.01

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D10: Prevalence and average marginal effects of stopping eating five or more portions of fruit and vegetables per day

	Unadjusted prevalence of stopping eating 5 or more portions per day	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age**						
16-24	59	277	201	Ref. 0.53		
25-34	49	605	522	-0.01	-0.12	+0.11
35-44	46	913	867	-0.04	-0.15	+0.07
45-54	41	1024	953	-0.10	-0.20	+0.01
55-64	39	1220	1168	-0.14	-0.25	-0.02
65+	43	1515	1363	-0.13	-0.25	-0.01
Sex**						
Male	49	2128	1802	Ref. 0.49		
Female	40	3425	3272	-0.09	-0.12	-0.06
Educational attainment**						
Degree or higher	34	1586	1436	Ref. 0.34		
A-levels or equivalent	40	1012	951	+0.06	+0.02	+0.11
O-levels or equivalent	49	875	781	+0.14	+0.09	+0.19
Other/none	53	1351	1210	+0.20	+0.16	+0.25
Missing	N/A			+0.13	+0.08	+0.18
Employment						
Paid employment/self employed	42	3036	2771	Ref. 0.43		
Unemployed	55	134	125	+0.04	-0.06	+0.13
Retired	42	1749	1606	-0.00	-0.05	+0.05
Student	60	161	129	+0.05	-0.07	+0.17
Other	50	474	443	+0.05	-0.01	+0.11
Ethnic group**						
White British	42	4954	4379	Ref. 0.43		
South Asian (Indian, Pakistani, Bangladeshi)	66	98	168	+0.20	+0.10	+0.31
Black African/Caribbean	70	54	100	+0.23	+0.10	+0.35
Other (includes mixed and White other)	47	402	397	+0.05	-0.01	+0.11
Marital and cohabitation status						
Married, civil partner	42	3459	3220	Ref. 0.43		
Single: never married	52	723	571	+0.03	-0.02	+0.09
Single: widowed, divorced, separated	45	858	815	+0.04	-0.01	+0.08
Cohabiting	43	512	467	-0.00	-0.06	+0.05
Area deprivation						
Lowest quintile (least deprived)	40	1378	1280	Ref. 0.43		
2 nd	41	1331	1202	-0.00	-0.04	+0.04
3 rd	44	1164	1054	+0.01	-0.04	+0.05

4 th	45	920	812	-0.00	-0.05	+0.05
Highest quintile (most deprived)	55	608	584	+0.06	-0.00	+0.12
Missing	N/A			-0.03	-0.13	+0.06
General health						
Excellent/very good/good	43	4610	4217	Ref. 0.43		
Fair	49	683	623	+0.03	-0.02	+0.08
Poor	46	260	234	-0.03	-0.10	+0.04
Equivalent household income quintile						
Highest	39	1514	1390	Ref. 0.43		
2 nd	42	1254	1140	-0.01	-0.05	+0.03
3 rd	46	1085	985	+0.02	-0.03	+0.07
4 th	46	941	862	+0.00	-0.05	+0.05
Lowest	50	757	696	+0.03	-0.03	+0.09

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D11: Prevalence and average marginal effects of starting to meet physical activity recommendations

	Unadjusted prevalence of starting to meet recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age**						
16-24	28	1969	1489	Ref. 0.23		
25-34	22	2908	2552	-0.03	-0.07	+0.01
35-44	19	3545	3484	-0.05	-0.09	-0.02
45-54	16	3724	3478	-0.07	-0.11	-0.04
55-64	12	3565	3371	-0.10	-0.14	-0.06
65+	7	4549	3931	-0.15	-0.19	-0.11
Sex**						
Male	18	9113	7629	Ref. 0.18		
Female	14	11147	10676	-0.04	-0.05	-0.02
Educational attainment**						
Degree or higher	21	3811	3543	Ref. 0.18		
A-levels or equivalent	20	3459	3173	-0.00	-0.02	+0.02
O-levels or equivalent	18	4011	3504	-0.02	-0.04	-0.00
Other/none	10	6430	5678	-0.05	-0.07	-0.03
Missing	N/A			-0.02	-0.05	-0.00
Employment						
Paid employment/self employed	19	10921	9910	Ref. 0.16		
Unemployed	19	1063	916	+0.01	-0.02	+0.04
Retired	7	5136	4546	-0.01	-0.04	+0.02
Student	29	850	727	+0.00	-0.03	+0.04
Other	12	2289	2205	-0.02	-0.04	+0.00
Ethnic group**						
White British	15	17591	14758	Ref. 0.16		
South Asian (Indian, Pakistani, Bangladeshi)	15	787	1412	-0.03	-0.06	-0.01
Black African/Caribbean	17	397	704	-0.02	-0.05	+0.01
Other (includes mixed and White other)	21	1313	1307	+0.02	-0.00	+0.05
Marital and cohabitation status**						
Married, civil partner	15	10911	10337	Ref. 0.15		
Single: never married	24	3817	3008	+0.03	+0.01	+0.05
Single: widowed, divorced, separated	9	3231	2963	-0.01	-0.03	+0.01
Cohabiting	18	2299	1995	-0.01	-0.02	+0.01
Area deprivation						

Lowest quintile (least deprived)	18	3891	3481	Ref. 0.18		
2 nd	16	4086	3584	-0.02	-0.04	+0.00
3 rd	15	4176	3685	-0.02	-0.04	-0.01
4 th	15	3838	3410	-0.03	-0.05	-0.01
Highest quintile (most deprived)	15	3701	3587	-0.02	-0.04	+0.00
Missing	N/A			-0.01	-0.05	+0.03
General health**						
Excellent/very good/good	18	15446	13996	Ref. 0.17		
Fair	10	3416	3053	-0.05	-0.06	-0.03
Poor	5	1393	1251	-0.11	-0.13	-0.09
Equivalised household income quintile						
Highest	20	3886	3549	Ref. 0.16		
2 nd	18	4337	3928	+0.00	-0.02	+0.02
3 rd	16	4262	3808	-0.00	-0.02	+0.02
4 th	13	4212	3794	-0.02	-0.04	+0.00
Lowest	12	3556	3222	-0.01	-0.04	+0.01

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D12: Prevalence and average marginal effects of stopping meeting physical activity recommendations

	Unadjusted prevalence of stopping meeting recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age						
16-24	44	1095	819	Ref. 0.46		
25-34	49	1198	980	+0.03	-0.03	+0.10
35-44	46	1274	1201	+0.00	-0.07	+0.07
45-54	49	1216	1108	+0.03	-0.04	+0.10
55-64	53	860	820	+0.07	-0.00	+0.15
65+	54	764	708	+0.06	-0.03	+0.16
Sex**						
Male	46	3419	2777	Ref. 0.46		
Female	52	2989	2859	+0.06	+0.03	+0.09
Educational attainment*						
Degree or higher	46	1750	1534	Ref. 0.48		
A-levels or equivalent	46	1316	1159	-0.01	-0.05	+0.03
O-levels or equivalent	47	1385	1140	-0.00	-0.05	+0.04
Other/none	57	1208	1079	+0.06	+0.01	+0.11
Missing	N/A			+0.02	-0.03	+0.07
Employment						
Paid employment/self employed	47	4054	3543	Ref. 0.48		
Unemployed	54	335	284	+0.03	-0.04	+0.10
Retired	54	941	891	+0.00	-0.06	+0.07
Student	44	621	492	-0.00	-0.07	+0.07
Other	57	456	426	+0.04	-0.02	+0.10
Ethnic group						
White British	48	5484	4582	Ref. 0.48		
South Asian (Indian, Pakistani, Bangladeshi)	57	195	323	+0.09	+0.01	+0.16
Black African/Caribbean	54	120	192	+0.05	-0.04	+0.14
Other (includes mixed and White other)	51	489	457	+0.02	-0.03	+0.08
Marital and cohabitation status						
Married, civil partner	50	3204	2950	Ref. 0.50		
Single: never married	46	1743	1360	-0.02	-0.07	+0.03
Single: widowed, divorced, separated	52	593	589	-0.04	-0.09	+0.01
Cohabiting	47	868	737	-0.02	-0.06	+0.03
Area deprivation						
Lowest quintile	48	1430	1287	Ref. 0.49		

(least deprived)						
2 nd	45	1352	1192	-0.03	-0.07	+0.02
3 rd	49	1305	1117	+0.01	-0.04	+0.05
4 th	48	1202	1012	-0.01	-0.05	+0.04
Highest quintile (most deprived)	55	913	843	+0.05	-0.01	+0.10
Missing	N/A			-0.03	-0.13	+0.06
General health**						
Excellent/very good/good	48	5849	5139	Ref. 0.48		
Fair	57	463	410	+0.06	+0.00	+0.12
Poor	67	95	86	+0.16	+0.05	+0.27
Equivalised household income quintile*						
Highest	44	1821	1607	Ref. 0.46		
2 nd	46	1502	1323	+0.01	-0.04	+0.05
3 rd	50	1252	1094	+0.04	-0.01	+0.08
4 th	55	997	868	+0.08	+0.03	+0.13
Lowest	54	835	744	+0.05	-0.00	+0.11

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D13: Prevalence and average marginal effects of decreasing the number of cigarettes smoked among stable smokers

	Unadjusted prevalence of decreasing number of cigarettes smoked	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age						
16-24	16	487	339	Ref. 0.16		
25-34	19	743	585	+0.03	-0.03	+0.08
35-44	21	831	738	+0.05	-0.01	+0.11
45-54	25	858	731	+0.09	+0.02	+0.15
55-64	26	632	555	+0.09	+0.02	+0.17
65+	25	370	308	+0.09	-0.02	+0.19
Sex						
Male	24	1905	1496	Ref. 0.23		
Female	21	2016	1760	-0.03	-0.06	+0.01
Educational attainment						
Degree or higher	17	337	295	Ref. 0.18		
A-levels or equivalent	23	537	467	+0.06	-0.00	+0.13
O-levels or equivalent	20	1040	827	+0.03	-0.03	+0.09
Other/none	25	1583	1269	+0.04	-0.02	+0.10
Missing	N/A			+0.01	-0.05	+0.08
Employment						
Paid employment/self employed	21	2037	1752	Ref. 0.23		
Unemployed	24	521	396	+0.01	-0.05	+0.07
Retired	25	495	421	-0.02	-0.09	+0.06
Student	12	128	105	-0.05	-0.15	+0.05
Other	23	739	582	-0.02	-0.07	+0.03
Ethnic group*						
White British	23	3493	2765	Ref. 0.23		
South Asian (Indian, Pakistani, Bangladeshi)	15	70	126	-0.07	-0.15	+0.01
Black African/Caribbean	11	56	103	-0.11	-0.18	-0.04
Other (includes mixed and White other)	18	272	242	-0.04	-0.10	+0.02
Marital and cohabitation status						
Married, civil partner	22	1393	1224	Ref. 0.21		
Single: never married	19	1094	817	+0.01	-0.04	+0.06
Single: widowed, divorced, separated	24	733	646	-0.00	-0.05	+0.04
Cohabiting	23	701	569	+0.04	-0.01	+0.09
Area deprivation						
Lowest quintile	20	437	374	Ref. 0.21		

(least deprived)						
2 nd	19	541	465	-0.01	-0.07	+0.05
3 rd	25	756	633	+0.04	-0.02	+0.10
4 th	22	894	724	+0.00	-0.05	+0.06
Highest quintile (most deprived)	22	1167	945	+0.01	-0.05	+0.06
Missing	N/A			+0.02	-0.08	+0.12
General health**						
Excellent/very good/good	19	2711	2268	Ref. 0.20		
Fair	27	832	676	+0.07	+0.03	+0.11
Poor	30	378	312	+0.08	+0.02	+0.15
Equivalised household income quintile						
Highest	19	481	426	Ref. 0.20		
2 nd	20	662	585	+0.00	-0.05	+0.06
3 rd	24	852	694	+0.04	-0.02	+0.09
4 th	20	964	774	-0.00	-0.06	+0.06
Lowest	25	961	777	+0.05	-0.02	+0.11

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D14: Prevalence and average marginal effects of increasing number of cigarettes smoked among stable smokers

	Unadjusted prevalence of increasing number of cigarettes smoked	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age**						
16-24	27	487	339	Ref. 0.27		
25-34	19	743	585	-0.08	-0.15	-0.01
35-44	17	831	738	-0.11	-0.18	-0.04
45-54	16	858	731	-0.12	-0.19	-0.05
55-64	14	632	555	-0.13	-0.21	-0.05
65+	15	370	308	-0.12	-0.23	-0.01
Sex*						
Male	19	1905	1496	Ref. 0.19		
Female	16	2016	1760	-0.03	-0.06	-0.00
Educational attainment						
Degree or higher	13	337	295	Ref. 0.14		
A-levels or equivalent	14	537	467	-0.00	-0.07	+0.06
O-levels or equivalent	21	1040	827	+0.05	-0.01	+0.11
Other/none	17	1583	1269	+0.03	-0.03	+0.09
Missing	N/A			+0.05	-0.02	+0.12
Employment						
Paid employment/self employed	15	2037	1752	Ref. 0.16		
Unemployed	25	521	396	+0.06	+0.00	+0.11
Retired	15	495	421	+0.00	-0.07	+0.08
Student	22	128	105	+0.00	-0.08	+0.08
Other	20	739	582	+0.03	-0.02	+0.08
Ethnic group						
White British	18	3493	2765	Ref. 0.18		
South Asian (Indian, Pakistani, Bangladeshi)	18	70	126	-0.02	-0.10	+0.06
Black African/Caribbean	11	56	103	-0.07	-0.14	-0.01
Other (includes mixed and White other)	15	272	242	-0.02	-0.08	+0.04
Marital and cohabitation status						
Married, civil partner	17	1393	1224	Ref. 0.19		
Single: never married	21	1094	817	-0.02	-0.06	+0.02
Single: widowed, divorced, separated	15	733	646	-0.01	-0.06	+0.03
Cohabiting	18	701	569	-0.02	-0.07	+0.02
Area deprivation						
Lowest quintile (least deprived)	14	437	374	Ref. 0.15		
2 nd	17	541	465	+0.03	-0.03	+0.08

3 rd	18	756	633	+0.03	-0.02	+0.09
4 th	16	894	724	+0.00	-0.05	+0.05
Highest quintile (most deprived)	21	1167	945	+0.04	-0.01	+0.10
Missing				+0.02	-0.06	+0.10
General health						
Excellent/very good/good	17	2711	2268	Ref. 0.17		
Fair	20	832	676	+0.03	-0.01	+0.06
Poor	18	378	312	+0.01	-0.04	+0.07
Equivalised household income quintile						
Highest	15	481	426	Ref. 0.17		
2 nd	14	662	585	-0.02	-0.08	+0.04
3 rd	19	852	694	+0.02	-0.04	+0.07
4 th	19	964	774	+0.01	-0.05	+0.07
Lowest	20	961	777	+0.01	-0.05	+0.07

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D15: Prevalence and average marginal effects of reducing units of alcohol consumed on heaviest drinking day among stable binge drinkers

	Unadjusted prevalence of reducing units of alcohol consumed	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age**						
16-24	20	359	267	Ref. 0.20		
25-34	11	572	484	-0.08	-0.17	-0.00
35-44	7	636	611	-0.13	-0.21	-0.04
45-54	10	606	551	-0.10	-0.19	-0.01
55-64	8	459	435	-0.12	-0.21	-0.03
65+	5	207	187	-0.15	-0.24	-0.05
Sex**						
Male	12	1689	1392	Ref. 0.12		
Female	8	1150	1143	-0.04	-0.07	-0.02
Educational attainment*						
Degree or higher	9	669	591	Ref. 0.10		
A-levels or equivalent	8	561	494	-0.02	-0.05	+0.02
O-levels or equivalent	12	683	588	+0.03	-0.01	+0.07
Other/none	9	546	471	-0.01	-0.05	+0.03
Missing	N/A			+0.03	-0.01	+0.08
Employment						
Paid employment/self employed	9	2053	1853	Ref. 0.09		
Unemployed	23	163	132	+0.10	+0.02	+0.18
Retired	6	298	281	+0.01	-0.05	+0.08
Student	17	158	125	-0.01	-0.06	+0.04
Other	11	165	144	+0.03	-0.04	+0.10
Ethnic group*						
White British	10	2657	2354	Ref. 0.10		
South Asian (Indian, Pakistani, Bangladeshi)	26	15	20	+0.19	+0.01	+0.38
Black African/Caribbean	18	9	21	+0.10	-0.13	+0.32
Other (includes mixed and White other)	14	140	129	+0.05	-0.02	+0.13
Marital and cohabitation status						
Married, civil partner	8	1444	1327	Ref. 0.10		
Single: never married	17	658	521	+0.02	-0.03	+0.07
Single: widowed, divorced, separated	9	256	252	+0.01	-0.04	+0.06
Cohabiting	8	480	435	-0.02	-0.05	+0.02
Area deprivation						
Lowest quintile (least deprived)	6	616	599	Ref. 0.07		
2 nd	11	617	549	+0.04	+0.00	+0.07

3 rd	11	615	555	+0.04	+0.00	+0.08
4 th	12	531	448	+0.04	+0.00	+0.08
Highest quintile (most deprived)	13	369	298	+0.04	-0.00	+0.09
Missing	N/A			+0.03	-0.04	+0.11
General health						
Excellent/very good/good	10	2491	2235	Ref. 0.10		
Fair	15	284	245	+0.05	-0.01	+0.10
Poor	15	62	55	+0.04	-0.06	+0.14
Equivalised household income quintile						
Highest	11	861	816	Ref. 0.14		
2 nd	8	735	663	-0.05	-0.09	-0.01
3 rd	9	527	455	-0.04	-0.09	-0.00
4 th	10	423	354	-0.05	-0.10	-0.00
Lowest	14	291	246	-0.03	-0.08	+0.02

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Table D16: Prevalence and average marginal effects of increasing units of alcohol consumed on the heaviest drinking day among stable binge drinkers

	Unadjusted prevalence of increasing units of alcohol consumed	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI Higher
		Weighted	Unweighted			
		%	<i>n</i>			
Age**						
16-24	18	359	267	Ref. 0.14		
25-34	16	572	484	+0.01	-0.06	+0.08
35-44	14	636	611	+0.00	-0.07	+0.07
45-54	11	606	551	-0.02	-0.09	+0.05
55-64	4	459	435	-0.10	-0.17	-0.03
65+	5	207	187	-0.10	-0.18	-0.02
Sex						
Male	12	1689	1392	Ref. 0.13		
Female	11	1150	1143	-0.02	-0.05	+0.01
Educational attainment						
Degree or higher	10	669	591	Ref. 0.10		
A-levels or equivalent	16	561	494	+0.05	+0.00	+0.09
O-levels or equivalent	11	683	588	+0.01	-0.03	+0.05
Other/none	12	546	471	+0.04	-0.01	+0.09
Missing	N/A			+0.00	-0.04	+0.05
Employment						
Paid employment/self employed	12	2053	1853	Ref. 0.11		
Unemployed	12	163	132	-0.01	-0.07	+0.05
Retired	5	298	281	+0.02	-0.08	+0.12
Student	22	158	125	+0.05	-0.04	+0.13
Other	15	165	144	+0.03	-0.04	+0.11
Ethnic group						
White British	12	2657	2354	Ref. 0.12		
South Asian (Indian, Pakistani, Bangladeshi)	15	15	20	+0.03	-0.19	+0.25
Black African/Caribbean	14	9	21	+0.03	-0.14	+0.19
Other (includes mixed and White other)	12	140	129	+0.01	-0.06	+0.08
Marital and cohabitation status						
Married, civil partner	9	1444	1327	Ref. 0.11		
Single: never married	17	658	521	+0.03	-0.02	+0.07
Single: widowed, divorced, separated	6	256	252	-0.02	-0.07	+0.02
Cohabiting	16	480	435	+0.04	+0.00	+0.08
Area deprivation						
Lowest quintile (least deprived)	13	616	599	Ref. 0.14		
2 nd	11	617	549	-0.03	-0.07	+0.01
3 rd	12	615	555	-0.01	-0.06	+0.03

4 th	11	531	448	-0.03	-0.08	+0.02
Highest quintile (most deprived)	12	369	298	-0.03	-0.08	+0.02
Missing	N/A			-0.06	-0.13	+0.01
General health						
Excellent/very good/good	12	2491	2235	Ref. 0.12		
Fair	15	284	245	+0.04	-0.02	+0.09
Poor	6	62	55	-0.04	-0.13	+0.05
Equivalised household income quintile						
Highest	12	861	816	Ref. 0.12		
2 nd	11	735	663	-0.01	-0.05	+0.02
3 rd	13	527	455	+0.01	-0.04	+0.05
4 th	11	423	354	-0.01	-0.06	+0.04
Lowest	13	291	246	0.01	-0.05	+0.07

*Denotes variable significant in regression model: $p < 0.05$ ** Denotes variable significant in regression model: $p < 0.01$

Tables for Chapter 5 – Odds of changing health behaviours between 2010/11 and 2013/4

Table D17: Odds of stopping smoking			
	Odds ratios	95% CI lower	95% CI Higher
Age*			
16-24	1		
25-34	0.97	0.69	1.36
35-44	0.74	0.53	1.05
45-54	0.61	0.42	0.88
55-64	0.75	0.50	1.10
65+	0.91	0.54	1.55
Sex			
Male	1		
Female	1.04	0.89	1.22
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	0.73	0.56	0.96
O-levels or equivalent	0.51	0.38	0.67
Other/none	0.42	0.32	0.55
Missing	0.54	0.39	0.74
Employment**			
Paid employment/self employed	1		
Unemployed	0.59	0.42	0.82
Retired	1.03	0.71	1.50
Student	1.29	0.81	2.07
Other	0.59	0.44	0.77
Ethnic group			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	1.32	0.86	2.03
Black African/Caribbean	1.21	0.72	2.06
Other (includes mixed and White other)	0.90	0.64	1.26
Marital status**			
Married, civil partner	1		
Single: never married	0.71	0.55	0.90
Single: widowed, divorced, separated	0.63	0.50	0.81
Cohabiting	0.78	0.60	1.00
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.95	0.71	1.29
3 rd	0.84	0.64	1.10
4 th	0.81	0.62	1.06
Highest quintile (most deprived)	0.77	0.57	1.02
Missing	0.88	0.53	1.45
General health			

Excellent/very good/good	1		
Fair	0.90	0.73	1.12
Poor	0.91	0.65	1.27
Equivalised household income quintile			
Highest	1		
2 nd	1.00	0.76	1.31
3 rd	0.91	0.69	1.20
4 th	0.87	0.65	1.16
Lowest	0.82	0.59	1.14

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Table D18: Odds of starting smoking			
	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.93	0.63	1.37
35-44	0.63	0.41	0.97
45-54	0.37	0.23	0.59
55-64	0.27	0.16	0.45
65+	0.10	0.04	0.25
Sex			
Male	1		
Female	0.86	0.70	1.05
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	1.55	1.08	2.22
O-levels or equivalent	2.03	1.44	2.85
Other/none	2.70	1.89	3.87
Missing	1.65	1.11	2.46
Employment			
Paid employment/self employed	1		
Unemployed	1.35	0.91	2.00
Retired	0.87	0.44	1.71
Student	1.10	0.74	1.64
Other	0.83	0.58	1.19
Ethnic group			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	0.60	0.37	0.98
Black African/Caribbean	0.75	0.45	1.23
Other (includes mixed and White other)	1.01	0.70	1.46
Marital status**			
Married, civil partner	1		
Single: never married	1.59	1.14	2.21
Single: widowed, divorced, separated	1.67	1.15	2.43
Cohabiting	1.93	1.41	2.63
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	1.00	0.70	1.43
3 rd	1.04	0.72	1.49
4 th	1.16	0.81	1.66
Highest quintile (most deprived)	1.52	1.06	2.18
Missing	0.94	0.48	1.83
General health**			
Excellent/very good/good	1		
Fair	1.61	1.21	2.15
Poor	1.59	1.02	2.49
Equivalent household income quintile			

Highest	1		
2 nd	1.00	0.72	1.40
3 rd	1.23	0.88	1.73
4 th	1.08	0.74	1.56
Lowest	1.49	1.01	2.21

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Table D19: Odds of stopping binge drinking

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.91	0.68	1.22
35-44	0.75	0.55	1.03
45-54	0.77	0.56	1.06
55-64	0.73	0.52	1.04
65+	1.35	0.87	2.07
Sex**			
Male	1		
Female	1.39	1.22	1.58
Educational attainment*			
Degree or higher	1		
A-levels or equivalent	1.17	0.95	1.44
O-levels or equivalent	1.22	0.99	1.50
Other/none	1.33	1.07	1.67
Missing	0.97	0.77	1.21
Employment			
Paid employment/self employed	1		
Unemployed	1.25	0.93	1.70
Retired	1.07	0.80	1.43
Student	0.97	0.67	1.42
Other	1.35	1.02	1.79
Ethnic group**			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	2.08	1.05	4.12
Black African/Caribbean	2.71	1.45	5.07
Other (includes mixed and White other)	1.51	1.10	2.08
Marital status			
Married, civil partner	1		
Single: never married	1.02	0.81	1.28
Single: widowed, divorced, separated	0.97	0.78	1.22
Cohabiting	0.97	0.79	1.19
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.99	0.81	1.21
3 rd	0.98	0.80	1.20
4 th	0.93	0.75	1.16
Highest quintile (most deprived)	1.21	0.95	1.55
Missing	1.24	0.86	1.78
General health*			
Excellent/very good/good	1		
Fair	1.26	1.02	1.56
Poor	1.46	0.97	2.19
Equivalent household income quintile			

Highest	1		
2 nd	1.02	0.84	1.23
3 rd	1.09	0.88	1.35
4 th	1.14	0.90	1.44
Lowest	1.41	1.09	1.84

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Table D20: Odds of starting binge drinking			
	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.79	0.61	1.01
35-44	0.76	0.59	0.98
45-54	0.64	0.49	0.82
55-64	0.51	0.39	0.67
65+	0.27	0.19	0.38
Sex**			
Male	1		
Female	0.80	0.72	0.88
Educational attainment			
Degree or higher	1		
A-levels or equivalent	1.16	0.98	1.38
O-levels or equivalent	1.24	1.04	1.46
Other/none	1.05	0.88	1.24
Missing	1.08	0.90	1.31
Employment*			
Paid employment/self employed	1		
Unemployed	0.97	0.72	1.31
Retired	0.83	0.66	1.06
Student	1.37	1.03	1.82
Other	0.84	0.68	1.03
Ethnic group**			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	0.14	0.09	0.22
Black African/Caribbean	0.49	0.34	0.71
Other (includes mixed and White other)	0.56	0.44	0.73
Marital status			
Married, civil partner	1		
Single: never married	1.01	0.85	1.21
Single: widowed, divorced, separated	0.86	0.72	1.04
Cohabiting	1.01	0.84	1.21
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	1.06	0.90	1.24
3 rd	0.92	0.78	1.09
4 th	0.98	0.82	1.17
Highest quintile (most deprived)	0.81	0.66	1.00
Missing	0.85	0.61	1.17
General health**			
Excellent/very good/good	1		
Fair	0.78	0.66	0.93
Poor	0.67	0.50	0.91
Equivalent household income quintile**			

Highest	1		
2 nd	0.92	0.78	1.07
3 rd	0.74	0.62	0.89
4 th	0.80	0.66	0.97
Lowest	0.67	0.54	0.84

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Table D21: Odds and average marginal effects of starting to eat 5 or more portions of fruit and vegetables

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	1.04	0.79	1.37
35-44	1.39	1.06	1.81
45-54	1.36	1.03	1.79
55-64	1.81	1.35	2.41
65+	1.68	1.21	2.33
Sex**			
Male	1		
Female	1.37	1.25	1.50
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	0.82	0.71	0.95
O-levels or equivalent	0.70	0.60	0.81
Other/none	0.59	0.51	0.69
Missing	0.65	0.54	0.77
Employment*			
Paid employment/self employed	1		
Unemployed	0.69	0.52	0.91
Retired	1.01	0.84	1.22
Student	1.22	0.90	1.65
Other	0.92	0.78	1.09
Ethnic group**			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	0.62	0.48	0.80
Black African/Caribbean	0.85	0.65	1.11
Other (includes mixed and White other)	1.14	0.94	1.38
Marital status**			
Married, civil partner	1		
Single: never married	0.77	0.65	0.91
Single: widowed, divorced, separated	0.87	0.75	1.00
Cohabiting	1.00	0.85	1.18
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.97	0.84	1.11
3 rd	1.01	0.87	1.17
4 th	1.06	0.90	1.24
Highest quintile (most deprived)	0.86	0.72	1.02
Missing	1.05	0.78	1.42
General health			
Excellent/very good/good	1		
Fair	0.93	0.81	1.06
Poor	0.84	0.68	1.04
Equivalised household income			

quintile			
Highest	1		
2 nd	0.96	0.83	1.11
3 rd	0.93	0.80	1.09
4 th	0.79	0.67	0.94
Lowest	0.88	0.74	1.06

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Table D22: Odds of stopping eating five or more portions of fruit and vegetables per day

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.97	0.61	1.56
35-44	0.86	0.54	1.37
45-54	0.67	0.42	1.06
55-64	0.56	0.35	0.90
65+	0.57	0.35	0.95
Sex**			
Male	1		
Female	0.67	0.59	0.77
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	1.33	1.10	1.61
O-levels or equivalent	1.83	1.49	2.26
Other/none	2.39	1.96	2.91
Missing	1.74	1.40	2.17
Employment			
Paid employment/self employed	1		
Unemployed	1.17	0.77	1.76
Retired	0.98	0.79	1.22
Student	1.24	0.73	2.09
Other	1.23	0.97	1.57
Ethnic group**			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	2.40	1.51	3.81
Black African/Caribbean	2.63	1.50	4.63
Other (includes mixed and White other)	1.23	0.96	1.59
Marital status			
Married, civil partner	1		
Single: never married	1.16	0.90	1.48
Single: widowed, divorced, separated	1.17	0.97	1.40
Cohabiting	0.98	0.78	1.25
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.99	0.83	1.19
3 rd	1.03	0.85	1.26
4 th	0.99	0.79	1.23
Highest quintile (most deprived)	1.28	0.99	1.65
Missing	0.87	0.58	1.31
General health			
Excellent/very good/good	1		
Fair	1.14	0.93	1.38
Poor	0.89	0.66	1.22
Equivalent household income quintile			

Highest	1		
2 nd	0.96	0.80	1.16
3 rd	1.09	0.89	1.34
4 th	1.00	0.81	1.25
Lowest	1.15	0.90	1.48

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Table D23: Odds of starting to meet physical activity recommendations

	Odds ratios	95% CI lower	95% CI Higher
Age**			
16-24	1		
25-34	0.82	0.66	1.03
35-44	0.72	0.58	0.89
45-54	0.61	0.49	0.77
55-64	0.50	0.39	0.63
65+	0.29	0.21	0.40
Sex**			
Male	1		
Female	0.76	0.69	0.83
Educational attainment**			
Degree or higher	1		
A-levels or equivalent	0.99	0.87	1.14
O-levels or equivalent	0.86	0.74	1.00
Other/none	0.69	0.59	0.80
Missing	0.84	0.71	1.00
Employment			
Paid employment/self employed	1		
Unemployed	1.04	0.83	1.31
Retired	0.92	0.74	1.15
Student	1.03	0.80	1.33
Other	0.85	0.71	1.01
Ethnic group**			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	0.76	0.61	0.95
Black African/Caribbean	0.85	0.65	1.12
Other (includes mixed and White other)	1.18	0.98	1.43
Marital status**			
Married, civil partner	1		
Single: never married	1.26	1.08	1.47
Single: widowed, divorced	0.93	0.80	1.09
Cohabiting	0.95	0.82	1.11
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.87	0.76	1.00
3 rd	0.83	0.72	0.96
4 th	0.80	0.68	0.93
Highest quintile (most deprived)	0.87	0.74	1.03
Missing	0.93	0.69	1.25
General health**			
Excellent/very good/good	1		
Fair	0.67	0.58	0.78
Poor	0.32	0.23	0.43
Equivalent household income quintile			

Highest	1		
2 nd	1.00	0.87	1.16
3 rd	0.99	0.85	1.15
4 th	0.87	0.74	1.03
Lowest	0.90	0.75	1.08

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Table D24: Odds of stopping meeting physical activity recommendations

	Odds ratios	95% CI lower	95% CI Higher
Age			
16-24	1		
25-34	1.15	0.87	1.51
35-44	1.00	0.75	1.33
45-54	1.13	0.85	1.52
55-64	1.36	0.99	1.86
65+	1.28	0.87	1.89
Sex**			
Male	1		
Female	1.29	1.15	1.45
Educational attainment*			
Degree or higher	1		
A-levels or equivalent	0.95	0.80	1.14
O-levels or equivalent	0.99	0.82	1.19
Other/none	1.28	1.06	1.55
Missing	1.07	0.88	1.31
Employment			
Paid employment/self employed	1		
Unemployed	1.12	0.84	1.50
Retired	1.00	0.77	1.31
Student	0.99	0.74	1.32
Other	1.18	0.93	1.49
Ethnic group			
White British	1		
South Asian (Indian, Pakistani, Bangladeshi)	1.43	1.06	1.92
Black African/Caribbean	1.22	0.85	1.76
Other (includes mixed and White other)	1.10	0.88	1.36
Marital status			
Married, civil partner	1		
Single: never married	0.91	0.74	1.11
Single: widowed, divorced, separated	0.85	0.70	1.04
Cohabiting	0.93	0.77	1.13
Area deprivation			
Lowest quintile (least deprived)	1		
2 nd	0.89	0.74	1.06
3 rd	1.04	0.86	1.24
4 th	0.97	0.80	1.17
Highest quintile (most deprived)	1.21	0.97	1.50
Missing	0.87	0.59	1.29
General health**			
Excellent/very good/good	1		
Fair	1.27	1.01	1.61
Poor	1.95	1.18	3.21
Equivalent household income quintile*			

Highest	1		
2 nd	1.03	0.87	1.22
3 rd	1.17	0.98	1.41
4 th	1.37	1.12	1.69
Lowest	1.24	0.99	1.56

*Denotes variable significant in regression model: $p < 0.05$

** $p < 0.01$

Appendix E: Tables for Chapter 6 – relationship between health behaviour change and experience of life transitions between 2010/11 and 2013/4

Table E1: Prevalence of stopping smoking cigarettes by relationship transitions						
Relationship transitions	Unadjusted prevalence of stopping cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into relationship						
Not in a relationship at both waves	20	2083	1624	Ref. 0.20		
Moved into a relationship	28	221	244	+0.06	-0.01	+0.12
Moved out of a relationship						
In a relationship at both waves	26	2612	2272	Ref. 0.26		
Moved out of a relationship	23	226	180	-0.03	-0.11	+0.04

Table E2: Prevalence of starting smoking cigarettes by relationship transitions						
Relationship transitions	Unadjusted prevalence of starting cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into relationship						
Not in a relationship at both waves	4	6678	5486	Ref. 0.04		
Moved into a relationship	4	442	594	-0.01	-0.03	+0.00
Moved out of a relationship**						
In a relationship at both waves	2	13882	13064	Ref. 0.02		
Moved out of a relationship	7	624	564	+0.04	+0.02	+0.06

**Denotes variable significant in the regression model: P<0.01.

Table E3: Prevalence of stopping binge drinking by relationship transitions						
Relationship transitions	Unadjusted prevalence of starting binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into relationship						
Not in a relationship at both waves	47	1531	1198	Ref. 0.47		
Moved into a relationship	53	206	273	+0.06	-0.01	+0.14
Moved out of a relationship						
In a relationship at both waves	42	3168	2877	Ref. 0.43		
Moved out of a relationship	40	156	136	-0.07	-0.15	+0.02

Table E4: Prevalence of starting binge drinking by relationship transitions						
Relationship transitions	Unadjusted prevalence of starting binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into a relationship						
Not in a relationship at both waves	13	5268	4300	Ref. 0.14		
Moved into a relationship	17	334	421	-0.00	-0.04	+0.03
Moved out of a relationship**						
In a relationship at both waves	13	10196	9533	Ref. 0.13		
Moved out of a relationship	18	473	422	+0.06	+0.02	+0.10

**Denotes variable significant in the regression model: P<0.01.

Table E5: Prevalence of starting to meet F&V recommendations by relationship transitions						
Relationship transitions	Unadjusted prevalence of starting to meet F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into relationship						
Not in a relationship at both waves	12	7233	5809	Ref. 0.12		
Moved into a relationship	12	579	724	+0.01	-0.02	+0.04
Moved out of a relationship						
In a relationship at both waves	16	12647	11758	Ref. 0.16		
Moved out of a relationship	14	682	590	-0.01	-0.04	+0.02

Table E6: Prevalence of stopping meeting F&V recommendations by relationship transitions						
Relationship transitions	Unadjusted prevalence of stopping meeting F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into relationship						
Not in a relationship at both waves	48	1497	1273	Ref. 0.48		
Moved into a relationship	51	83	112	-0.00	-0.11	+0.10
Moved out of a relationship*						
In a relationship at both waves	41	3800	3531	Ref. 0.41		
Moved out of a relationship	51	166	151	+0.10	+0.00	+0.19

*Denotes variable significant in the regression model: P<0.05.

Table E7: Prevalence of starting to meet PA recommendations by relationship transitions						
Relationship transitions	Unadjusted prevalence of starting to meet PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into relationship						
Not in a relationship at both waves	17	6556	5361	Ref. 0.17		
Moved into a relationship	21	467	588	-0.02	-0.06	+0.01
Moved out of a relationship**						
In a relationship at both waves	15	12519	11723	Ref. 0.15		
Moved out of a relationship	19	676	595	+0.05	+0.01	+0.08

**Denotes variable significant in the regression model: P<0.01.

Table E8: Prevalence of stopping meeting PA recommendations by relationship transitions						
Relationship transitions	Unadjusted prevalence of stopping meeting PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>N</i>	<i>n</i>			
Moved into relationship**						
Not in a relationship at both waves	46	2131	1694	Ref. 0.46		
Moved into a relationship	61	194	249	+0.16	+0.09	+0.23
Moved out of a relationship						
Not in a relationship at both waves	49	3896	3536	Ref. 0.49		
Moved out of a relationship	47	169	145	-0.01	-0.10	+0.08

**Denotes variable significant in the regression model: P<0.01.

Table E9: Prevalence of stopping smoking by employment transitions

Employment transition	Unadjusted prevalence of stopping cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
		%	<i>n</i>			
Moved into employment						
Not in employed in 2010/11 and 2013/4	11	208	163	Ref. 0.11		
Moved into employment in 2013/4	13	219	171	+0.02	-0.05	+0.09
Moved out of employment						
Employed in 2010/11 & 2013/4	28	2471	2122	Ref. 0.28		
Moved into unemployment in 2013/4	20	98	81	-0.07	-0.17	+0.03
Students: moved into employment**^						
Full time student in 2010/11 & 2013/4	50	37	30	Ref. 0.59		
Moved into employment in 2013/4	28	104	78	-0.34	-0.54	-0.14
Students: moved into unemployment^						
Full time student in 2010/11 & 2013/4	50	37	30	Ref. 0.57		
Moved into unemployment in 2013/14	35	38	31	-0.26	-0.54	+0.02
Retired						
Employed in both 2010/11 & 2013/4	28	2471	2122	Ref. 0.28		
Retired in 2013/4	30	110	104	+0.08	-0.03	+0.19

** Denotes variable significant in regression model: P<0.01.

^ The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly.

Table E10: Prevalence of starting smoking by employment transitions

Employment transition	Unadjusted prevalence of starting cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into employment[^]						
Not in employed in 2010/11 and 2013/4	14	188	156	Ref. 0.14		
Moved into employment in 2013/4	7	378	331	-0.07	-0.14	+0.01
Moved out of employment*						
Employed in 2010/11 & 2013/4	3	10694	9664	+0.03		
Moved into unemployment in 2013/4	7	250	223	+0.03	-0.00	+0.06
Students: moved into employment^{**^}						
Full time student in 2010/11 & 2013/4	3	498	432	+0.03		
Moved into employment in 2013/4	8	614	485	+0.05	+0.02	+0.09
Students: moved into unemployment^{**^}						
Full time student in 2010/11 & 2013/4	3	498	432	+0.03		
Moved into unemployment in 2013/4	13	116	99	+0.14	+0.04	+0.23
Retired						
Employed in both 2010/11 & 2013/4	3	10694	9664	+0.03		
Retired in 2013/4	1	786	746	-0.01	-0.03	+0.00

** Denotes variable significant in regression model: $P < 0.01$. * Denotes variable significant in regression model: $P < 0.05$.

[^] The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly.

Table E11: Prevalence of stopping binge drinking by employment transitions

Employment transition	Unadjusted prevalence of stopping binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Moved into employment*^						
Not in employed in 2010/11 and 2013/4	61	103	71	Ref. 0.63		
Moved into employment in 2013/4	47	151	120	-0.17	-0.32	-0.01
Moved out of employment						
Employed in 2010/11 & 2013/4	39	3075	2775	Ref. 0.39		
Moved into unemployment in 2013/4	37	83	72	-0.04	-0.16	+0.08
Students: moved into employment^						
Full time student in 2010/11 & 2013/4	46	76	62	Ref. 0.44		
Moved into employment in 2013/4	43	172	137	+0.01	-0.14	+0.17
Students: moved into unemployment^\$						
Full time student in 2010/11 & 2013/4	46	76	62	Ref. 0.44		
Moved into unemployment in 2013/14	59	35	25	+0.16	-0.09	+0.41
Retiring						
Employed in both 2010/11 & 2013/4	39	3075	2775	Ref. 0.39		
Retired in 2013/4	41	139	131	+0.02	-0.08	+0.12

\$ = age not included in the regression model due to homogeneity of the population

** Denotes variable significant in regression model: P<0.01. * Denotes variable significant in regression model: P<0.05.

^ The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly.

Table E12: Prevalence of starting binge drinking by employment transitions

Employment transition	Unadjusted prevalence of starting binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
		%	<i>n</i>			
Moved into employment[^]						
Not in employed in 2010/11 and 2013/4	14	212	155	Ref. 0.17		
Moved into employment in 2013/4	15	302	257	-0.03	-0.13	+0.07
Moved out of employment*						
Employed in 2010/11 & 2013/4	17	7546	7040	Ref. 0.17		
Moved into unemployment in 2013/4	9	194	163	-0.08	-0.12	-0.03
Students: moved into employment[^]						
Full time student in 2010/11 & 2013/4	30	365	314	Ref. 0.30		
Moved into employment in 2013/4	26	354	297	-0.02	-0.10	+0.07
Students: moved into unemployment**[^]						
Full time student in 2010/11 & 2013/4	30	365	314	Ref. 0.31		
Moved into unemployment in 2013/14	14	78	67	-0.19	-0.30	-0.08
Retiring						
Employed in both 2010/11 & 2013/4	17	7546	7040	Ref. 0.17		
Retired in 2013/4	13	638	598	+0.01	-0.03	+0.06

** Denotes variable significant in regression model: P<0.01. * Denotes variable significant in regression model: P<0.05.

[^] The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly.

Table E13: Prevalence of starting to meet F&V recommendations by employment transitions

Employment transition	Unadjusted prevalence of starting to meet F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
		%	<i>n</i>			
Moved into employment[^]						
Not in employed in 2010/11 and 2013/4	6	381	304	Ref. 0.06		
Moved into employment in 2013/4	8	524	437	+0.02	-0.03	+0.06
Moved out of employment[*]						
Employed in 2010/11 & 2013/4	15	10515	9379	Ref. 0.15		
Moved into unemployment in 2013/4	8	300	261	-0.06	-0.10	-0.02
Students: moved into employment[^]						
Full time student in 2010/11 & 2013/4	9	475	415	Ref. 0.10		
Moved into employment in 2013/4	14	631	495	+0.04	-0.01	+0.09
Students: moved into unemployment[^]						
Full time student in 2010/11 & 2013/4	9	475	415	Ref. 0.09		
Moved into unemployment in 2013/14	9	137	117	-0.02	-0.08	+0.05
Retiring						
Employed in both 2010/11 & 2013/4	15	10515	9379	Ref. 0.15		
Retired in 2013/4	19	643	607	+0.02	-0.02	+0.06

** Denotes variable significant in regression model: P<0.01. * Denotes variable significant in regression model: P<0.05.

[^] The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly.

Table E14: Prevalence of stopping meeting F&V recommendations by employment transitions

Employment transition	Unadjusted prevalence of stopping meeting F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
		%	<i>n</i>			
Moved into employment[^]						
Not in employed in 2010/11 and 2013/4	69	16	14	Ref. 0.75		
Moved into employment in 2013/4	65	72	65	-0.12	-0.47	+0.23
Moved out of employment						
Employed in 2010/11 & 2013/4	42	2627	2382	Ref. 0.42		
Moved into unemployment in 2013/4	42	47	43	-0.00	-0.16	+0.15
Students: moved into employment[^]\$						
Full time student in 2010/11 & 2013/4	67	59	47	Ref. 0.64		
Moved into employment in 2013/4	55	84	66	-0.06	-0.26	+0.14
Students: moved into unemployment[£]						
Full time student in 2010/11 & 2013/4	67	59	47	Ref. 0.67		
Moved into unemployment in 2013/14	67	13	10	-0.01	-0.34	+0.32
Retired						
Employed in both 2010/11 & 2013/4	42	2627	2382	Ref. 0.42		
Retired in 2013/4	35	247	239	-0.04	-0.11	+0.04

\$ = health status not included in the regression model due to homogeneity of the population

£ = age, education, and health status not included in the regression model due to homogeneity of the population

** Denotes variable significant in regression model: P<0.01. * Denotes variable significant in regression model: P<0.05.

[^] The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly.

Table E15: Prevalence of starting to meet PA recommendations by employment transitions

Employment transition	Unadjusted prevalence of starting to meet PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
		%	<i>n</i>			
Moved into employment[^]						
Not in employed in 2010/11 and 2013/4	16	315	254	Ref. 0.18		
Moved into employment in 2013/4	25	420	356	0.06	-0.01	+0.14
Moved out of employment						
Employed in 2010/11 & 2013/4	20	9495	8577	Ref. 0.20		
Moved into unemployment in 2013/4	20	266	239	0.01	-0.05	+0.06
Students: moved into employment[^]						
Full time student in 2010/11 & 2013/4	37	297	266	Ref. 0.37		
Moved into employment in 2013/4	29	415	330	-0.08	-0.17	+0.01
Students: moved into unemployment^{**}						
Full time student in 2010/11 & 2013/4	37	297	266	Ref. 0.38		
Moved into unemployment in 2013/14	15	92	81	-0.24	-0.35	-0.14
Retired						
Employed in both 2010/11 & 2013/4	20	9495	8577	Ref. 0.19		
Retired in 2013/4	14	712	678	+0.01	-0.03	+0.05

** Denotes variable significant in regression model: $P < 0.01$.

[^] The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly

Table E16: Prevalence of stopping meeting PA recommendations by employment transitions

Employment transition	Unadjusted prevalence of stopping meeting PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
		<i>n</i>	<i>n</i>			
	%					
Moved into employment						
Not in employment at both waves	52	82	65	Ref. 0.51		
Moved into employment at W5	46	176	145	-0.04	-0.20	+0.11
Moved out of employment						
Employment at both waves	46	3644	3183	Ref. 0.46		
Moved into unemployment at W5	55	80	64	+0.07	-0.07	+0.21
Students: moved into employment[^]						
Student at both waves	40	234	194	Ref. 0.39		
Moved into employment	44	303	233	+0.06	-0.05	+0.17
Students: moved into unemployment[^]						
Student at both waves	40	234	194	Ref. 0.40		
Moved into unemployment	48	62	49	+0.05	-0.14	+0.23
Retired						
Employed at both waves	46	3644	3183	Ref. 0.47		
Retired at wave 5	49	179	168	-0.05	-0.14	+0.04

[^] The base size for regression models are slightly lower than the unadjusted prevalence rates. This is because some cases were dropped in the regression model where category membership in some of the control variables predicted failure perfectly

Table E17: Prevalence of stopping smoking cigarettes by changes in equivalised household income

Household income change	Unadjusted prevalence of stopping cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	23	2194	1840	Ref. 0.23		
Income increased	22	1899	1579	-0.01	-0.04	+0.02
Income decreased						
Income stable	23	2194	1840	Ref. 0.23		
Income decreased	26	1027	880	+0.03	-0.01	+0.07

Table E18: Prevalence of starting smoking cigarettes by changes in equivalised household income

Household income change	Unadjusted prevalence of starting cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	3	9984	9000	Ref. 0.03		
Income increased	3	7684	7014	+0.00	-0.00	+0.01
Income decreased						
Income stable	3	9984	9000	Ref. 0.03		
Income decreased	3	3904	3644	+0.01	-0.00	+0.01

Table E19: Prevalence of stopping binge drinking by changes in equivalised household income

Household income change	Unadjusted prevalence of stopping binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	44	2294	2032	Ref. 0.44		
Income increased	45	1835	1601	+0.01	-0.03	+0.04
Income decreased						
Income stable	44	2294	2032	Ref. 0.44		
Income decreased	41	903	823	-0.02	-0.07	+0.02

Table E20: Prevalence of starting binge drinking by changes in equivalised household income

Household income change	Unadjusted prevalence of starting binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	14	7576	6797	0.14		
Income increased	14	5657	5073	0.00	-0.01	0.01
Income decreased*						
Income stable	14	7576	6797	0.14		
Income decreased	12	3014	2780	-0.02	-0.03	-0.00

* Denotes variable significant in regression model: P<0.05.

Table E21: Prevalence of starting to meet F&V recommendations by changes in equivalised household income

Household income change	Unadjusted prevalence of starting to meet F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	15	9599	8493	0.15		
Income increased	13	7659	6845	-0.01	-0.02	0.00
Income decreased						
Income stable	15	9599	8493	0.15		
Income decreased	15	3828	3493	-0.00	-0.02	0.01

Table E22: Prevalence of stopping meeting F&V recommendations by changes in equivalised household income.

Household income change	Unadjusted prevalence of starting to meet F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	42	2549	2319	Ref. 0.42		
Income increased	44	1895	1719	+0.01	-0.02	+0.05
Income decreased						
Income stable	42	2549	2319	Ref. 0.42		
Income decreased	45	1082	1009	+0.03	-0.01	+0.08

Table E23: Prevalence of starting to meet PA recommendations by changes in household income

Household income change	Unadjusted prevalence of starting to meet PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	16	9247	8268	Ref. 0.16		
Income increased	16	7231	6533	+0.00	-0.01	+0.01
Income decreased						
Income stable	16	9247	8268	Ref. 0.16		
Income decreased	16	3671	3409	+0.00	-0.01	+0.02

Table E24: Prevalence of stopping meeting PA recommendations by changes in household income

Household income change	Unadjusted prevalence of stopping meeting recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
Income increased						
Income stable	48	2880	2529	Ref. 0.47		
Income increased	49	2292	2008	+0.01	-0.02	+0.05
Income decreased						
Income stable	48	2880	2529	Ref. 0.47		
Income decreased	51	1213	1074	+0.04	-0.00	+0.08

Table E25: Prevalence of stopping smoking by addition of child to previously child-free household

Addition of child to household	Unadjusted prevalence of stopping cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	23	3077	2548	Ref. 0.23		
Yes	34	189	179	+0.05	-0.03	+0.13

Table E26: Prevalence of starting smoking by addition of child to previously child-free household

Addition of child to household	Unadjusted prevalence of starting cigarette smoking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	2	14218	12538	Ref. 0.02		
Yes	3	744	712	-0.00	-0.01	+0.01

Table E27: Prevalence of stopping binge drinking by addition of child to previously child-free household

Addition of child to household	Unadjusted prevalence of stopping binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	45	3127	2764	Ref. 0.45		
Yes	50	203	198	+0.07	-0.02	+0.15

Table E28: Prevalence of starting binge drinking by addition of child to previously child-free household

Addition of child to household*	Unadjusted prevalence of starting binge drinking	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	12	10622	9348	Ref. 0.13		
Yes	13	584	537	-0.04	-0.07	-0.01

*Denotes variable significant in regression model: $p < 0.05$.

Table E29: Prevalence of starting to meet F&V recommendations by addition of child to previously child-free household

Addition of child to household	Unadjusted prevalence of starting to meet F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	15	13250	11434	Ref. 0.15		
Yes	13	780	741	-0.01	-0.04	+0.03

Table E30: Prevalence of stopping meeting F&V recommendations by addition of child to previously child-free household

Addition of child to household	Unadjusted prevalence of stopping meeting F&V recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	41	3980	3595	Ref. 0.41		
Yes	49	149	147	+0.05	-0.06	+0.17

Table E31: Prevalence of starting meeting PA recommendations by addition of child to previously child-free household

Addition of child to household**	Unadjusted prevalence of starting to meet PA recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	14	13254	11596	Ref. 0.15		
Yes	17	626	622	-0.05	-0.07	-0.03

**Denotes variable significant in regression model: $p < 0.01$.

Table E32: Prevalence of stopping meeting PA recommendations by addition of child to previously child-free household

Addition of child to household	Unadjusted prevalence of stopping meeting recommendations	Bases		Average Marginal Effect (percentage point change from reference group)	95% CI lower	95% CI upper
		Weighted	Unweighted			
	%	<i>n</i>	<i>n</i>			
No	48	3899	3373	Ref. 0.48		
Yes	51	304	266	+0.08	+0.01	+0.16

*Denotes variable significant in regression model: $p < 0.05$.

Appendix F: Rapid Evidence Assessment: Search protocols

Background

Objective 3 aims to explore whether certain life transitions are related to changes in health behaviours, and if so, in what way. The following four life transitions were considered:

- Changes in relationship status – moving from being in a relationship to not being in a relationship, and vice versa
- Changes in employment – focusing on key transitions, such as moving from employment to unemployment and vice versa, moving from full time education to paid employment etc.
- Changes in income – defined as changes in income of +/- 20% between 2010/11 and 2013/4
- Adding a child to a household.

For each of the four health behaviours (smoking, drinking, F&V consumption, PA), we conducted a Rapid Evidence Assessment (REA) to identify pertinent literature and evidence relating to the relationship between each life transition and changes in each health behaviour. This meant sixteen different REAs were conducted in total. A REA is a technique recommended by the Government Social Research Unit²⁵ and is a delineated form of evidence review undertaken to establish the scope and strength of the evidence in areas where existing review evidence is limited. It uses the same principles as a broader evidence assessment in that it is conducted with clear research questions and predefined inclusion and exclusion criteria (see Table F1) but, as a rapid review, is conducted within a short time frame and thus considers fewer outputs in lesser detail.

Although sixteen different REAs were conducted in total, the search protocol was the same for each and is shown below. Searches were conducted using PubMed and University of Glasgow Advance Serial Solution, which is the University's main searching and citation database, searching print and online records held by the University and beyond. Both primary studies and systematic/critical reviews were identified and are included in our review.

Table F1: Search protocol for the REAs

Table F1: Search protocol for the REAs	
Research question	What evidence is there about the relationship between a) changes in relationship status, b) changes in employment status, c) changes in income and d) having/adding a child to a household and changes in smoking behaviour/drinking behaviour/F&V consumption/PA levels?
Methods	
Search databases:	
Academic	PubMed, University of Glasgow Advance Serial Solution.
Grey literature	None
Search terms (in title/abstract)	Change(s) + smoking + (relationship status/marital status) OR change(s) + (binge drinking/alcohol consumption) + (relationship status/marital status) OR change(s) + (binge fruit and vegetable/dietary change) + (relationship status/marital status) OR change(s) + (exercise/physical activity) + (relationship status/marital status) OR Change(s) + smoking + (employment/jobs/unemployment)OR change(s) + (binge drinking/alcohol consumption) + (employment/unemployment)OR change(s) + (binge fruit and vegetable/dietary change) + (employment/unemployment)OR change(s) + (exercise/physical activity) + (employment/unemployment) OR Change(s) + smoking + household income OR change(s) + (binge drinking/alcohol consumption) + household income OR change(s) + (binge fruit and vegetable/dietary change) + household income OR change(s) + (exercise/physical activity) + household income OR Change(s) + smoking + (childbirth/having child(ren)/parenthood) OR change(s) + (binge drinking/alcohol consumption) + (childbirth/having child(ren)/parenthood) OR change(s)

	+ (binge fruit and vegetable/dietary change) + (childbirth/having child(ren)/parenthood) OR change(s) + (exercise/physical activity) + (childbirth/having child(ren)/parenthood).
Inclusion criteria:	
Types of studies	Systematic reviews and primary studies included. Types of primary studies included: longitudinal studies; cohort studies; cross-sectional follow-up studies. Types of primary studies excluded: cross-sectional; RCTs; pilot, localised or regional intervention studies.
Types of participant	Adults aged 16 and over living in the general population (not institutions or special population groups).
Types of articles	Studies that present empirical data about changing health behaviours over time and their relationship to one of the four life transitions. Comment/discussion articles excluded.
Types of comparisons	Changing behaviour over time.
Types of outcome measure	Rates of changing health behaviours over time; variance in rates among those experiencing different life events.
Other	English only; online access online; focus on OECD countries
Data collection and analysis:	
Selection of studies	Searches will be conducted and screened according to the selection criteria by the review authors (HW & DP). The full text of any potentially relevant papers will be retrieved for closer examination. All studies which initially appear to meet the inclusion criteria but on inspection of the full text paper do not meet the inclusion criteria will be documented. Overall figures for all sixteen reviews combined are shown in below; individual results for each REA are available from the authors.
Data extraction	Data extracted for each article will include: <ul style="list-style-type: none"> • Author • Year of publication • Year of study • Country or region of study • Study type • Population/sample size • Results • Quality assessment* *see below
Assessment of methodological quality	Studies will be assessed using the Government Social Research Unit's Framework for Assessing Quality. This considers the following domains: Conceptual framing: Does the study acknowledge existing research? Does the study pose a research question or outline a hypothesis? Transparency: Is it clear what is the geography/context in which the study was conducted? Does the study present or link to the raw data it analyses? Does the study declare sources of support/funding? Appropriateness of method: Does the study identify a research design and data collection and analysis methods? Does the study demonstrate why the chosen design and method are well suited to the research question? Internal validity: To what extent is the study internally valid? Cultural/context sensitivity: Does the study explicitly consider any context-specific cultural factors that may bias the analysis/findings? Cogency: To what extent does the author consider the study's limitations and/or alternative interpretations of the analysis? Are the conclusions clearly based on the study's results (rather than on theory, assumptions or policy priorities)? Systematic reviews: Does the study describe where and how studies were selected for inclusion? Does the study assess the quality of the studies included? Does the study draw conclusions based on the reviews conducted?

Data synthesis	Summary of findings and strength of evidence tables will be produced (these are available on request from the authors). Descriptive summaries about the relationship between health behaviour change and life transitions will be generated, see below.
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Search results:

Overall, 4962 papers were identified across the 16 searches. 4673 were excluded on initial screening and 220 shortlisted for further review. Of these, 87 were duplicates between the two databases and 60 were excluded based on fuller examination of the paper (see Table F2 for details for each individual search and reasons for exclusion). In total, 73 papers were retrieved and fully reviewed.²⁵ Table F2 summarises the search results for each individual REA.

Table F2: REA search results							
Search	Total identified	Total excluded	Shortlist	Duplicates removed from shortlist	Excluded after shortlist (including reasons)	Additional studies identified in other searches	Number of studies for full review
Smoking and marital/relationship behaviour change	255	234	9	2	4 (2 analysed marital status, not change in status; 1 not OECD country; 1 only focused on 18-20 year-olds);	1	4
Smoking and employment change	499	476	24	10	7 (3 used macro data on unemployment change, not change for individuals; 1 analysed data cross-sectionally; 1 was intervention study; 1 looked at the impact of stopping smoking on employment change; 1 focused on special population group)	0	7
Smoking and income change	609	593	16	5	8 (3 looked at impact of specific US tax credit; 3 looking at macro level changes in either health behaviours or income; 1 is a review; 1 based on cross-sectional data)	1	4
Smoking and adding a child	143	124	19	5	9 (5 small base sizes <200; 1 intervention study; 2 looking at cross-sectional data; 1 about smoking during pregnancy)	0	5
Drinking and marital/relationship behaviour change	276	253	23	9	8 (7 did not look at change in marital status; 1 small base sizes (<200);	1	7
Drinking and employment change	513	417	38	25	3 (1 small base sizes (<200); 1 uses data cross-sectionally; 1 focused on specific sub group)	0	10
Drinking and income change	591	577	14	6	6 (2 focused on macro trends; 2 did not look at household income change; 1 review; 1 focused on comparisons between	1	3

²⁵ Because of the number of studies included, we have not presented a summary of each study in this report. This information is available on request from the authors.

					special population groups)		
Drinking and adding a child	115	105	10	3	0	0	7
F&V and marital/relationship behaviour change	47	43	4	1	0	0	3
F&V and employment change	135	130	5	2	3 (2 did not look at employment change; 1 focus group of US women)	0	0
F&V and income change	506	500	6	0	5 (3 looked at macro changes in income; 1 review of interventions; 1 focused on special population group)	0	1
F&V and adding a child	158	152	6	2	2 (2 did not look at diet changes)	0	2
PA and marital/relationship behaviour change	255	248	7	2	1 (did not look at PA change over time)	1	5
PA and employment change	371	352	19	10	2 (did not look at either PA change or employment change)	1	8
PA and income change	334	327	7	1	5 (3 did not look at changes in income; 1 used macro data only; 1 was comment article)	0	1
PA and adding a child	155	142	13	4	4 (3 did not include PA change/did not present results; 1 did not look at change in number of children)	1	6

Descriptive summary of findings from the REA

A) Marital/Relationship transitions

Smoking

There was mixed evidence about the relationship between marital/relationship transitions and changes in smoking behaviour. One UK-based study found no relationship between stopping or starting smoking, once other confounders were taken into account (Giordano & Lindstrom, 2010). A further study from the USA found no relationship between getting married and starting or stopping smoking though they did find that getting divorced increased the odds of smoking (Kutob et al, 2017). Two further studies, one French and one from the USA, highlighted a significant relationship between marriage and smoking, with the odds of smoking being lower among those who got married (Tamers et al, 2015; Merline & Schlenberg, 2008). Tamers et al (2015) also demonstrated a relationship between divorce and smoking, with the odds of smoking being lower among those who got divorced (the converse pattern to that reported by Kutob et al, 2017).

Overall, there is some evidence that marital or relationship transitions are associated with changing smoking behaviour, but the evidence is mixed and the patterns are not consistent between studies. Some studies found no relationship with marriage, others found a decrease in smoking among those who got married. The only UK-based study located through our review showed no relationship between any marital/relationship transition and smoking behaviour once changes in other factors, like income and education change, were taken into account.

Drinking

Eight studies were included in the review, including five from the USA. Four of the eight studies found that getting married or entering a new relationship was associated with reduced alcohol consumption, including one study from the UK (Merline et al, 2008; Kretsch & Paige, 2014; Vladimirov et al, 2016; Staff et al, 2014). One other study found no relationship between marriage and alcohol consumption (Molander et al, 2010); and two studies found that among older people marriage and remarriage increased alcohol consumption (Reczek et al, 2016; Kutob et al, 2017).

The relationship with divorce or leaving a relationship was mixed. Of the studies that looked at this (5 out of the 8), two found no relationship between becoming divorced and changing alcohol consumption (Molander et al, 2010; Kutob et al, 2017), two found that alcohol consumption increased among those who became divorced or left a relationship (Reczek et al, 2016; Kretsch & Paige, 2014) and one study of older people in Finland found that leaving a relationship was a predictor of increased consumption among men but of decreased consumption among women (Vladimirov et al, 2016).

There appears to be a relationship between marital/relationship transitions and changes in alcohol consumption, though the findings are by no means consistent across studies. Half of the studies reviewed found that marriage reduced alcohol consumption and half of the studies which considered divorce/separation found that this increased alcohol consumption. The studies reviewed looked at patterns for different genders and age cohorts and potentially highlight that patterns may differ particularly for older women.

F&V

Only three studies meeting the inclusion criteria for our review looked at marital/relationship transitions and changing fruit and vegetable consumption. The evidence was mixed. One Australian study found no relationship between marital transitions and changing dietary quality (Smith et al, 2017). One study of mid-age/older adults in Norfolk, UK, found a relationship for men but not women, with men who became separated, divorced or widowed reducing their fruit and vegetable consumption (Vinther et al, 2016). A final study from Switzerland found that vegetable intake reduced for those who became partnered (Hartmann et al, 2014).

There seems to be a paucity of evidence about the impact of marital/relationship transitions on fruit and vegetable consumption and what evidence exists is mixed. The single UK-based study of older people showed different impacts for men and women.

PA

Two systematic reviews were identified examining the relationship between physical activity changes and marital/relationship transitions (Enberg et al, 2012; Allender et al, 2008). Both reviews had similar results, with the evidence being mixed. Enberg et al (2012) included 12 studies, which showed mixed results. Three studies showed no relationship between marital/relationship transitions and physical activity whereas three further studies, focusing on younger women, showed a decline in physical activity among those who became married. Other studies, however, showed that starting a relationship or getting remarried (among older women) was associated with an increase in physical activity.

Looking at the impact of separation or divorce, studies included in the review by Enberg et al (2012) tended to show that physical activity increased after divorce among men but that results for women were mixed. Two further studies, not included in Enberg et al's (2012) review, were considered. One showed that among young women, odds of decreasing levels of physical activity were higher among those who became married. Among middle aged women, widowhood was associated with an

increase in physical activity though this was not observed among older women (Brown et al, 2011). The final study showed no relationship between marital/relationship transitions and physical activity, though the study may have been underpowered to detect such changes (Hull et al, 2010).

Overall, there appears to be some emerging evidence that, among young women, marriage is associated with lower levels of physical activity and that, among men, divorce is associated with an increase in physical activity. However, these patterns were not universal across all studies considered and there were no recent studies identified focusing on patterns of change in the UK.

B) Employment transitions

Smoking

Seven studies examined the relationship between employment transitions and changing smoking behaviour, two of which looked at the impact of retirement and found that retiring was associated with stopping smoking (Lang et al, 2007; Tamers et al, 2015). Lang et al (2007) used the English Longitudinal Study of Aging to explore this. The other five studies (including one using UK data; Giordano & Lindstrom, 2011) looked at the relationship between other employment transitions and smoking behaviour. Four studies considered the relationship between becoming unemployed or involuntary job loss and smoking behaviour, and three of these found this to be associated with an increase in smoking (Golden & Perreira, 2015; Arcaya et al, 2015; Giordano & Lindstrom, 2011). However, Arcaya et al (2015) found this association for men and not women. The fourth study found no association between employment transitions and changing smoking status, though the authors did note that smoking rates increased most among chronically unemployed women (those who were unemployed across a number of years) (Virtanen et al, 2008). A final study found that moving into employment increased the odds of smoking, which the authors interpreted as people having more money with which to purchase cigarettes (Blakely et al, 2014).

Overall, there is some broadly consistent evidence that becoming unemployed or remaining unemployed is associated with an increase in smoking.

Drinking

Eleven studies were reviewed which explored the relationship between employment transitions and alcohol consumption, two of which found no relationship between any employment transition once other cofounders had been taken into account (Vladimirov et al, 2016; van der Deen et al, 2014). Five studies looked at becoming unemployed, three of which found a relationship between becoming unemployed and increased levels of alcohol consumption (Popovici & French, 2013; Bosque-Prous et al, 2015; Molander & Yorke, 2010; Virtanen et al, 2008), though Virtanen et al (2008) only observed this for men and not women. The fifth study found that becoming unemployed lead to a one-unit reduction in alcohol consumption (Arcaya et al, 2014).

Three studies examined entering employment and found mixed results. Virtanen et al (2008) found, among men, that an upward employment trajectory (i.e. moving from unemployment to employment or ad hoc employment to more permanent employment) was associated with a decrease in alcohol consumption – but no such pattern for women. Colell et al (2014) found that women who became employed after being ‘home makers’ increased their alcohol consumption. Staff et al (2013) also found that employment was associated with increased alcohol intake. Zins et al (2011) looked at the transition from employment to retirement (among employees of Electricité de France-Gaz de France) and found an increase in the proportion of heavy drinkers around the period of retirement among both men and women, followed by a decrease post retirement - with some variation by socioeconomic category.

There is evidence that changing employment status is related to changing alcohol consumption. Broadly speaking, it appears that becoming unemployed is associated with an increase in consumption whereas the pattern for becoming employed is more mixed. As previously, there is some evidence that patterns differ for men and women and that these associations may be related to life stage and prior economic activity.

F&V

No studies were identified that looked at the relationship between employment transitions and fruit and vegetable consumption.

PA

Evidence from a systematic review (Engberg et al, 2012) reported that starting paid employment was associated with decreasing levels of physical activity among younger men and women, that retirement was associated with increased levels of physical activity and that becoming a student was associated with reduced levels of physical activity. A further five studies and one additional review were located through the REA and broadly confirmed these findings (Koeneman et al, 2012; Feng et al, 2016; Virtanen et al 2008; Hivensalo et al, 2011; Barnett et al 2013; Brown et al, 2011), although Barnett et al (2013) pointed out that changes in PA among those retiring very much depended on the type of job people were retiring from. Barnett et al (2013) found that retirement was associated with a reduction in occupational and travel activity and an increase in recreational and household activity. The net pattern was actually a decrease in PA overall. This was the sole study reviewed based on UK data.

Across all studies, there was very little insight into the impact of unemployment upon PA. One study among older adults saw light levels of PA increase among older adults who became unemployed (Hivensalo et al, 2011) whereas another study (Virtanen et al, 2008) saw a reduction in PA among women who became unemployed, though this pattern was not evident for men.

Broadly speaking, moving into paid employment seems to be associated with a reduction in PA whereas becoming retired is associated with an increase in leisure time PA. The net impact on overall levels of PA among those retiring is contingent on what their occupation was prior to this. There is little evidence about the impact of unemployment on PA.

C) Income transitions

Smoking

Very few studies were identified that looked at the impact on individual changes in personal or household income and smoking behaviour. Of the four studies reviewed, three found no association between changing income and changing smoking status (Giordano & Lindstrom, 2011; Golden & Perreira, 2015; Young-Hoon, 2012). Blakely et al (2014) found that the odds of smoking increased as income increased and, correspondingly, that the odds of smoking decreased as income decreased. This was broadly supported by Young-Hoon (2012) who overall found no association between income change and smoking behaviour unless the income change moved someone out of poverty. Those whose increase in income moved them out of poverty were less likely to stop smoking than those whose income stayed the same.

Drinking

As with smoking, there were few studies that looked at the relationship between income change and alcohol consumption change. Those that did showed mixed results. One study found no relationship between changing income and alcohol consumption (van der Deen et al, 2014) though noted an

increase in subjective individual deprivation was associated with slight increase in average alcohol consumption. Similarly, Kalousova & Burgard (2014) found that a perceived reduction in economic resources was associated with an increase in harmful and hazardous levels of drinking whereas Olafsdottir and Asgeirsdottir (2015) found that reduced incomes were associated with reductions in alcohol consumption among men but not women.

F&V

Only one study examined the relationship between changing income and diet. This study looked at the impact of changing household income on children's diet and so is only indirectly relevant for this project. The authors found no relationship and concluded that changes in income do not predict changes in diet very well (Skafida & Treanor, 2014).

PA

Engberg et al's (2012) systematic review of factors associated with changing PA included just one study which looked at the relationship with changing income. This focused on women and found that a decrease in income was associated with a decrease in PA among younger women, whereas among older women, a decrease in income was associated with an increase in PA (this may be related to changing employment status, moving from employment to retirement). No further studies were identified.

D) Adding children/having children

Smoking

There is a well-established body of literature examining changes in smoking behaviour during pregnancy. The REA focused on longitudinal evidence for continued behaviour change post-partum, as this best reflects our analysis for objective 3, whereby we are looking at behaviour change over a three year period.

The REA identified five studies, including one critical review. All studies noted that having a child/pregnancy was associated with changes in smoking behaviour but that often this did not lead to sustained behaviour change. Among smokers who quit during pregnancy, resumption of smoking post-partum was common. Martin et al (2008) estimated that 60% of smokers who quit during pregnancy started smoking again post-partum. Similar patterns were found by Gilbert et al (2015) in their study of Canadian first-time mothers. Interestingly, Martin et al (2008) also found that 3% of those who were non-smokers pre- and during pregnancy started smoking post-pregnancy. Mumford and Lie (2016) categorised mothers into five different groups based on their smoking status over a five year period. 70% of mothers were persistent non-smokers but 12% were persistent smokers. The rest had variable smoking behaviour, smoking prior to pregnancy, stopping during pregnancy and then seeing a smoking relapse at some point in the next five years.

Common correlates of smoking resumption were: living with other smokers, whether the mother continued to breastfeed (or had ever breastfed) and alcohol consumption (Meernik et al, 2015; Martin et al, 2015; Mumford & Liu, 2016). Only one study was identified that looked at the impact of having a child upon the smoking behaviour of partners. This study saw a slight reduction in smoking among partners during pregnancy but that quit rates were very low compared to women and, as with women, a high degree of resumption of smoking post-partum (Kaneko et al, 2008).

Having a child is clearly associated with changes in smoking behaviour, but there are a range of trajectories evident and positive behaviour change tends not to be sustained for the majority. There appears to be little evidence on the impact of having a child on the smoking status of partners.

Drinking

There was a fairly consistent pattern among the articles reviewed that alcohol consumption reduced among those who became parents. However, one study of alcohol consumption among mothers in Norway found that their alcohol consumption increased post-partum compared with the three months prior to pregnancy (Mellingen et al, 2015). It is unclear whether the women reduced their alcohol consumption whilst trying to conceive and thus whether this influenced results.

The association between parenthood and reduced alcohol consumption was subject to some mediating factors. For example, Staff et al (2014), using UK data, noted that changes in alcohol consumption depended on the age of the child, with alcohol use being lower when the parent resides with a child under the age of 5 compared with those who do not. They also noted that changes in number of units of alcohol consumed were related to the age of the child. The authors stated that:

“Heavy-daily drinking was less likely when respondents resided with young children. Women, but not men, were also less likely to drink heavily when they resided with school-aged children (i.e. ages 5–16). Residing with older children was not related to changes in heavy-daily drinking....men in particular showed a slight increase in alcohol consumption when they resided with older children (i.e. ages 17–21)”.

Mellingen et al (2015) in a study of Norwegian mothers noted that those who were married increased their frequency of consumption the most whilst those who were single increased their frequency the least. Single mothers, however, had a greater increase in number of units consumed than other mothers, suggesting that they consumed more alcohol on the days they drank. For one study in the USA, results varied based on the age at which people became parents. For those becoming parents in their early twenties, alcohol consumption reduced. Those who became parents as adolescents saw their alcohol consumption increase (though it is not clear whether this is associated with the legal age of consumption) (Little et al, 2009).

F&V

Only two studies were identified which examined the relationship between becoming parents and changes in F&V consumption. These showed mixed results. One study from the USA found no relationship between becoming a parent and changes in F&V intake. However, this study looked at changes over a seven year period which may have been too long to detect any shorter terms changes (Laroche et al, 2012). Hartmann et al (2014) found different relationships for men and women. Among women, becoming a parent was associated with an increase in vegetable (but not fruit) consumption whereas among men, it was associated with a decrease in vegetable (but not fruit) consumption.

PA

Engberg et al's (2012) systematic review of evidence relating to changes in PA included focus on pregnancy and having children. Of the eight studies included in Engberg et al's review, four found that PA levels decreased post pregnancy compared with pre-pregnancy levels for mothers. Two studies found no significant differences and the two other studies looked at pre-pregnancy to pregnancy changes. Engberg et al (2012) also noted how the type of activity that mothers take part in may change, with some studies reporting that new mothers had lower levels of occupational activity and participation in formal sports and exercise but increased participation in activities like walking and household activity.

Two further studies, not included in Engberg's review, were included in the REA. These broadly confirmed the association between adding a child to the household and a reduction in PA (Brown et al, 2011; Hull et al, 2010). Hull et al (2010) noted a different pattern for men and women. Among

men, the addition of the first child to a household was associated with a decrease in PA but there were no changes for women. However, among women, adding a subsequent child to the household was associated with a decrease in PA. The equivalent pattern was not observed for men. In this study, the major change for men seems to be adding the first child whereas for women it is adding a subsequent child.

Finally, two qualitative studies explored reasons and motivations for PA change after having children. Garfield et al (2010) explored attitudes to PA among American fathers, who stated that having children motivated them to stay fit and that fitness improved because they 'ran around' more after their kids. Hamilton and White's (2010) exploration of PA change with parents displayed different views, with parents reporting general declines in activity for a variety of reasons, though also noting the switch from formal to informal forms of activity.