tion of a broader range of interests and perspectives, rather than relying on key informant groups.

Second, we believe more emphasis should be put on the health inequalities relating to transport policy, following the Government’s emphasis on reducing inequalities in health.3 The construction of a population profile as part of the preparatory methods would help to focus on the different health needs of population sub-groups. This would allow identification of the health impacts likely to be borne by the various sub-groups of the Merseyside population. For instance, Edinburgh’s HIA looked at young families, adolescents, elderly people, and working and unemployed people, living in affluent and deprived areas of Edinburgh.2 Other examples might include ethnicity, and household amenities, characteristics and tenure.

We feel that these measures might be incorporated in future HIAs of public policy in a particular area, leading to richer results that are more sensitive to the needs of, and impacts on, the various population sub-groups within that area. Let’s put the ‘public’ back into public policy.

References

Yours faithfully,
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The health of students

Sirs,

Stewart-Brown et al.1 illustrate neatly a number of methodological problems of survey studies. The use of historical controls is fraught with problems. The main two are secular trends and equivalence of methods. Their Figure 2 illustrates both the long-term increase in prevalence of long-standing illness, disability or infirmity and the differences in prevalence between different types of survey. Although there were differences in the formulation of a few questions in the SF-36 in the 1997 local population survey, this does not make comparison between the students and the 1991–1992 local population surveys more appropriate. Those involved with survey design, whether repeated cross-sectional surveys or follow-up of a cohort, have a dilemma. Improving a question because of evidence of previous poor wording or changed circumstances must be weighed against loss in continuity when studying time-trends.

I am not surprised that many students are worried by their studies and finances. Only one-fifth of the students were aged >25 but this was presumably not the case in the local surveys. Is it possible to analyse the local population surveys by age groups 18–24 and 25–34 or to obtain an age-matched sample from within the local population survey? Worries and health problems vary with age, so the comparison surveys may be misleading in this way.

Most of the discussion in the paper by Stewart-Brown et al. is taken up with the issue of low response rates. However, as 49 per cent of their samples replied, their results show robustly a minimum prevalence of problems (of half the values stated in the results) that is still higher than desirable. Perhaps the most appropriate public health response is to campaign for the reinstatement of student grants. This would also help to reduce inequalities in access to higher education, particularly for longer courses, such as medicine.

Reference

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Reply

Sirs,

Dr Mindell makes some important points in her letter, one of which is that the sample of students who responded to our survey had an age distribution that was different from that of the comparison group. She is quite right that this important potential confounding variable needs to be taken into account in interpreting our results. However, before publishing we ran a series of regression analyses on the combined datasets comparing the SF-36 scores, long-standing illness prevalence, and the frequency of worries between students and people who were not students, adjusted for age and sex and social class. After this adjustment most differences were unchanged and some increased slightly. This suggested to us that our results were not