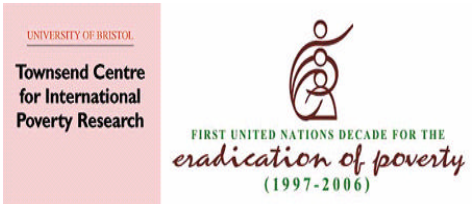
# Jersey Health Survey

**David Gordon**
**Liz Lloyd**
**Pauline Heslop**

**University of Bristol**
8 Priory Road
Bristol BS8 1TZ
United Kingdom



# Contents

# PREFACE

The aim of public health is to profoundly influence both the policies and actions needed to improve the quality of life of the population. Measuring quality of life and the aspects of health, which contribute to our general well-being, is not usually part of routine data collection. It requires a separate exercise. Jersey Health Survey was designed to give a baseline measure on quality of life, health, and a range of factors which influence our health.

The data collection for the Jersey Health Survey was undertaken in 1999. Preliminary results were available last year. There has been a necessarily long period of data validation and analysis. I am very pleased to publish this major report prepared by the research group lead by David Gordon at Bristol University.

The steering group for the survey sought collaboration with an academic department for two main reasons. The first was to assure the quality of the project – the design of the questionnaire, the methodology, and the analysis. The second was to provide an external analysis and comment on the key aspects of health and quality of life in Jersey. I am very grateful to David Gordon, Liz Lloyd, and Pauline Heslop for their report which reflects their enthusiasm for the project, careful analysis, and a genuine interest in the life of the island.

This is also a good time to say thank you again to all the people of Jersey who took part, and completed a lengthy questionnaire. Judging by many comments, the opportunity to contribute was welcomed.

We agreed not to include a set of recommendations about policies and initiatives, which would address some of the issues raised by the information in the report. This is because external prescriptions for change are most often disregarded. Rather it is intended to invite relevant States Departments and other agencies to adjust or develop strategic plans to tackle those issues in the light of the evidence. Since real progress will not be made without the key sectors working together in partnership, the big challenge will be to find a practical way to ensure that happens.

John Harvey
Director of Public Health Services
September 2001

Terms - throughout this report the term "highly significant" is used when the likelihood of the findings being due to chance were less than one in a thousand. Statistically, this is expressed as $p < 0.001$.

The term "significant" is used when the likelihood of the findings being due to chance were less than one in a hundred. Statistically, this is expressed as $p < 0.01$.

The term "borderline significance" is used when the likelihood of the findings being due to chance is less than one in twenty. Statistically, this is expressed as $p = <0.05$.

Where the report says there is "no significant difference" the likelihood of the results being due to chance are greater than one in twenty ($p > 0.05$).

# Acknowledgements

We would like to acknowledge the help, advice and encouragement of Dr John Harvey who made this research possible. Pamela Barker provided us with excellent help and support throughout this project and undertook the hard work of helping develop the sampling frame and inputting and checking the survey data to ensure that it is of the highest quality. We wish to thank Terjinder Manku-Scott from the University of Bristol for help with the interviewer training and all the telephone interviewers for their hard work.

We acknowledge the help and advice of all the members of the steeringgroup and would like to thank Christina Allan and Nick Heather of the Northern Regional Drug and Alcohol Service for help and advise with the AUDIT questionnaire. George Ellison from London University (Institute of Education) provided us with helpful information on the health effects of the occupation during World War II.

Finally, we would like to thank Helen Anderson for editing and correcting this report.

**The project steering group:**

Jill Birbeck, Executive Officer, Public Health Services
Mike Entwistle, Director of Strategic and Performance Management, Health & Social Services
John Harvey, Director of Public Health Services
Steve Harvey, Director of Health Promotion
Ed Sallis, Principal, Highlands College
Bill Saunders, Director, Alcohol and Drugs Service, Health & Social Services (until June 2000)
Janice Waddell, Policy Principal, Employment and Social Security

# Section 1

# The Health of the Population

## Introduction

In 1999, the States of Jersey Health and Social Services, in collaboration with the Department of Employment and Social Security, undertook a health survey of the adult population. The aims of the survey were:

- To contribute to health and social need assessment
- To provide a baseline for monitoring the health promotion strategy and further strategic programmes to improve health
- To inform the priority setting in the context of allocating limited resources
- To provide a tool for evaluation of programmes and projects
- To provide information to influence the policies of other States departments and other sectors
- To raise the profile of health issues with local people.

The survey questionnaire was posted to 3,445 individuals (aged 18 years or over) who were identified through an initial short interview with heads of households. The households had been selected at random from a sample frame created by Public Health Services from the 1999 Jersey Almanac. The overall response rate to the questionnaires was 60% (n=2,019). Comparison of the responders with data from the 1996 Census showed an under-representation of young men aged 18-29 and the very elderly (80+). These differences have been taken account of by weighting the data from the Jersey Health Survey (JHS) by age, sex and household type to ensure that they are representative of the population as a whole.

### Measuring health and social well-being

The strategy of Health & Social Services for 2001-2005, *Improving health and social services*, aims to meet the health and social care needs of the people of Jersey, through **promoting the health and well-being of individuals, families, and the community;** providing prompt, high quality services based on assessed need and agreed entitlement; and protecting the interests of the frail, vulnerable and those whose need are greatest.

In order to provide a baseline for monitoring the health and social well-being of a population, a standardised, generic measure of health was needed that would facilitate the collection of a common data set for reference purposes. Since the 1970s, a number of instruments have been designed to be used as general purpose measures of health, independent of diagnostic categorisation or disease severity. Most of these measures, however, have been country-specific and their validity for use as cross-cultural tools has been called into question (Anderson *et al*, 1993). An exception to this is the EuroQol EQ-5D questionnaire which was developed by an international research network established in 1987.

From the outset, the EuroQol Group has been multi-country, multi-centre and multi-disciplinary. The focus of EuroQol has been global and one of its key aims was to create the capacity to generate cross-national comparisons (Brooks, 1996). The EuroQol questionnaire was piloted in England, the Netherlands, Norway, Sweden and Finland and, following further developmental work, has been used in population surveys in the UK, Spain, Germany and Canada (Kind *et al*, 1998). Exploratory studies in non-western cultures (in Eastern Europe, Japan, Thailand and among Bangladeshis living in England) have also demonstrated its acceptability (Brooks, 1996). The steering group of the JHS decided to include the EuroQol questionnaire because it provides a validated, repeatable measure of health status that has the potential for international comparisons. Further, it was originally designed to be self-completed by the respondent, making it ideal for use in a postal survey.

The EuroQol EQ-5D is a two-part measure. The first part is a descriptive system which defines current health state in terms of five dimensions:

- Mobility
- Self-care
- Usual activities
- Pain/discomfort
- Anxiety/depression

Each dimension has three levels of severity (no problem; moderate problems; extreme problems) and respondents select one level of severity for each dimension to describe their current health.

The second part of the EuroQol EQ-5D consists of a vertical 20cm, 0-100 visual analogue scale (VAS) like a thermometer, where 0 represents the worst imaginable health state and 100 represents the best imaginable health state. The respondent is asked to mark a point on the scale to reflect their overall health on that day. Together, the two parts of the EuroQol EQ-5D provide descriptive information about each of the five EuroQol dimensions and quantitative information about the respondents rating of their own health.

A number of other measures of health assessment were used in the JHS, in conjunction with the EuroQol questionnaire. Firstly, respondents were asked to state whether, over the past twelve months, they thought that their health on the whole had been 'good', 'fairly good' or 'not good'. Secondly, respondents were asked about 'any long-standing illness, disability or infirmity' ('long-standing' was explained as meaning anything that had troubled the respondent over a period of time or was likely to affect the respondent over a period of time). Those respondents who answered 'yes' to the question about long-standing illness were then asked the name of the condition that affected their health and whether it limited their activities in any way. This General Health Question (GHQ) and Limiting Long Standing Illness Question (LLTI) have been asked for over 25 years in the annual British General Household Survey (GHS) and both were asked in the UK 2001 Census.

Finally, a series of twelve questions was asked in the JHS that related to the mood and affect of the respondent. Together, these questions comprise the short-form General Health Questionnaire (GHQ-12) which is commonly used as a screening tool to determine anxiety and depression

(Goldberg, 1972). The response categories to the GHQ were coded 0-0-1-1 with possible scores ranging from 0 (the lowest probability of having problems of anxiety or depression) to 12 (the highest probability). A score of 4 or above was suggestive of anxiety or depression.

**General health**

Over half (57%) of respondents to the JHS reported their health over the past twelve months to be 'good', with a further 35% of respondents stating that it had been 'fairly good'. Most (63%) reported no long-standing illness, disability or infirmity (referred to as long-standing illness for brevity) that had troubled them or was likely to affect them, over a period of time. However, just under a quarter of all respondents (24%) stated that they had a long-standing illness that limited their activities in some way.

Table 1.1 compares the results from the JHS with those from the British 1998/1999 General Household Survey (GHS). The rates of long term illness and limiting long term illness (LLTI) are almost identical in Jersey and Britain. There are differences in the rates of general health, with people in Jersey slightly less likely to report their health to be 'good' than in Britain (57% compared with 59%). Conversely, the Jersey population was also significantly less likely to rate their health as 'not good' than the population of Britain (8% compared with 14%).

**Table 1.1: Comparison of general health rates and long term health rates in Jersey and Britain**

| **Health question** | **JHS** (N=2,019) | **GHS** (N=15,877) |
|---|---|---|
| | **%** | **%** |
| *General health* | | |
| Good | 57 | 59 |
| Fairly Good | 35 | 27 |
| Not Good | 8 | 14 |
| | | |
| *Long-term illness* | | |
| Yes | 37 | 38 |
| No | 63 | 62 |
| | | |
| *Limiting long-term illness* | | |
| Yes | 24 | 24 |
| No | 76 | 76 |

Note: Jersey results are from people at least 18 years old. British GHS results are from people at least 16 years old.
Source: Bridgewood *et al* (2000).

The overall mean self-rated health status of Jersey respondents was 76.7 on the EuroQol VAS. This is lower than that recorded in the UK national survey and in samples of the Swedish and US

populations but higher than the mean VAS score recorded in a study of the Catalan general population (Table 1.2).

**Table 1.2: Mean EuroQol VAS scores for different population groups**

| Survey | Mean EuroQol VAS Score | Number in survey | Reference |
|---|---|---|---|
| Sweden (1989) | 85.4 | 208 | Brooks *et al*, 1991 |
| United Kingdom (1993) | 82.5 | 3,395 | Kind *et al*, 1998 |
| United States | 82.2 | 427 | Johnson and Coons, 1998 |
| Jersey (1999) | 76.7 | 2,019 | JHS |
| Catalan (Spain) (1994) | 71.1 | 12,245 | Badia *et al*, 1998 |

Two fifths (40%) of respondents to the JHS reported one or more problems (moderate or extreme) on at least one of the EuroQol dimensions. Table 1.3 shows the percentages of respondents reporting a problem in each EuroQol dimension and comparative figures from the UK national survey. A *moderate* problem on at least one dimension was reported by almost two fifths of respondents to the JHS, whereas fewer than 4% reported an *extreme* problem on at least one dimension. This pattern was similar to that of the UK. In the Jersey, UK, US and Catalan surveys, the dimension that respondents most frequently reported problems in was that of pain/discomfort (30% in the JHS; 29% in the UK survey; 40% in the US survey; 26% in Catalan). Over a third more respondents reported this to be a problem than any other dimension. The second most frequently reported problem in all four surveys was that of anxiety/depression (20% in the JHS; 19% in the UK survey; 27% in the US survey; 12% in Catalan).

The proportion of Jersey residents (20%) reporting some anxiety or depression on the EuroQol dimension was rather more than that assessed as being depressed using the GHQ-12 (12%). This is a similar pattern to that found in the Catalan study which also used both the EuroQol questionnaire and the GHQ-12. Twelve per cent of respondents in Catalan reported some anxiety or depression on the EuroQol dimension but only 8% were assessed as being depressed using the GHQ-12.

**Table 1.3: Percentages of respondents to the 1999 JHS reporting a problem in each EuroQol dimension. Comparative figures are given for the 1998 *Guernsey Healthy Lifestyle Survey* and a 1993 UK survey**

| EuroQol dimension | Moderate problem (%) | | | Extreme problem (%) | | | Any problem (%) | | |
|---|---|---|---|---|---|---|---|---|---|
| | JHS | GHLS | UK | JHS | GHLS | UK | JHS | GHLS | UK |
| Pain/discomfort | 28 | 34 | 29 | 2 | 2 | 4 | 30 | 36 | 33 |
| Anxiety/depression | 18 | 36 | 19 | 1 | 2 | 2 | 20 | 38 | 21 |
| Mobility | 14 | 12 | 18 | 0.1 | 0.1 | 0.1 | 14 | 12 | 18 |
| Usual activities | 13 | 9 | 14 | 1 | 1 | 2 | 14 | 10 | 16 |
| Self care | 3 | 1 | 4 | 0.2 | 0.1 | 0.1 | 3 | 1 | 4 |
| Any problem | 39 | | 42 | 4 | | 6 | 40 | | 43 |

Note: Sample size in Jersey was 2,019 and in UK was 3,395. There were 919 responses to the Guernsey survey but only 790 responses to the EuroQol questions
Source: Goddard *et al* (1998); Kind *et al* (1998)

It is clear from Table 1.3 that, for all five health problems measured by EuroQol, the Jersey population had similar rates of ill health to the UK population. A more positive comparison might have been expected given the higher average income and standard of living of the Jersey population compared with the UK. However, the results from the 1998 *Guernsey Healthy Lifestyle Survey* show a very different comparative pattern of ill health. There were much higher rates of pain/discomfort and anxiety/depression on Guernsey than Jersey but lower rates of mobility, self care and problems with usual activity problems. However, the Guernsey results need to be treated with some caution as the survey did not follow the full EuroQol protocol and omitted the VAS question and this may have distorted the results. The Townsend Centre for International Poverty Research at the University of Bristol undertook a survey of standards of living on Guernsey in February/March 2001 which included the full set of EuroQol questions and fully comparative results will become available in the near future.

**Mental health**

There appear to be significant numbers of people suffering from anxiety and depression on Jersey. However, the Jersey population as a whole is relatively happier and less anxious than city dwellers in other parts of the world. The mean score on the GHQ-12 for JHS respondents was 1.18 which compares favourably with that of respondents from 15 cities who completed the GHQ-12 in a 1992 study by the World Health Organisation (WHO) (Goldberg *et al*, 1997). The mean score for each of these study centres is shown in Table 1.4. The average GHQ-12 score of people in Manchester was over twice as high as it is in Jersey (2.78 compared with 1.18), indicating that the population of Manchester suffers on average from considerably more mental stress than the population of Jersey.

In each centre (other than for the JHS) consecutive patients attending clinics were asked to complete the GHQ-12. All participants had to fulfil the following criteria:

- be older than 17 years of age
- not be too ill to participate
- be able to communicate, and
- have a fixed address

The questionnaire was translated into 11 different languages for the study and was self-completed in all centres apart from Bangalore, where most of the respondents were illiterate and had it read out to them. A total of 25,916 respondents completed the GHQ-12 in the 15 centres.

**Table 1.4: Mean scores on the GHQ-12 for respondents from 15 cities in a WHO study in 1992 and Jersey in 1999**

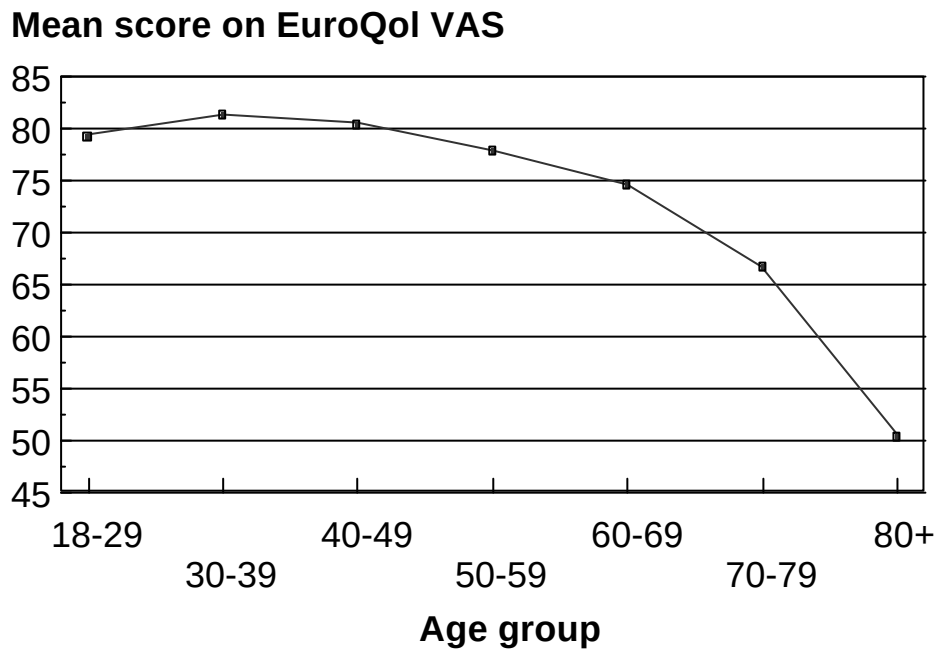
| City/country | Mean score on GHQ-12 |
|---|---|
| Ibadan, Nigeria | 1.09 |
| Nagasaki, Japan | 1.12 |
| **Jersey Health Survey** | **1.18** |
| Shanghai, China | 1.19 |
| Ankara, Turkey | 1.35 |
| Seattle, USA | 1.67 |
| Verona, Italy | 1.82 |
| Athens, Greece | 1.89 |
| Mainz, Germany | 2.11 |
| Paris, France | 2.14 |
| Groningen, Netherlands | 2.21 |
| Rio de Janeiro, Brazil | 2.32 |
| Berlin, Germany | 2.56 |
| Manchester, England | 2.78 |
| Bangalore, India | 3.03 |
| Santiago, Chile | 3.66 |

**Health and age**

The rates of reported health problems in the JHS increased significantly with age. Just 5% of those aged 18-29 years reported that their health during the past year had been 'not good'. However, this proportion increased steadily with age and 19% of those aged 80 or more reported their health over the past year to be 'not good'. The differences between the age groups was statistically highly significant. Similarly, a statistically significant difference was found between the age groups in the reporting of long-standing illness. Here, 11% of the 18-29 year old age group reported long-standing illness that limited their activities. The proportion increased with each successive age group to 56% of respondents aged 80 or more.

Figure 1.1 shows the mean self-rated health status of JHS respondents by age group. The mean value was at its maximum (81 out of a possible 100) in the 30-39 year old age group and then decreased to 50 in the oldest age group. The rate of decrease in self-rated health was greatest after the age of 60.

**Figure 1.1: Mean self-rated health status of JHS respondents using the EuroQol Visual Analogue Scale (VAS), by age group**




In general, the rates of reported problems in each of the EuroQol dimensions increased with age - with the exception of the anxiety/depression dimension, for which there was a difference between the age groups of just borderline significance . This was a similar pattern to that found in the UK and US surveys. In the Catalan survey, older respondents were more likely to report problems on all of the EuroQol dimensions. There was no significant difference between the Jersey age groups in the results of the GHQ-12 assessing depression.

**Health and gender**

Overall, a greater proportion of men (61%) than women (54%) in the JHS reported themselves to be in good health during the past year. This finding was highly significant. This was particularly so in the oldest age group where 32% of men described their health during the past year to be 'good', compared with just 18% of women. However, there was no significant difference in the gender of those reporting long-standing illness nor was there any significant difference in the mean EuroQol VAS score of men and women in the Jersey, UK or US populations. In the Catalan survey,

however, the EuroQol VAS did discriminate between men and women, where women rated their own health as significantly worse than men.

**Table 1.5: Percentages reporting health problems (either moderate or extreme) in the JHS, in each age group for each of the EuroQol dimensions, by sex**

| | Age group | | | | | | |
|---|---|---|---|---|---|---|---|
| **EuroQol dimension** | **18-29** | **30-39** | **40-49** | **50-59** | **60-69** | **70-79** | **80+** |
| *Pain/discomfort* | | | | | | | |
| Men | 11 | 25 | 30 | 35 | 39 | 58 | 81 |
| Women | 13 | 20 | 29 | 34 | 39 | 49 | 71 |
| *Anxiety/depression* | | | | | | | |
| Men | 21 | 19 | 19 | 17 | 12 | 21 | 16 |
| Women | 16 | 13 | 28 | 20 | 21 | 25 | 36 |
| *Mobility* | | | | | | | |
| Men | 6 | 7 | 7 | 13 | 24 | 37 | 48 |
| Women | 4 | 6 | 12 | 7 | 24 | 39 | 68 |
| *Usual activity* | | | | | | | |
| Men | 6 | 8 | 7 | 13 | 22 | 32 | 46 |
| Women | 5 | 9 | 12 | 11 | 24 | 29 | 56 |
| *Self-care* | | | | | | | |
| Men | 0.5 | 3 | 0 | 2 | 3 | 7 | 15 |
| Women | 1 | 1 | 2 | 0 | 4 | 5 | 24 |

As Table 1.5 shows, the JHS rates of reported problems (either moderate or severe) in each age group, except the oldest, for the EuroQol dimensions of mobility, self-care, usual activities and pain/discomfort were similar for each sex. The rate of reported anxiety/depression was greater for women after the age of 40. For each EuroQol dimension apart from pain/discomfort, women in the oldest age group (80 years and older) reported problems far more frequently than men of the same age. For the EuroQol dimension of pain/discomfort, however, men in the oldest age group reported a problem more frequently than women of the same age.

A small difference, of borderline significance, was found between men and women in the measurement of depression using the GHQ-12. Eleven percent of men were assessed as being depressed, compared with 14% of women.

**Health and marital status**

JHS respondents who were widowed/divorced/separated had significantly poorer health, on a number of different measures, than single respondents or those living as a couple. Of those widowed/divorced/separated, 42% reported good health during the past year, compared with 60% of single respondents and 61% of those living as a couple. Similarly, 45% reported no long-standing illness, compared with 72% of single respondents and 64% of those living as a couple. Their mean self-rated health status score on the EuroQol VAS was 68, compared with a mean score of 77 for single respondents and 80 for those living as a couple. This is a similar pattern to that found in the UK, US and Catalan surveys and is mainly due to the fact that widowers, divorced and separated people are, on average, older than those who are single or 'living as a couple'. However, not all of the differences disappear when the same analyses are undertaken with a younger age group. For example, taking only those respondents aged 60 or less, a significantly greater proportion of those who were widowed or divorced reported having some long-standing illness than did respondents who were single or married but there was no significant difference in the proportion reporting their health during the last year to be good or not.

**Figure 1.2: Percentage of those in the JHS within each marital status category who reported any problem (moderate or extreme) on each of the EuroQol dimensions**


Figure 1.2 shows the significantly poorer health status of respondents who were widowed/divorced/separated as reflected in each of the five EuroQol dimensions. Far more respondents who were widowed/divorced/separated reported either moderate or extreme problems, on each of the dimensions, than did respondents who were single or living as a couple. Again, this was a similar picture to that in the UK, US and Catalan populations.

**Health and place of birth**

Place of birth was considered in the four categories of 'Jersey/other Channel Island', 'United Kingdom', 'other European country' (the majority of respondents in this category were born in Madeira or the Irish Republic) and 'elsewhere outside Europe' (from a wide variety of countries). When exploring the health of each of these groups, a complex pattern was found. There was no significant difference in the health of the respondents over the past year, nor in the mean EuroQol VAS score, by the respondent's place of birth. Nor were there any significant differences in the proportion of respondents with any problems on the EuroQol health dimensions of mobility, self-care, usual activities and pain/discomfort - according to place of birth.

This was not the case, however, for anxiety/depression. Here, significant differences were found by place of birth on both the EuroQol dimension of anxiety/depression and the GHQ-12 score. The trend was that, of those born 'elsewhere outside Europe', a greater proportion reported no problems with anxiety or depression than did the proportion born, in descending order, in Jersey or the other Channel Islands, the UK or other European countries, *ie* those born in UK/Europe were more likely to experience anxiety/depression than those born in Jersey.

A different pattern was found between the groups when long-standing illness was considered. Here, a greater proportion of those born 'elsewhere' (75%) or in Europe (69%) reported no more long-standing illness than did those born in the Jersey or the other Channel Islands (64%) or the UK (59%) This is a highly significant finding.

Thus, it appears that those born outside Europe rated their health better than other respondents in terms of anxiety or depression and reported the least long-standing illness. People born in Jersey or any of the other Channel Islands and the UK had similar health profiles and a greater proportion of these respondents reported long-standing illness. Those born in Europe (apart from Jersey and the Channel Islands or the UK) reported the most anxiety/depression.

**Health and ethnic group**

In addition to their place of birth, respondents to the JHS were asked which of a range of ethnic groups they considered they belonged to. For ease of analysis, these groups have been coded in a similar way to that pertaining to place of birth. Almost half of the population (48%) considered themselves to belong to Jersey or the other Channel Islands, with a further 36% considering themselves to be English, Scottish, Welsh, Northern Irish or British. Four percent considered themselves to belong to another European grouping and 3% to a group from elsewhere in the world. Nearly one in ten respondents (9%) stated that they belonged to two or more groups, most commonly Jersey and another.

No significant differences were found between any of the measures of health and the groups that the respondents felt that they belonged to. One interesting pattern was found with the EuroQol dimension of anxiety/depression. Here, almost a quarter (24%) of those stating that they belonged to more than one ethnic group reported problems with anxiety/depression, compared with 22% of those belonging to British groupings or those elsewhere in the world, 19% of those in other European groupings and 17% of those who considered that they belonged to a Jersey/Channel Island group This was not statistically significant but it may be an important finding.

The measure of self-rated health using the EuroQol VAS yielded a different pattern of health according to feelings of belonging to an ethnic group. Those rating their health the highest (suggesting better perceived health) were respondents belonging to European groups other than Jersey or Britain (mean VAS score 83), followed by those belonging to Jersey or the Channel Islands (mean score 77), more than one group (mean score 76), British groups (mean score 76) and finally groups belonging elsewhere in the world (mean score 70).

There is, therefore, some discrepancy between place of birth and belonging to a particular ethnic group, in terms of health. Those actually born outside Europe reported the least anxiety or depression and the least long-standing illness. However, those who considered that they *belonged* to a group from outside Europe rated their own health well below that of any of the other ethnic groups. Thus, it seems that one of the components of good self-perceived health is the feeling of belonging to the cultural *milieu*, rather than one's place of birth *per se*. One reflection of this may be the finding that those who considered themselves to belong to more than one ethnic grouping had a slightly greater risk of anxiety or depression than other respondents.

**Health and social class**

There is a vast and growing literature in the UK on the association between social class and health which has accumulated since the 1920's when the Registrar General started to record and analyse health and demographic data in this manner. There are clear differences in the incidence of ill health by social class. People in lower social classes, including children, are more likely to suffer from infective and parasitic diseases, pneumonia, poisonings or violence. Adults in lower social classes are more likely, in addition, to suffer from cancer, heart disease and respiratory disease. There are also gender-related problems. Men in lower social classes are more likely to suffer from malignant neoplasms (cancer), accidents, and diseases of the nervous system. Women in lower social classes suffer more from circulatory diseases, and endocrine or metabolic disorders (Shaw *et al*, 1999).

There are several possible explanations for these inequalities:

- artefact explanations - both 'health' and 'social class' are artificial categories constructed to reflect social organisation
- natural and social selection - this would depend on the view that people who are fittest are most likely to succeed in society, and classes reflect this degree of selection
- poverty leads to ill health, through nutrition, housing and environment
- cultural and behavioural explanations
- genetic inheritance

Low social class is not thought to be a cause of ill health in itself but it is a robust marker in Britain and other industrialised countries for both lower economic and social status. Extensive research has now demonstrated that it is particularly the 'poorer' economic circumstances associated with Social Class IV and V jobs that are likely to cause ill health. Over the past 20 years, there have been three major summaries of the research in this field - the 'Black' report in 1980, *The Health Divide* report in 1988 and more recently the 'Acheson' report (Townsend, Davidson and Whitehead, 1992; Acheson, 1998; Gordon *et al*, 1999).

Table 1.6 compares the proportion of respondents with different self reported health status by Social Class grouped into four categories (I&II, III Non Manual, III Manual and IV&V). The differences in health status that have been documented in other countries are, unsurprisingly, also present in Jersey. Respondents in non-manual social classes (*eg* I, II and III Non Manual) were more likely to report their health as 'good' compared with respondents in manual social classes. Respondents in manual social classes were also more likely to report limiting long term illnesses than non-manual social class respondents.

**Table 1.6: Comparison of health status by Social Class**

| | Social Class | | | |
|---|---|---|---|---|
| **Health question** | **I&II** | **III Non Manual** | **III Manual** | **IV&V** |
| | **(%)** | **(%)** | **(%)** | **(%)** |
| *General health* | | | | |
| Good | 68 | 63 | 57 | 58 |
| Fairly good | 27 | 33 | 36 | 36 |
| Not good | 5 | 4 | 7 | 6 |
| | | | | |
| *Long-term illness* | | | | |
| Yes - limiting | 17 | 14 | 19 | 18 |
| Yes - not limiting | 15 | 13 | 11 | 11 |
| No | 69 | 72 | 70 | 71 |
| | | | | |
| **EuroQol dimensions** *(any problem)* | | | | |
| Pain | 19 | 18 | 27 | 30 |
| Depression | 16 | 18 | 18 | 16 |
| Mobility | 5 | 4 | 7 | 8 |
| Usual activities | 7 | 4 | 8 | 7 |
| Self-care | - | 1 | 1 | - |
| Average VAS score | 82 | 81 | 80 | 80 |

Table 1.6 shows that the results for the different EuroQol dimensions present a more complex picture. There are much greater rates of pain/discomfort reported by Social Class IV&V respondents than those in non-manual social classes. There are also slightly higher rates of mobility and usual activity limitations in the manual social classes. However, there appears to be no Social Class gradient for self care and anxiety/depression in Jersey. These results suggest that in Jersey the relationship between Social Class and health is not as strong as it is in Britain or many other industrialised countries. This may be a result of the 'full' employment situation on the Island which leads to improved conditions at work and reduced average pay rate differentials. It may also, in part, be explained by the relatively large proportion of service sector jobs in Jersey.

**Health and education**

There has been a considerable amount of research into health and education level and qualifications, particularly in the USA. This has shown that those with the highest level of educational

qualification generally have considerably better health compared with people who have only lower level education al qualifications or no qualifications at all. However, much of this influence of educational qualification level on health is a result of the higher incomes and the better standard of living usually enjoyed by people who have good educational qualifications.

**Table 1.7: Percentage of JHS respondents achieving educational qualifications**

| Highest educational qualification | Percent |
|---|---|
| No qualifications | 31.2 |
| GCSE (D-E), CSE (2-5) | 5.8 |
| O Level, GCSE (A-C), CSE (Grade 1) | 17.8 |
| A Level, AS level, ASC | 9.5 |
| NVQ/SVQ Level 1, GNVQ Foundation | 1.2 |
| NVQ/SVQ Level 2, GNVQ Intermediate, etc | 8.8 |
| NVQ/SVQ Level 3, GNVQ Advanced, etc | 6.4 |
| NVQ Level 4, HND, HNC, RSA Higher, etc | 3.8 |
| First Degree | 6.0 |
| NVQ Level 5 | 0.3 |
| Higher Degree | 1.4 |
| Professional Degree | 7.9 |
| **Total** | **100.0** |

Table 1.7 shows the results from the JHS on the highest level of educational qualifications that adults over 18 had achieved at the time of the survey. Over 31% of the Jersey population had no qualifications at all, however, by contrast, 15% of people had degree level qualifications or higher.

**Table 1.8: Highest educational qualifications grouped by general health**

| Highest educational qualifications | Describe health | | |
|---|---|---|---|
| | Good | Fairly good | Not good |
| | (%) | (%) | (%) |
| No qualifications | 46 | 42 | 12 |
| GCSE or O levels | 63 | 32 | 6 |
| A Levels or higher, below degree | 67 | 27 | 7 |
| Degree or higher | 63 | 33 | 4 |
| **Total** | **59** | **33** | **8** |

Table 1.8 shows the answers to the general health question by highest level of educational qualifications. As would be expected, people with no qualification had the worst health, three times as many people in this group (12%) rated their health as 'not good', compared with those who had degree level or higher qualifications (4%). People with no educational qualifications had worse health than those with educational qualifications on all the different measures used in the Jersey Health Survey.

# Section 2

# Health and Lifestyle in Jersey

**Introduction**

There are a number of well-known factors that affect the level of health and social well-being that a person enjoys, amongst which are human biology, the environment and access to health care. Another crucial factor is lifestyle. At an individual level, people have the choice of many actions every day that directly determine their well-being. The aggregate of these behaviours composes what we call our *lifestyle*. Up to a half of all deaths are attributable to lifestyle factors such as smoking, alcohol abuse, improper diet or lack of exercise. In addition to achieving long-term benefits, adopting a healthy lifestyle can result in an increase in quality of life in the short and medium term and to a perception of good health and well-being.

This section explores the health of respondents to the Jersey Health Survey (JHS) in relation to lifestyle factors, discussing the healthy living practices of the respondents and identifying target groups where lifestyle factors might give cause for concern. We will explore, in turn, lifestyle practices of a healthy diet, weight control, exercise, smoking, alcohol consumption and time stress.

**Diet**

Food is a necessary and usually highly enjoyable part of our daily existence and we cannot live long without it. A balanced diet provides us with the materials necessary for the growth and maintenance of body tissues and with essential nutrients that give the body energy. However, dietary patterns have changed dramatically during the past century, largely as a result of a more affluent lifestyle, and data suggest that there are major associations between dietary factors and a range of diseases, including cancer and cardiovascular disorders (Henderson, 1987). In an attempt to help reduce these risks, many governments have set nutritional and dietary goals. In England and Wales, guidelines for a balanced diet were drawn up following the publication of the White Paper, *The Health of the Nation* (DoH, 1992).

Government guidelines focus, in the main, on reducing the amount of saturated fat, salt and refined and processed sugar in the diet (Health Education Authority, 1995). Nutritional advice therefore centres on encouraging the consumption of more food of plant origin (fruit, vegetables, cereals, beans and pulses) and of more fish, poultry, lean meats, non-fat and low-fat dairy products, whilst limiting the use of fat in food preparation, cutting down on the amount of fatty meat in the diet and reducing the amount of refined and processed sugar consumed.

*Changes in diet in Jersey*

In general, the healthy-eating message seems to be getting across to Jersey residents. Over a third (37%) of respondents were eating less red meat and 42% less processed meat than during the previous year. Whilst this was the case across all age groups, it was more prevalent for women than men. Thus, 43% of women had reduced their intake of red meat, compared with 31% of men. Similarly, 47% of women had reduced their intake of processed meat, compared with 36% of men.

Possibly in compensation for the reduction of red or processed meat in the diet, 23% reported eating an increased amount of fish, 29% an increased amount of white meat and 40% an increased amount of fresh vegetables and fruit. This increase in consumption was predominantly amongst middle-aged men and women, particularly those under the age of 60 (for fish and white meat) and under the age of 70 (for fresh vegetables and fruit). There was little difference in the proportions of men and women who had increased their intake of fish and white meat although more women reported increasing their intake of fresh vegetables and fruit than men (44% compared with 36%).

There has been a reduction of the amount of biscuits, cakes, pudding, ice cream, chocolate and sweets, and fried foods, including chips, eaten by the Jersey population during the past year. Over a third of people (38%) reported eating less biscuits, cakes, pudding, ice cream, chocolate and sweets and almost half (47%) were eating less fried food, including chips. Again, the healthy eating message seems to have got through.

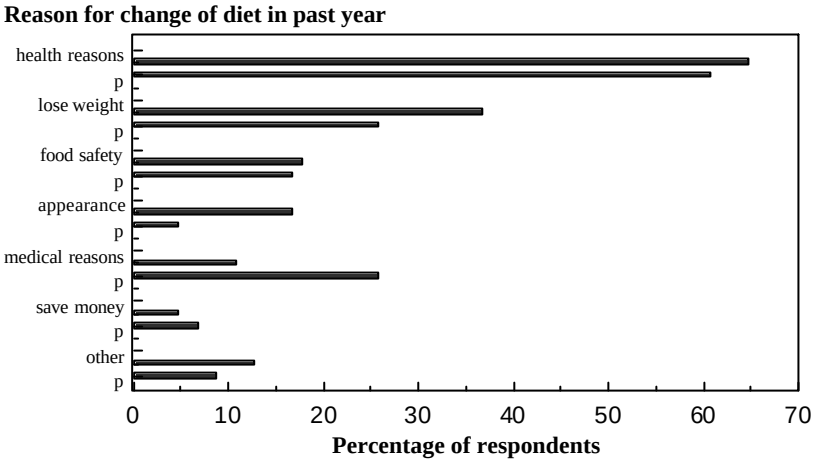
Although there was no clear-cut pattern across the age groups when considering the consumption of these food categories, it tended to be those in the younger and oldest age groups who were least likely to heed healthy eating advice. There were, however, significant differences between the sexes. More women (42%) reported decreasing their intake of biscuits, cakes, pudding, ice cream, chocolate and sweets than men (34%). Similarly, more women (51%) reported decreasing their intake of fried foods, including chips, than men (43%).

For most food categories, there was a small percentage of respondents (generally less than 10%) who reported not eating the food or not being sure about whether they ate it. However, this proportion increased markedly for three food categories. Almost a fifth of respondents (19%) reported not eating (or not being sure of eating) wholemeal bread. Almost a quarter (24%) reported not consuming (or not being sure of consuming) low fat milk and almost a half of respondents (48%) didn't eat (or were not sure of eating) organic foods. There was little difference across the age groups for the consumption of these foods but there were significant differences by sex, with women, rather than men, moving towards the healthy eating option in all cases.

It seems, therefore, that the quality of men's diets tends to be lower than those of women- a similar pattern to the one found in the survey, *Health in England 1998: investigating the links between social inequalities and health* (Rainford *et al*, 2000). The Jersey results are also broadly in line with those from England in terms of age. In both Jersey and England, those in the middle age groups were more likely to be moving towards a more healthy diet compared with those in the youngest or oldest age groups.

Figure 2.1 illustrates the differences in the reasons why respondents had changed what they ate during the past year, by whether the respondent was an old age pensioner or not.

**Figure 2.1: Reasons why respondents had changed what they ate during the past year, by whether the respondent was an old age pensioner or not**




**KEY**: bars without a prefix represent non-pensioners
p = pensioners

As Figure 2.1 illustrates, the majority of respondents reported that they had changed what they ate in the past year because of health reasons (62% of cases). This applied across all age groups (except those 80 years of age or older, of whom only 31% reported this reason) and to both men and women. Health reasons were given far more frequently than those of losing weight (36%), concern about food safety (18%), one's appearance (17%) or medical reasons (13%). More women (43%) than men (27%) had changed their diet to lose weight but, otherwise, there was little difference between the sexes in the reasons for changing what they ate during the past year. There was, however, some difference between the age groups, with a greater proportion of younger people changing their diet for the sake of their appearance and a greater proportion of older people changing their diet for medical reasons.

Of those mentioning 'other reasons' for the change in their diet over the past year (13%), most (around a third) reported this to be due to a change in their circumstances or lifestyle. This was the case for a larger proportion of men (48%) than women (25%). The next mo st frequently reported 'other' reason was a change in one's taste or choice of food or its availability. Here there was no difference between the sexes. The numbers in each age group reporting these reasons were too small to be able to reliably detect any difference between age groups.

*Changes in diet and reported health state*

A person's diet is likely to influence both their short and long-term health and this seems to be the case for the Jersey population.

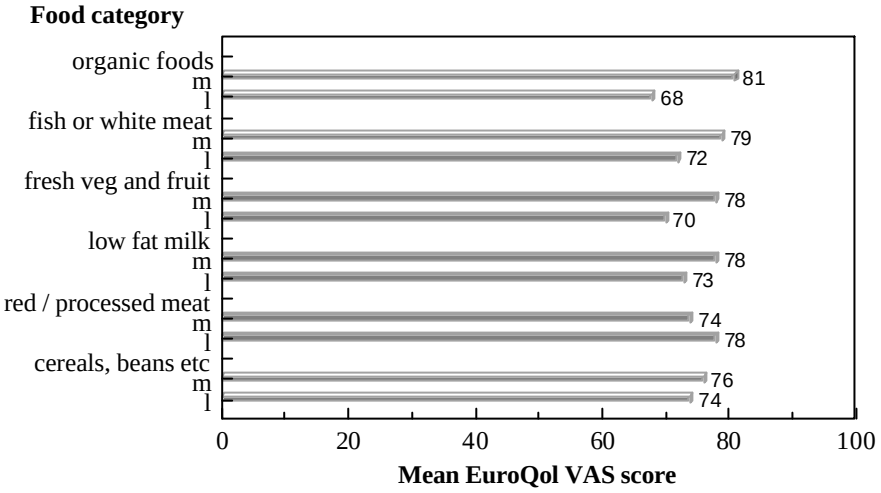
The dietary changes of those who reported themselves to be in 'not good' health during the past year were examined. Although these respondents did not increase their intake of red meat or processed foods any more than their healthier counterparts, they did more frequently report a reduction in the amounts of fish, white meat and fresh vegetables and fruit that they ate. A higher proportion of this group (15%) reported eating a greater amount of biscuits, cakes, puddings, ice cream, chocolate and sweets than did those in 'fairly good health' (10%) or 'good health' (7%). The reason for their change in diet over the past year was given as their health by 63%, to lose weight by 36%, for their appearance by 18%, and/or for medical reasons by 11%. (These figures add up to more than 100% because respondents were able to choose more than one reason for their change in diet). There is some evidence, therefore, that, for those in poorer self-reported health, the key elements of a healthy diet have not been correctly interpreted.

There were also some significant differences in the change of diet between those reporting long-standing illness, disability or infirmity and those reporting no long-standing illness. Those reporting long-standing illness more frequently reported a reduction in the amount of red meat that they ate and reported eating less or didn't eat any (or were not sure about eating) fried foods, including chips. The main reasons given by those with long-standing illness for the change in their diet over the past year were, once again, for their health or to lose weight. However, far more of the changes were made for medical reasons (24%) than by respondents with no long-standing illness (5%).

It seems, therefore, that there is some discrepancy between the change of food consumption for those who rate their own health as 'not good' and those who report that they have a long-standing illness. The former, although stating that they had changed their diet for health reasons or to lose weight had not, in fact, changed to a healthier diet. The latter, although as likely to have changed for health reasons or to lose weight, *had* changed to a healthier diet. The key difference seems to be that those reporting themselves to be in 'not good' health were less than half as likely to have changed their diet for medical reasons than those with a long-standing illness. One possible explanation is that healthy eating messages are at their most effective and influential once a medical condition has actually been recognised.

Another way of exploring the perceived health of respondents, in relation to the change in their diet during the previous year, is to compare the mean self-rated EuroQol Visual Analogue Scale (VAS) score for those who have changed their intake of particular foods. The VAS score ranges from 0 (worst health) to 100 (best health) and the mean score for the JHS respondents was 76.7. Figure 2.2 shows the mean VAS score for those who had increased their intake of particular foods in the previous year compared with those who had decreased their intake over the same time period.

**Figure 2.2: Mean EuroQol VAS score for those who have increased their intake of particular foods in the previous year compared with those who have decreased their intake over the same time period**




**KEY:** m – has eaten more of this food in the past year
l – has eaten less of this food in the past year

As Figure 2.2 highlights, a change to a healthier diet with regards to increasing the amount of organic food, white meat or fish, fresh vegetables or fruit, low fat milk, and cereals, beans, peas or dried fruit, and decreasing the amount of red or processed meat eaten, does seem to lead to a better perception of one's own health than does a change to a less healthy diet. Respondents reporting a change to a healthier diet with regard to these food categories all rated their health higher than respondents who reported changing to a less healthy diet over the course of the year. There was little or no difference in the EuroQol VAS scores for those reporting that they ate more (or less) biscuits, cakes, puddings, ice cream, chocolate and sweets, fried food including chips, butter and cheese, tea or coffee, or wholemeal bread.

A more complex picture is presented when the scores obtained from the GHQ-12, which assesses the psychological health of respondents, are examined in relation to change in dietary pattern. Respondents classified as depressed, according to the GHQ-12, were more likely to report that they had changed the amount of particular foods eaten during the previous year. For most food types, the changes had occurred in both directions, with some respondents reporting an increased amount of food of a given type eaten and others less. This pattern was also found when the association between the EuroQol dimension of anxiety/depression and the change in the amount of food eaten was explored.

However, there were significant differences between depressed and non-depressed respondents, in the amount of some food types eaten. On the whole, respondents classified as depressed according

to the GHQ-12 scoring system or the EuroQol dimension of anxiety/depression were more likely to have decreased their intake of organic foods, white meat, and cereals, beans, peas or dried fruit, than those classified as not depressed. They also reported a greater increase in the amount of biscuits, cakes, puddings, ice cream, chocolate and sweets than their counterparts.

Nevertheless, the larger proportion of depressed respondents reporting changes in the amount of particular foods that they ate is worth reiterating. For some, this change was towards healthier eating but, for others, it was not. Overall, it seems that being depressed, according to the GHQ-12 or the EuroQol dimension of anxiety/depression, does not necessarily imply a slide into unhealthy eating. When the reasons for the changes in what was eaten during the past year were examined, there was little difference between depressed and non-depressed respondents with one exception. Depressed respondents twice as frequently reported that they changed the amount of different foods that they ate to save money (10%) compared with the percentage of non-depressed respondents (5%).

Analysis of the EuroQol dimensions reinforces the suggestion that poorer health is generally associated with moves towards a poorer diet and Table 2.1 details the association between the five EuroQol dimensions and changes towards (or away from) a healthy diet. As the table shows, there were no significant differences on any of the EuroQol dimensions for the amount of red meat, butter and cheese and wholemeal bread eaten during the past year. For each of the other food categories, there was a significant difference on at least one of the EuroQol dimensions. What these results portray, however, is that, where there are significant differences between the groups, respondents with any problem on a EuroQol dimension tend to change the food they eat *away* from a healthy diet. Thus, for example, about one in nine respondents with a mobility problem reported eating less fish, white meat, or cereals and about the same proportion of those with problems of usual activity reported eating less fish and white meat. In these dimensions, the proportion changing to eat the healthier option was twice as large. Whilst it also seems true that healthy people do not necessarily eat increasing amounts of healthy foods, it appears that some in poorer health are changing their diet *away* from healthy eating options.

**Table 2.1: Association between the EuroQol dimensions and change in food eaten (%)**

| Change in food eaten | Mobility | | Self-care | | Usual activity | | Pain/ discomfort | | Anxiety/ depression | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **none** | **any** | **none** | **any** | **none** | **any** | **none** | **any** | **none** | **any** |
| **HEALTHIER FOODS** | | | | | | | | | | |
| **Fish** | | | | | | | | | | |
| Less | **9** | **12** | 9 | 9 | **9** | **12** | 9 | 11 | **9** | **13** |
| More | **23** | **21** | 23 | 26 | **23** | **24** | 23 | 22 | **22** | **25** |
| | *** | | ns | | * | | ns | | *** | |
| **White meat** | | | | | | | | | | |
| Less | **4** | **11** | 5 | 11 | **4** | **11** | **4** | **8** | **4** | **9** |
| More | **30** | **22** | 29 | 17 | **30** | **23** | **29** | **27** | **28** | **29** |
| | *** | | ns | | *** | | *** | | *** | |
| **Veg/fruit** | | | | | | | | | | |
| Less | 4 | 6 | 4 | 10 | 4 | 7 | 4 | 5 | **4** | **7** |
| More | 41 | 36 | 41 | 32 | 40 | 41 | 40 | 41 | **41** | **37** |
| | ns | | ns | | ns | | ns | | ** | |
| **Cereals etc** | | | | | | | | | | |
| Less | **7** | **11** | **8** | **13** | **8** | **9** | 7 | 9 | **7** | **11** |
| More | **19** | **19** | **19** | **13** | **19** | **21** | 19 | 19 | **19** | **20** |
| | *** | | *** | | ** | | ns | | *** | |
| **Organic** | | | | | | | | | | |
| Less | 6 | 9 | 6 | 6 | 7 | 6 | **6** | **9** | **5** | **11** |
| More | 13 | 12 | 13 | 10 | 13 | 10 | **13** | **13** | **13** | **14** |
| | ns | | ns | | ns | | * | | *** | |
| **Low fat milk** | | | | | | | | | | |
| Less | 6 | 8 | **6** | **13** | 6 | 8 | **5** | **9** | **6** | **10** |
| More | 20 | 15 | **20** | **7** | 20 | 17 | **21** | **15** | **19** | **21** |
| | ns | | ** | | ns | | *** | | ** | |
| **LESS HEALTHY FOODS** | | | | | | | | | | |
| **Red meat** | | | | | | | | | | |
| Less | 37 | 39 | 37 | 39 | 37 | 41 | 37 | 39 | 37 | 39 |
| More | 5 | 4 | 4 | 6 | 4 | 3 | 4 | 5 | 4 | 4 |
| | ns | | ns | | ns | | ns | | ns | |
| **Processed meat** | | | | | | | | | | |
| Less | 42 | 41 | **42** | **32** | **42** | **40** | 42 | 41 | 42 | 40 |
| More | 4 | 3 | **4** | **2** | **3** | **4** | 3 | 4 | 3 | 4 |
| | ns | | * | | ** | | ns | | ns | |
| **Biscuits etc** | | | | | | | | | | |
| Less | 38 | 39 | 38 | 35 | 38 | 38 | 37 | 40 | **38** | **36** |
| More | 8 | 9 | 8 | 12 | 8 | 11 | 8 | 9 | **8** | **10** |
| | ns | | ns | | ns | | ns | | * | |
| **Fried food** | | | | | | | | | | |
| Less | **47** | **51** | **48** | **30** | **47** | **50** | 47 | 49 | 48 | 46 |
| More | **4** | **2** | **4** | **2** | **4** | **1** | 4 | 3 | 3 | 5 |
| | *** | | *** | | ** | | ns | | ns | |
| **Butter/Cheese** | | | | | | | | | | |
| Less | 22 | 22 | 22 | 22 | 23 | 20 | 22 | 23 | 22 | 22 |
| More | 6 | 4 | 5 | 0 | 6 | 5 | 6 | 5 | 6 | 6 |
| | ns | | ns | | ns | | ns | | ns | |
| **Tea/coffee** | | | | | | | | | | |
| Less | 12 | 15 | 13 | 9 | 13 | 11 | 12 | 13 | **13** | **11** |
| More | 12 | 7 | 12 | 8 | 12 | 8 | 13 | 9 | **10** | **17** |
| | ns | | ns | | ns | | ns | | ** | |
| **W'ml bread** | *1690* | *269* | *1899* | *52* | *1693* | *274* | *1376* | *577* | *1561* | *387* |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Less | 8 | 8 | 8 | 10 | 8 | 8 | 8 | 9 | 8 | 10 |
| More | 19 | 19 | 19 | 19 | 18 | 20 | 19 | 19 | 18 | 19 |
| | ns | | ns | | ns | | ns | | ns | |

**KEY**: *** significant at <.001 ** significant at p <.01 * significant at p <.05 ns – not statistically significant

**Weight/fat control – Body Mass Index**

Maintaining optimal body weight is a key component of well-being and a way of reducing the risk of premature death. Weight is largely determined by lifestyle factors, however, it is fatness that is the main risk factor for morbidity and mortality. This implies that it is not necessarily one's weight alone that is the key factor but rather one's measure of fatness. A simple way to estimate this is to calculate body mass index (BMI) from a person's weight and height.

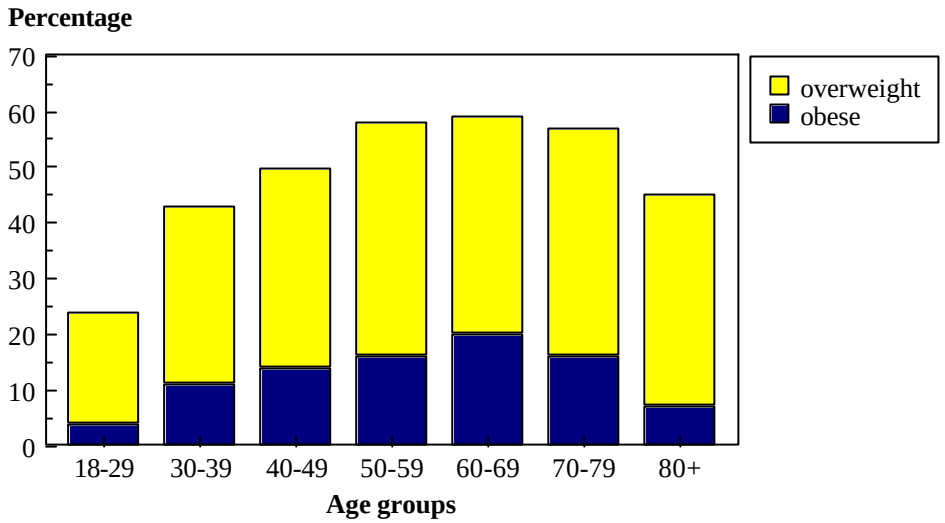
$$\text{BMI} = \text{weight in kilograms}/(\text{height in metres})^2$$

*Health in England 1998* defined obesity as a body mass index greater than 30 and 'overweight' as greater than 25 but less than 30. These are also the values adopted in this section.

Of the JHS respondents, 33% were overweight with a further 12% classed as obese, giving a total of 46% who were either overweight or obese in Jersey. This compares with 57% of respondents in the 1998 *Guernsey Healthy Lifestyle Survey* (Goddard *et al*, 1998) and 58% in the English health survey. As in England, there were highly significant differences between men and women. The prevalence of obesity was slightly higher in women (13%) than in men (12%) but a greater proportion of men (41%) were overweight than women (26%).

There were also highly significant differences by marital status and by age. Twenty-nine percent of single people were overweight or obese, compared with 50% of those widowed/divorced/separated and 52% of those 'living as married'. Of those in the youngest age group (18-29 years of age), 24% were overweight or obese, the proportion steadily increasing with age to 59% of 60-69 year-olds, before reducing again in the oldest age group to 46% of those aged 80 or over (Figure 2.3).

**Figure 2.3: The relationship between age and body mass index in the JHS**




The relationship between well-being and BMI is well documented (Henderson, 1987). For JHS respondents, there were significant associations between BMI and all measures of health, apart from those relating to anxiety or depression. Respondents describing their health over the past year as 'good' were far less likely to be obese (8%) than those describing their health as 'fairly good' (17%) or 'not good' (22%). Similarly, only 8% of those reporting no long-standing illness were obese, compared with 18% of those with non-limiting long-standing illness and 19% of those with limiting long-standing illness. On each of the EuroQol dimensions of mobility, self-care, usual activities and pain/discomfort, those reporting no problems were much less likely to be obese than those reporting any problems (a highly significant finding for all dimensions). Finally, the mean EuroQol VAS score of those who were obese was 70, compared with a mean score of 78 for those who were overweight and 80 for those of normal or under normal weight.

As mentioned earlier, the exception to the strong relationship between poorer health and obesity concerned measures of mental health. Although those reporting symptoms of anxiety/depression on that EuroQol dimension and those assessed as being depressed by the GHQ-12 were more likely to be obese, this was not significant. Nor were anxious or depressed respondents any more likely to be under or over normal weight.

A multivariate analysis was undertaken to determine the most significant relationships between obesity and sex, age, marital status and health. The most important predictor of whether people in Jersey were obese was age. Compared with those in the youngest age group, those up to the age of 60 had a much greater likelihood of being obese. Men and women between 60 and 69 years old were almost five times more likely to be obese than 18 to 29 year-olds. Less strikingly, but nonetheless significant, were the greater odds of being obese of those in 'fairly good' or 'not good' health compared with those in 'good health', of those in non-limiting long-standing illness compared with those with no long-standing illness and of those with problems on the EuroQol

dimension of self-care than those with no such problems. The previously considered associations between BMI and other measures of health were all accounted for by other variables in the analysis.

Therefore, taking account of age, sex and marital status, the odds of being obese were significantly less for young people whose health in the past year had been good and who had had no long-standing illness or problems with self-care.

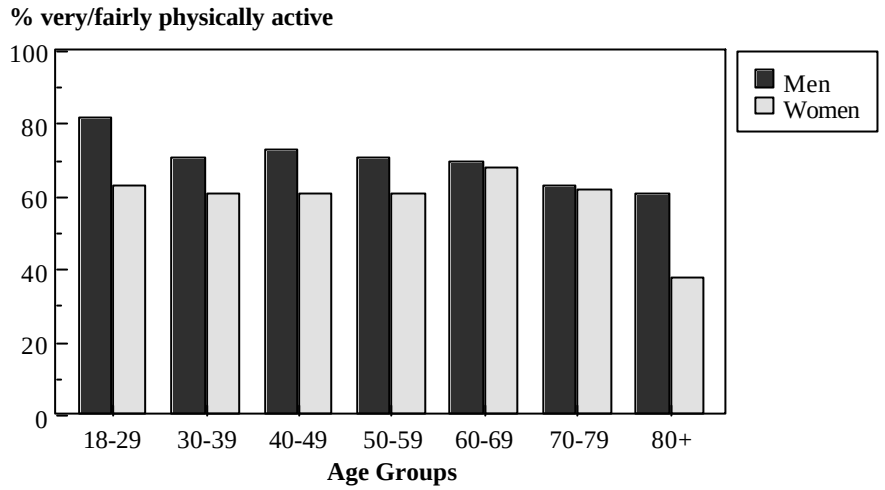
**Exercise**

As the 20th Century progressed, the proportion of the population working in sedentary jobs steadily increased. On top of this, changing patterns of transport, the increased use of labour-saving devices and more in-home entertainment have led to a general decrease in levels of activity. However, there are many health-related benefits of physical activity, including psychological, cardiovascular, weight control and disease prevention (Mullen *et al*, 1990) and the role of increased physical activity in the promotion of good health is well-documented (Killoran *et al*, 1994; DoH, 1995a; Rainford *et al*, 2000).

In answer to the question asking how physically active respondents thought themselves to be, over two thirds reported themselves to be 'very' or 'fairly' physically active (67%) but over a quarter (27%) assessed themselves as 'not very' physically active. Within these figures, however, there was a significant ($p < 0.001$) difference between the levels of physical activity of men and women. Of men, 73% reported themselves to be 'very' or 'fairly' physically active compared with 61% of women. Twice as many men as women reported that they were 'very' physically active (18% compared with 9%) and twice as many women as men reported themselves to be 'not at all' physically active (8% compared with 4%).

There were also significant differences in the level of physical activity reported by the different age groups, most markedly so for the men (Figure 2.4).

**Figure 2.4: Percentage of respondents reporting that they were 'very' or 'fairly' physically active, by age group and sex**




As Figure 2.4 shows, more men reported themselves to be 'very' or 'fairly' physically active than did women, particularly in the younger age group and again at or after the age of 80. Overall, however, the proportion reporting that they were at least fairly active remained steady across the age groups for both sexes. For men, the biggest drop came between the 18 to 29 and older age groups. For women, there was an increase in the proportion reporting themselves to be active between the ages of 60 and 69 but then a sharp drop in the proportion at or after the age of 80. However, people usually overestimate their level of activity in answer to this question.

In general, physical activity at the following levels is recommended as providing a benefit to health:

- Five or more occasions per week of at least moderate intensity activity (*eg* swimming, aerobics, or cycling) lasting at least 30 minutes per occasion, or
- Three or more occasions per week of vigorous intensity activity (*eg* playing squash or football or circuit training) lasting at least 20 minutes per occasion.

These recommendations were agreed by an international panel of experts that examined the scientific evidence associated with physical activity and health (Killoran *et al*, 1994). Less than a quarter of the respondents to the JHS (23%) reported that they engaged in exercise to this intensity. Of these, 59% were men (compared with 48% of all respondents) and most were in the 18 to 29 age group (31%, compared with 22% of all respondents). A greater proportion than in the population as a whole described their health over the past year as being 'good' (68%, compared with 57% of all respondents) and they more frequently reported no problems on each of the EuroQol dimensions of mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Those who engaged in physical exercise at a level judged to be beneficial to health also rated their own health

better than other respondents using the EuroQol VAS – their mean score was 82.8 compared with a mean score of 76.7 for all respondents.

*Health in England 1998* used three measures of physical activity in their analyses:

- those taking part in at least moderate-intensity exercise lasting at least 30 minutes on less than one day per week – these people were classed as 'sedentary'
- those taking part in at least moderate-intensity activity lasting at least 30 minutes on five or more days per week
- those taking part in vigorous activity lasting at least 20 minutes on at least three days per week

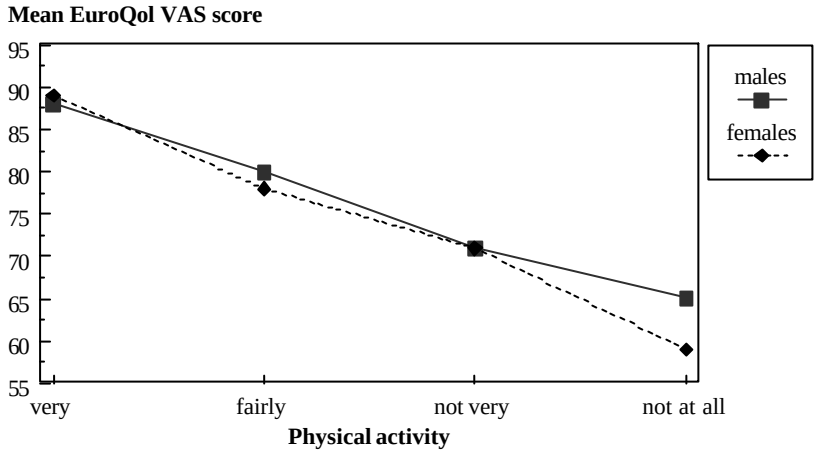
A comparison between the Jersey and English data is possible for these measures, although the JHS asked about moderate-intensity exercise lasting 20 minutes or more, rather than 30 minutes or more (as was asked in the English study) and the Jersey study is restricted to those age 18 or over whereas the English study was of those aged 16 and over.

In 1998, in England, 31% of the population were classified as sedentary (27% men and 35% women) – that is, they participated less than once a week in moderate-intensity activity. In Jersey, in 1999, the comparative proportion was similar - 32% (25% men and 33% women). However, there was a far greater difference between the Jersey and English respondents for all other levels of activity. Thirty-six percent of men and 24% of women in England took part in at least moderate-intensity activity on five or more days per week, compared with 15% of men and 15% of women in Jersey. Seventeen percent of men and 6% of women in England took part in vigorous physical activity lasting 20 minutes or more at least three times a week but the comparative proportion for Jersey respondents was only 10% of men and 2% of women.

Comparative data are not available for England on the association between individual activity and health status. In Jersey, however, there was a strong association between individual activity and health status, as measured in a number of different ways. Over three quarters (77%) of those respondents describing their health over the past year as being 'good' reported that they were 'very' or 'fairly' physically active, compared with a third (34%) of those describing their health as 'not good'. Three quarters (74%) of those with no long-standing illness reported that they were 'very' or 'fairly' active, compared with just over a half (55%) of those with some long-standing illness and 70% of respondents not considered to be depressed according to the GHQ-12 assessment were 'very' or 'fairly' active, compared with 46% of depressed respondents. Figure 2.5 shows the mean EuroQol VAS score for males and females according to their reported levels of physical activity.

Figure 2.5 highlights a steady decline in the mean EuroQol VAS score with a decrease in levels of physical activity for both men and women. Overall, there is little difference between the mean scores for men and women when considering levels of physical activity, apart from those reporting that they are 'not at all' active. Here, women have poorer self-rated health than men.

**Figure 2.5: The mean EuroQol VAS score for males and females according to reported levels of activity**




To summarise, the majority of respondents reported that they were 'very' or 'fairly' physically active although this varied by age, sex and marital status. However, less than a quarter of respondents took part in exercise at a level recommended as providing a benefit to health. Additionally, those in poorer health, as measured in a number of ways, tended to be less active than those in good health. While many of the reasons why respondents did not get enough exercise were to some extent as might be expected – health reasons, lack of time, motivation and not enjoying physical exercise, a significant minority (11%) of those taking little or no exercise reported a lack of confidence as a reason for their inactivity.

**Alcohol consumption**

Both between and within communities, there are wide differences of opinion on the desirability of mind-altering substances. Most societies, however, have at least one drug which is tolerated and, in Europe and North America, it is alcohol that is the most potent psychoactive substance legally available without prescription. There is conflicting evidence about the relationship between alcohol consumption and its impact on health but longitudinal studies suggest that the relationship is U-shaped rather than linear. Thus, no alcohol intake appears to be less beneficial to health than small to moderate amounts but a high alcohol intake is associated with increased rates of nutritional, gastrointestinal, neurological, cardiovascular and cancer problems (Mullen *et al*, 1990).

In Britain, the White Paper, *The Health of the Nation*, recommended maximum weekly levels of alcohol consumption of 21 units for men and 14 units for women (DoH, 1992). Standard units equate to a half a pint of beer, cider or lager, a small glass of wine, sherry or port, or a single measure of spirits, aperitifs or liqueurs. Subsequent guidance introduced daily benchmarks to avoid the recommendations being interpreted as allowing 'binge' drinking (DoH, 1995b). This

stated that consistently drinking more than three or four units on average a day for men and two or three units a day for women, is not recommended because of the progressive health risks that this carries.

The JHS asked respondents how frequently they consumed alcohol and how many standard drinks were consumed on a typical day when drinking. These aspects have been analysed separately because of the different social and health profiles of those who reported drinking alcohol frequently and those that reported drinking a greater number of units in one day.

*Frequent drinking*

Just over a quarter (27%) of all respondents reported drinking alcohol once a month or less often – or never. Of these *least frequent drinkers*, two thirds were female, many were over 60 years old and were widowed/divorced/separated, had a limiting long-standing illness and reported problems on one or more of the five EuroQol dimensions (mobility, self-care, usual activity, pain/discomfort, anxiety/depression). Twice as many less frequent drinkers as average (13%, compared with 7% of all respondents) described their health during the past year as being 'not good' and their mean score of self-rated health was lower (EuroQol VAS score 70) than that of average (EuroQol VAS score 77).

By contrast, half of all respondents (50%) stated that they had a drink containing alcohol more than once a week, including 18% who drank alcohol five or more times a week. Of these *most frequent drinkers*, two thirds were male and more than expected were over 40 years old, were married and described their health during the past year as being 'good'. There was little or no difference between the most frequent drinkers and all respondents with respect to long-standing illness, problems on any of the five EuroQol dimensions, depression as measured by the GHQ-12, or self-rated health using the EuroQol VAS Scale.

*Heavy drinking*

The frequency of drinking alcohol is associated with a different set of health-related dangers than the number of alcoholic drinks consumed in one sitting. Of those who reported ever drinking, a fifth (20%) said that they on ly had one standard drink on a typical day when they were drinking. Of these, the *lightest drinkers*, two thirds were female, more than expected were in the older age groups (aged 40 or over), were widowed/divorced/separated, had a long-standing illness and reported problems on one or more of the five EuroQol dimensions (mobility, self care, usual activity, pain/discomfort, anxiety/depression). There was little difference between the average EuroQol VAS score of all respondents and that of the lightest drinkers, nor between the lightest drinkers and any of the other health-related measures. Unsurprisingly, the people in Jersey who drink very little alcohol when they do drink have similar characteristics to those people who never drink or hardly drink at all.

In contrast to this, a quarter (26%) of all respondents who reported ever drinking, stated that they consumed five or more standard drinks on a typical day that they were drinking. Of these *heaviest drinkers*, two thirds were male and more than expected were in the 18-39 year old age groups, were single, reported no long-standing illness and stated that they had no problems on the EuroQol dimensions of mobility, self-care, usual activities or pain/discomfort. There was little or no

difference between the heaviest drinkers and all respondents with respect to self-reported health during the past year, any problem on the EuroQol dimension of anxiety or depression, depression as measured by the GHQ-12, or self-rated health using the EuroQol VAS Scale.

In order to determine the most significant predictors of heavy drinking, a multivariate analysis was performed. The most significant variable was gender, with men being twice as likely as women to drink five or more units. The variable of next greatest significance was marital status – single respondents were almost three times as likely to drink five or more units in a day than married respondents or widowed/divorced/separated respondents. The variable of third greatest significance was that of age, with respondents under 40 years of age being far more likely to drink five or more units in one day than older age groups. The only health-related variable of significance was that of self-rated health during the past year. Here, the odds of drinking five or more standard units of alcohol in a typical day of drinking were over one and a half times greater for those in 'fairly good' health than those in 'good' health.

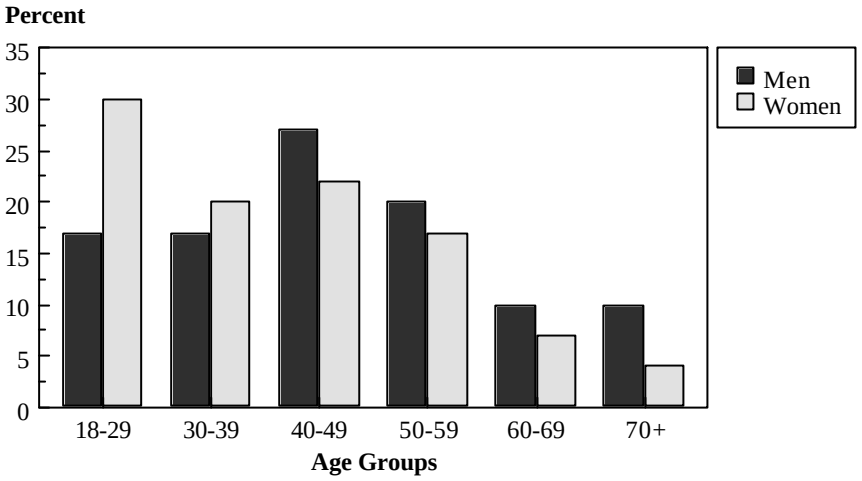
As can be seen, therefore, the profiles of frequent drinkers and heavy drinkers are very different. Although both are likely to be male, frequent drinkers tend to be older, married men, whilst heavy drinkers are more likely to be young, single men. Frequent drinkers reported more than average problems with anxiety or depression (as measured by the EuroQol dimension), whilst heavy drinkers had greater odds of rating their health as 'fairly good' rather than 'good'. There were few, if any, other significant differences in the health-related measures.

*Heavy **and** frequent drinking*

Fewer than 5% of respondents reported having drinks containing alcohol on five or more days each week *and* consuming five or more standard drinks on a typical day that they were drinking. Of these, the majority were men (86%) and twice as many as average (37%, compared with18%) were in the age 40-49 year old age group. They were more likely to report problems on the EuroQol dimension of anxiety/depression than average (30%, compared with an average for all respondents of 20%) and were also classed as depressed using the GHQ-12 scale more frequently than average (16% compared with 12%). For each of the other health measures considered, these heavy, frequent drinkers rated their health no differently than the population as a whole.

The conventional way of measuring alcohol consumption is in mean weekly units consumed. Calculating weekly levels therefore allows some comparison with other populations but it must be borne in mind that the average number of units consumed each week is an estimate based on categories of responses. In the JHS, 23% of men and 10% of women reported drinking more than the recommended number of units per week (21 units for men and 14 units for women). The comparative proportions for England in 1998 were 30% of men and 17% of women (Rainford *et al*, 2000). There was a different pattern for Jersey men and women across the age groups, as Figure 2.6 shows.

**Figure 2.6: The proportion of men and women drinking more than the weekly recommended units of alcohol for their sex, by age group**




As Figure 2.6 shows, most men who drink more than the weekly-recommended number of units of alcohol were aged 40-49. By contrast, most women consuming over the weekly-recommended limit were in the youngest age group, aged 18–29. This pattern differs from that of England, where the proportions drinking over the weekly-recommended limit were in the youngest age groups for both men and women. In both the JHS and Health Education Monitoring Study of England, the proportions drinking more than 21 units a week for men or 14 units a week for women were lowest in the older age groups.

Jersey respondents who drank over the weekly-recommended number of units described their health over the past year little differently from their peers. Nor did they report any more, or less, long-standing illness and were not assessed as being depressed using the GHQ-12 scale any more than the other respondents. They reported fewer than average problems on the EuroQol dimensions of mobility, self-care, usual activities and pain/discomfort but more frequently reported problems of anxiety/depression on the EuroQol measure than the population as a whole (24% compared with 20% in the total population).

As well as the frequency of drinking alcohol and the number of standard units of alcohol consumed during a typical day's drinking, the JHS asked a number of other questions about problematic alcohol consumption relating to control over one's drinking and the effect of drinking on one's day-to-day life. These questions are based on the work of the World Health Organisation (WHO) on the *Identification and treatment of persons with harmful alcohol consumption* and are known as the AUDIT (Alcohol Use Disorders Identification Test) questionnaire.

Over 90% of respondents stated that, during the past year, they had **never**:

- not been able to stop drinking once they had started (90%)
- failed to do what was expected of them because of their drinking (91%) or
- needed an alcoholic drink in the morning to get going after a heavy drinking session (98%)

A slightly smaller percentage of all respondents reported that during the past year they had **never**:

- been unable to remember what happened the night before because they had been drinking (82%) or
- had a feeling of guilt or regret after drinking (83%).

A small proportion of respondents (9%) reported one or more aspects of problematic drinking on a monthly or more frequent basis. The majority were men (68%) and a half were single (50%). Almost half (47%) were in the 18-29 year old age group with a further quarter (25%) aged 30-39. They were less likely than average to have any problems on the EuroQol dimensions of mobility, self-care, usual activities or pain/discomfort but were more likely than average to have problems with anxiety/depression (29%, compared with an average for all respondents of 20%) and were twice as likely to be classed as depressed using the GHQ-12 scale than average (24% compared with 12%). For each of the other health measures considered, the respondents who reported problematic drinking once a month or more rated their health no differently than the population as a whole.

The picture that emerges, therefore, is that those reporting heavy frequent drinking, drinking over the weekly-recommended number of units of alcohol, or problematic drinking once or more a month have a higher than average chance of being anxious or depressed, as measured on the EuroQol dimension and, in two out of three circumstances, were more depressed as assessed using the GHQ-12 scale. In all other respects, these respondents rated their health no differently from their peers and had no greater likelihood of reporting poor health over the past year, poorer self-rated health using the EuroQol VAS scale nor a greater incidence of long-term illness.

A score of 15 or more on the AUDIT questions has been taken as an indicator of alcohol dependence. In the JHS, 7% of the population (9% of men and 5% of women) were found to be alcohol dependent and this may lead to long term detrimental health consequences.

**Smoking**

In the developed world, smoking is the greatest single self-imposed risk to health and cigarette smoking is the main cause of diseases leading to early death (Henderson, 1987; Rainford *et al*, 2000). Both overall and for each of the smoking-related causes of death, smokers have higher death rates than people who have never smoked. Targets to reduce adult smoking and smoking amongst young people were laid out in Britain in the White Paper, *Smoking Kills: a white paper on tobacco* (DoH, 1998b). The White Paper also set out measures to reduce levels of smoking, including an end to tobacco advertising and the provision of new services to help people who want to give up smoking.

In England in 1998, just under a half of those aged 16 or over (48%) reported that they had never or had only occasionally smoked cigarettes and, of these, there was a slight over-representation of women. Similarly, in the JHS, 50% of respondents (aged 18 or over) reported that they had never smoked or had only occasionally smoked. The 1998 *Guernsey Healthy Lifestyle Survey* found that only 45% of those over 18 had never smoked, implying that smoking appears to be a slightly smaller health problem in Jersey.

There was a greater over-representation of women who had never smoked in the JHS (63% compared with 52% of all respondents) than in the UK study. More of these respondents described their health during the past year as being 'good' (64% compared with 57% of all respondents) (Figure 2.7) and they rated their own health using the EuroQol VAS scale slightly better (mean 79.2) than did all respondents (mean 76.7) (Figure 2.8). Those reporting that they had never smoked were far less likely than average to have any problems on the EuroQol dimension of anxiety/depression (14% compared with an average of 20%). There was, however, little or no difference in the reporting of any problems on the EuroQol dimensions of mobility, self-care, usual activities or pain/discomfort between 'never' smokers and all respondents, nor were they any less likely to be assessed as depressed as measured on the GHQ-12 scale or to experience long-standing illness.

Two fifths (21%) of all respondents in Jersey reported that they had given up smoking compared with the figure for England of 25%. In this, men were over-represented (59% compared with 48% of the total respondents), as was the case in the English study. Those who had given up smoking were more likely to be aged between 50 and 79 than the general population. They were also more likely to be married – whereas 57% of the total population was married (or living as a couple), this applied to 73% of those who used to smoke daily. The mean age when they started to smoke was 16 years. In general, ex-smokers had poorer health during the past year than the population as a whole (Figure 2.7). Over a half of all ex-smokers described their health over the past year as 'good' but this applied to 54% of those who used to smoke daily compared with 58% of the total population. Further, 11% of those who used to smoke described their health during the past year as 'not good', compared with 8% of the total population. Overall, those who used to smoke were rather more likely than average to report problems on the EuroQol dimensions of mobility, self-care, usual activity and pain/discomfort.

Over a quarter (29%) of respondents in the JHS were current smokers, compared with 27% of the population in England. Of the Jersey smokers, one in five said that they only smoked occasionally, the remainder reporting that they smoked daily. The mean age of starting to smoke for both groups was 16 years. The social profile of current occasional smokers and current daily smokers were quite different. The proportion of men and women who were current occasional smokers was similar to that of the general population but women were over-represented in current daily smokers (56% compared with 52% of all respondents). Current daily smokers were over-represented in all but the youngest and oldest (over 70 years of age) age groups but, for current occasional smokers, this was the case only for those less than 40 years of age. Finally, current occasional smokers were more likely to be single (33%) than current daily smokers (20%) or the total population (24%).

Current occasional smokers tend to be single young people, whereas current daily smokers are rather more similar to the Jersey population as a whole.

The health profile of current daily and current occasional smokers is rather more complex. A smaller proportion of current smokers described their health during the past year as 'good' (49% of daily smokers and 53% of occasional smokers) than the population as a whole (57%) (Figure 2.7). However, current occasional smokers reported fewer problems on the EuroQol dimensions of mobility, usual activities and pain/discomfort than current daily smokers or the general population. Current daily smokers reported no more problems than expected on the EuroQol dimensions of mobility, self-care or usual activities but did report problems on the dimensions of pain/discomfort and anxiety/depression more frequently than average. They also rated their own health on the EuroQol VAS Scale lower (mean 74) than current occasional smokers (mean 78) or the total population (mean 77) (Figure 2.8).

The most significant factor for whether respondents smoked every day or not was their age. The odds of smoking every day were far less for people over 60 years of age than for those in the youngest age group.

**Figure 2.7: Proportion of respondents reporting 'good' health in past year, by smoking status**

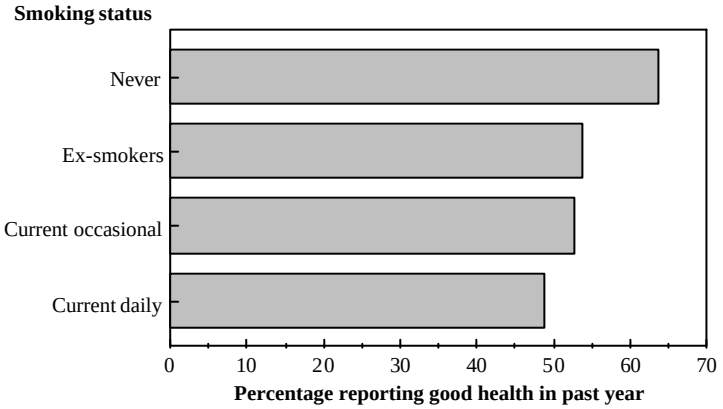
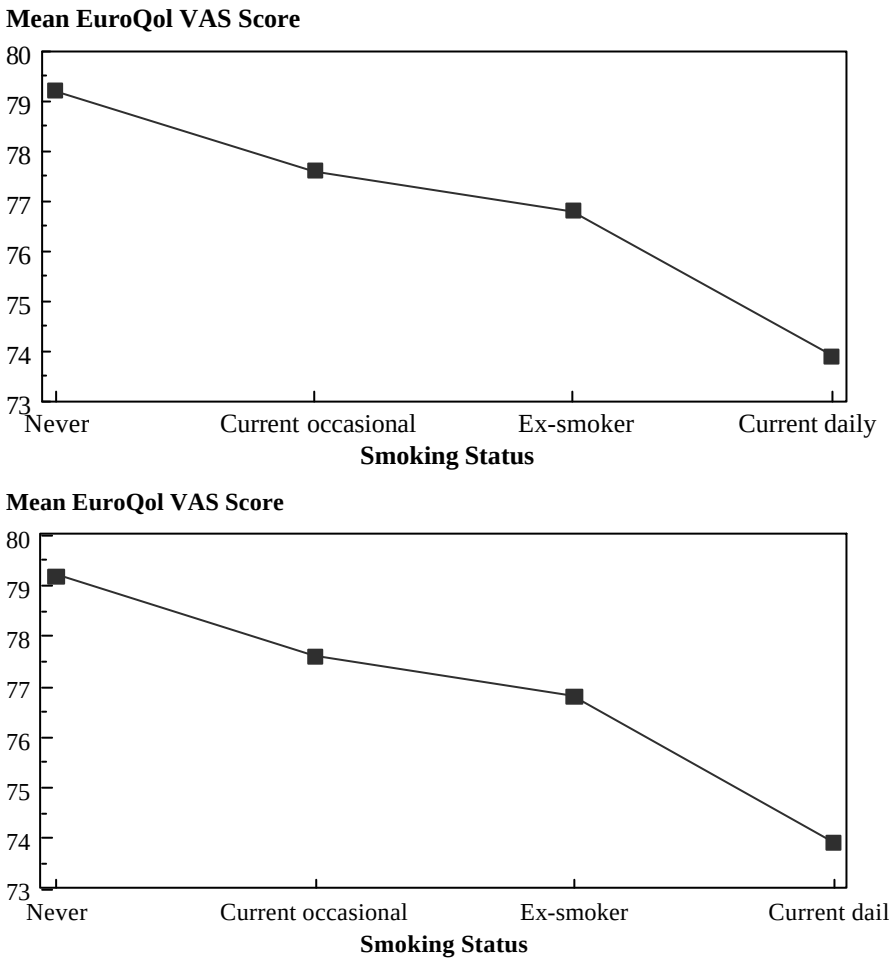


**Figure 2.8: the Mean EuroQol VAS Score for respondents by smoking status**




All current smokers were asked if they would like to give up smoking and almost three quarters (73%) responded that they would. This is slightly more than the 68% of smokers in the English survey who reported that they would like to give up smoking. The only significant differences in the social or health profiles of the Jersey respondents who would like to stop smoking comp ared with those who didn't want to stop smoking were that those who reported problems on the EuroQol dimensions of mobility and self-care *less frequently* reported that they wanted to stop smoking, and those assessed as being depressed on the GHQ-12 scale *more frequently* reported that they wanted to stop.

Current smokers were also asked if they had made a serious attempt to stop smoking in the past twelve months and over a third (34%) stated that this was the case. Men were significantly more likely to have tried to give up smoking (and failed) than women but there were no other significant differences in the social or health profiles of those who had tried to give up smoking compared with those who hadn't.

**Time stress**

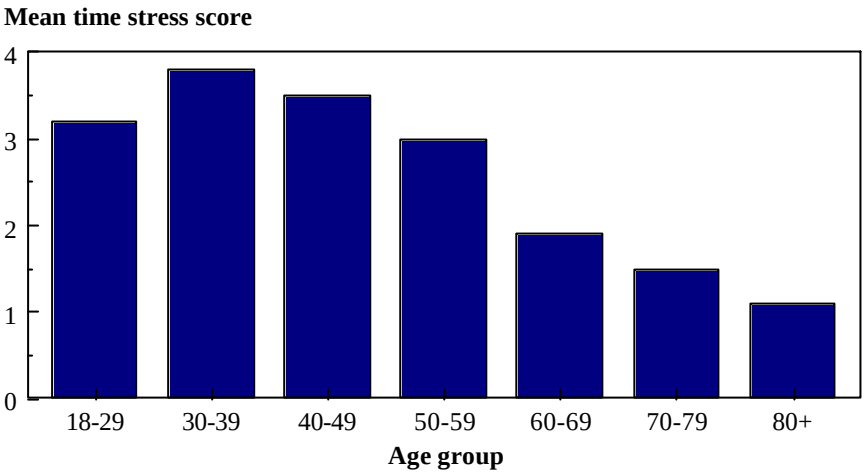
Everyone experiences stress at some point in their lives. Each day we are all faced with a variety of stressors, of a range in strength, and all stressors elicit the stress response to some degree and require that we adapt or cope. Stress, however, is not *necessarily* a bad thing: a certain amount of it may be necessary for achieving a high quality of life. The optimal amount of stress varies from person to person but too much stress is harmful and results in significant physiological changes within the body. Chronic stress suppresses the immune system so diminishing the body's disease-fighting capabilities and may lead to a number of disorders including cardiovascular and gastrointestinal conditions.

Stressors can be found in a wide variety of situations and environments. Common sources of stress include interpersonal relationships, work, money concerns, technology or changing health patterns. The JHS questioned respondents about time pressure as a source of stress. Time pressure is known to both cause stress directly but can also increase the stress brought on by other factors (Boskin *et al*, 1990). A series of ten questions relating to time pressure was asked in the questionnaire, including questions about time for work, friends and family, fun, sleep, daily accomplishments and one's reaction to not having enough time. Each required a simple yes/no answer and they have been scored on a ten-point scale with a score of 10 as maximum time stress (responding positively to each of the 10 stress-related questions) and 0 as no time stress (responding negatively to each of the 10 stress-related questions). This series of questions had first been developed in the USA and was used previously in the 1992 *Canadian General Social Survey* (Frederick, 1995).

Almost one in five (19%) of respondents to the JHS scored 0 on the time stress scale, suggesting no time pressure on them. At the other end of the scale, fewer than 10 respondents (0.5%) responded positively to all of the 10 stress-related questions asked. However, over a quarter (26%) of respondents did score between four and six on the scale, suggesting moderate time stress, and 12% scored seven or more - indicating severe time stress.

The mean time stress score for all respondents was three, there being little or no significant differences between men and women, nor between the different marital statuses. There was, however, a difference in the mean time stress scores by age groups, as Figure 2.9 shows. The peak highest stress score was in the age 30-39 age group, with a subsequent decline in scores with increasing age.

**Figure 2.9: Mean time stress scores for Jersey Health Survey respondents, by age group**




Stress scale scores: 0 = no time stress; 10 = maximum time stress

The 12% of people suffering from extreme time stress were less likely than average to assess their health during the past year as being 'good' (46%, compared with 57% of the total population). They reported twice the amount of anxiety/depression on the EuroQol dimension (40%, compared with 20% of all respondents), were more than twice as frequently assessed as being depressed on the GHQ-12 scale (31%) compared with all respondents (12%). In addition, those reporting severe time stress more frequently reported limiting long-standing illness (30%, compared with 24% of respondents as a whole).

The chances of suffering from extreme time stress were greatest for those with problems on the EuroQol dimension of anxiety/depression: their odds of experiencing high time stress were over two and a half times as great as those with no problems on this dimension. The odds of experiencing severe time stress were also almost twice as great for those assessed as depressed on the GHQ-12 scale, compared with those not assessed as being depressed. Age was also a significant factor: the greatest odds of experiencing severe time pressure was felt by the 30-39 year old age group, with their odds of being stressed in this way over twice that of the 18-29 year-old age group. Finally, compared with those describing their health over the past year as being 'good', those with 'fairly good' health also had greater odds of experiencing time stress.

There is a commonly held but mistaken belief that it is mainly relatively well-off people with over-busy lives are most likely to suffer from extreme time stress. The image of time stress often portrayed is one of the over-worked, high flying executive who works long hours and rushes from meeting to meeting with little time for the family or relaxation. However, the reality is often different and Table 2.2 shows the percentage of people suffering from extreme time stress by poverty group. In the JHS, people were asked *"Do you think you could genuinely say that you are poor now?"* and given three options: 'all the time', 'sometimes' or 'never. The table shows clearly

that people who answered they were genuinely poor 'all the time' were almost four times more likely to suffer from extreme time stress than those who were 'never' poor (29% compared with 9%).

**Table 2.2: Amount of time stress by poverty group**

| **Genuinely poor 'now'** | **No time stress** | **Moderate time stress** | **Extreme time stress** |
|---|---|---|---|
| | (%) | (%) | (%) |
| All the time | 30 | 41 | 29 |
| Sometimes | 50 | 30 | 20 |
| Never | 68 | 23 | 9 |
| **Total** | **63** | **25** | **12** |

**Healthy lifestyles?**

From the information collected on the health status of Jersey respondents and their patterns of diet and exercise, body mass index, consumption of alcohol, smoking behaviour and stress levels, it is possible to build a picture of what aspects of one's lifestyle contribute the most (or least) to good health.

After allowing for differences in age, sex and marital status, the lifestyle factor influencing Jersey peoples' health the most was the amount of exercise taken. The odds of those who were 'very physically active' describing their health over the past year as 'good' were 11 times greater than those who were 'not at all physically active'. Even those who described themselves as 'not very physically active' had significantly greater odds of describing their health as good than those 'not at all' active – the odds here being three and a half times greater. However, it must b e stressed that this does not mean that ill health is caused by lack of exercise. These large differences are, in part, a result of the fact that sick people are often simply not well enough to engage in a lot of physical activity.

The second greatest in fluence on Jersey people's health was that of time stress. As the amount of time pressure increased, the odds of reporting good health fell significantly. Again, it seems that even a small reduction in the amount of time pressure experienced may result in significant health benefits. Stress management techniques that involve managing the limited amount of time that each of us has could therefore be greatly beneficial to health at an individual level and, as with increasing the amount of activity undertaken, small changes as well as major ones will improve the odds of an individual's good health.

The third lifestyle factor significantly influencing health was that of smoking. Respondents who never smoked were over twice as likely to describe their health as 'good' as those who smoked on a daily basis. There was no significantly greater odds of good health for ex-smokers over daily smokers, nor for occasional smokers over daily smokers. Thus, the most important health message to emerge here is to prevent people taking up the smoking habit in the first place. In the JHS, the

average age of starting to smoke was 16 and health promotion messages targeted at teenagers to prevent this would seem to be the most beneficial to health in the long-term.

A further significant influence on describing health as good was that of body mass index. Respondents with a BMI of less than 30 had odds of good health over 1.8 times greater than those who were obese. This even applied for those overweight compared with those who were obese, suggesting that even a small amount of weight lost from an obese state can result in beneficial effects on health.

In general, a similar pattern was found when predicting health as determined by having no long-standing illness, no problems on any of the EuroQol dimensions or not being depressed as assessed by the GHQ-12. The two most significant predictors of each of these health states were time stress and physical activity; lack of time stress being the most significant predictor of having no problems on any of the EuroQol dimensions (mobility, self-care, usual activities, pain/discomfort and anxiety/depression) and of not being assessed as depressed by the GHQ-12, and physical activity being the most significant predictor of having no long-standing illness.

As before, small changes in both of these predictors led to significant alterations in each of the health states. BMI was a significant predictor of long-standing illness only. Here, the odds of having no long-standing illness were over one and a half times greater for those of under/normal weight and those over weight, compared with those who were obese. Never smoking (compared with daily smoking) increased the odds of having no problems on any of the EuroQol dimensions by a similar proportion.

In conclusion, therefore, the Jersey Health Survey provides evidence that, when age, gender and marital status have been adjusted for, health status is associated with the lifestyle factors of physical exercise and pressures of time. A small increase in the amount of physical exercise undertaken or a small reduction in the amount of time pressure could lead to significant gains in health, as measured in a number of different ways. In general, it would also appear that not being obese, having never smoked and not drinking excessive amounts of alcohol improves health.

# Section 3

# The Environment and Housing

**Introduction**

The environment is a key influence on people's health and the importance of good housing conditions for maintaining health has been known since the 19th Century. Numerous studies have shown that poor housing can impact on both physical and mental health in detrimental ways (Hunt, 1997; Universities of Sussex and Westminster, 1996; Leather *et al*, 1994). In recognition of this, the link between health and housing has moved up the UK policy agenda. *The Independent Inquiry into Inequalities in Health* (Acheson, 1998) showed that, if health inequalities are to be reduced, housing and the environment must become key areas for policy development. The UK Government Green Paper, *Our Healthier Nation* (DoH, 1998a) and the subsequent White Paper, *Saving Lives* (DoH, 1999a), also recognised housing and environmental factors which affect health.

The Jersey Health Survey (JHS) asked a number of questions about the housing and environment of respondents. In this chapter, we explore these in relation to different measures of health.

**Housing tenure**

More men (58%) than women (52%) lived in owner-occupied housing compared with rented or other accommodation. In addition, a greater than average proportion of those living in owner-occupied housing were married or widowed and over the age of 40. Typically, those living in rented accommodation tended to be young, single people and those living in 'other' accommodation were largely married women above the age of 55.

There was a significant association between tenure and different measures of health. Respondents who described their health during the past year as being 'good' were significantly more likely to live in owner-occupied (59%) or rented (54%) accommodation than any other kind (36%). Similarly, a greater proportion of those living in owner-occupied (59%) and rented accommodation (67%) reported no long-standing illness, compared with less than a half (42%) of those in 'other' accommodation. The mean VAS score for owner-occupiers was 76.18 whilst, for those renting their accommodation, it was 75.81 and, for those living in other types of accommodation, it was 64.68.

No significant difference between the tenure groups was found in the reporting on the EuroQol dimension of self-care. However, for each of the other EuroQol dimensions, there were significant differences by the tenure of accommodation. On the dimensions of mobility, usual activities and pain/discomfort, a greater proportion of those in rented accommodation reported no problems. Those reporting problems the most frequently were those living in accommodation other than that owner-occupied or rented. On the dimension of anxiety/depression, however, the pattern was somewhat altered. Here, roughly equal proportions (19%) of those in owner-occupied housing and

rented accommodation reported problems, compared with almost twice this proportion (36%) of people in other types of accommodation. Those assessed as being depressed on the GHQ-12 scale were more likely to live in 'other' types of accommodation (19%) than in rented (13%) or owner-occupied housing (11%).

**Satisfaction with housing**

Respondents were asked about their own satisfaction with their accommodation and allowed to choose whether they were 'very satisfied', 'fairly satisfied', 'neither satisfied or dissatisfied', 'slightly dissatisfied' or 'very dissatisfied'. Over half (58% n=1154) of all respondents reported that they were "very satisfied' with their accommodation, with a further 28% saying that they were 'fairly satisfied'. Thus, well over four fifths of respondents expressed a degree of satisfaction with the accommodation that they lived in. Less than one in ten (8%) expressed dissatisfaction. There was no significant difference between the sexes in the degree of satisfaction with accommodation but there was a significant difference across the age groups, as Figure 3.1 illustrates.

**Figure 3.1: Proportion of respondents reporting themselves to be 'very satisfied' with their accommodation, by age group**

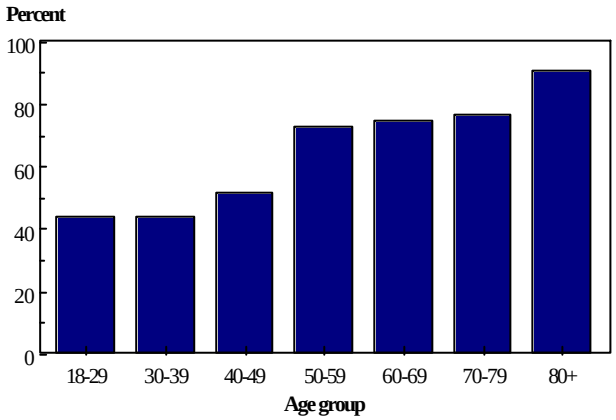



Figure 3.1 shows that the proportion of respondents who were 'very satisfied' with their accommodation increased with their age. Over three quarters of those aged 50 or more were 'very satisfied' with their accommodation, compared with approximately half or fewer of younger respondents. At the other end of the satisfaction scale, 14% of those in the 18-29 age group were dissatisfied with their accommodation to some extent, compared with less than half this proportion of those over the age of 50. Perhaps reflecting the age differences in satisfaction with their accommodation, significantly fewer single respondents were very satisfied with their accommodation (46% compared with 62% of married respondents and 62% of those widowed/divorced/separated).

There was some association between satisfaction with accommodation and different measures of health. Respondents who described their health during the past year as 'good' were significantly less likely to be dissatisfied with their accommodation (5% dissatisfied, compared with 10% of those describing their health as 'fairly good' and 15% of those describing their health as 'poor'). Similarly, respondents reporting no long-standing illness were also less likely to be dissatisfied with their accommodation (6%, compared with 9% of those reporting some long-standing illness).

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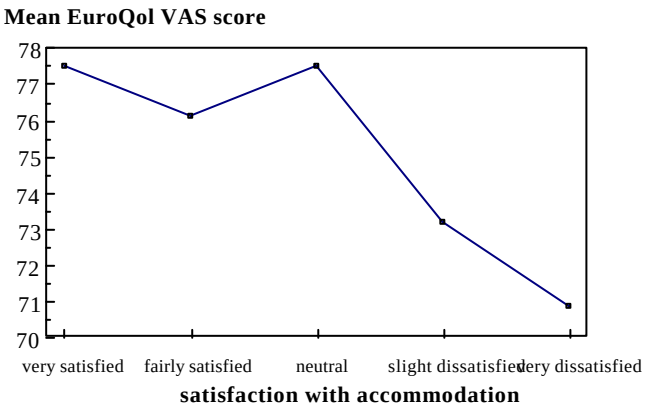
A more complex picture emerges when considering the EuroQol dimensions of mobility, usual activities and pain/discomfort. Here, those respondents reporting any problems on these dimensions were both more likely to be 'very satisfied' and also more likely to be dissatisfied with their accommodation. It seems that there was a broader range of experiences in these groups of respondents than in any others.

Data from the JHS also provides evidence of a link between depression and dissatisfaction with accommodation. Respondents reporting any problems on the EuroQol dimension of anxiety/depression or assessed as being depressed on the GHQ-12 scale, were less likely to be 'very satisfied' and more likely to be dissatisfied with their accommodation than other respondents. In both health measures, the results were highly statistically significant ($p < .001$). Those reporting problems of anxiety/depression on the EuroQol measure were two and a half times as likely to report dissatisfaction with their accommodation (15%) compared with those reporting no problems (6%). There was a similar difference between those assessed as depressed using the GHQ-12 scale (16% of whom were dissatisfied with their accommodation) and those not depressed (7% of whom reported dissatisfaction).

Finally, when asked to rate their own health using the EuroQol Visual Analogue Scale (VAS), respondents who were dissatisfied with their accommodation rated their own health less well than those who were satisfied or neutral about their accommodation, as shown in Figure 3.2.

**Figure 3.2: Mean EuroQol VAS scores for respondents, by reported satisfaction with their accommodation**



Respondents were also asked about the state of repair of their home and whether this was 'good', 'adequate' or 'poor'. Almost three quarters (70% n= 1394) reported that their home was in a good state of repair, with only 5% stating that it was in a poor state of repair. There was no significant difference by gender but differences were apparent by age and marital status. Figure 3.3 shows the percent of respondents reporting that their home was in a good state of repair, by age group.

**Figure 3.3: The proportion of respondents reporting that their home was in a good state of repair, by age group**

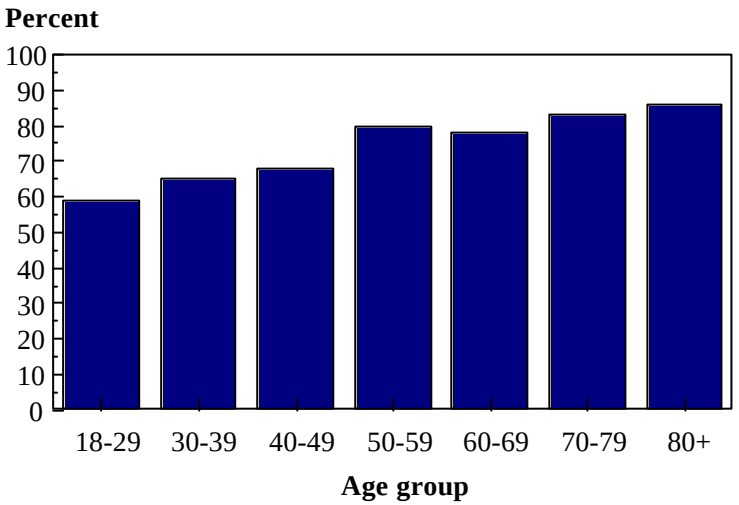



Figure 3.3 shows that it was those in the younger age groups who were the least likely to be living in a home that they considered to be in good repair. Whereas 59% of those in the 18-29 age group lived in a home in good repair, this proportion increased to over four fifths of those in the oldest age groups. Directly associated with the age structure of the respondents was their marital status and, here again, significant differences were found in the state of repair of homes. Single respondents reported that their home was in a good state of repair less frequently (61%) than widowed/divorced/separated people (70%) or those who were married (74%).

There was a greater association between state of repair and different measures of health status than there was between satisfaction with accommodation and measures of health status. Respondents describing their health during the past year as 'good' were significantly more likely to live in a home in a good state of repair (76%) than other respondents (62% of those describing their health as 'fairly good' and 67% of those describing their health as 'not good'). Correspondingly, they were the least likely to live in a home in a poor state of repair (4%, compared with 7% of those describing their health as 'fairly good' and 12% of those describing their health as 'not good').

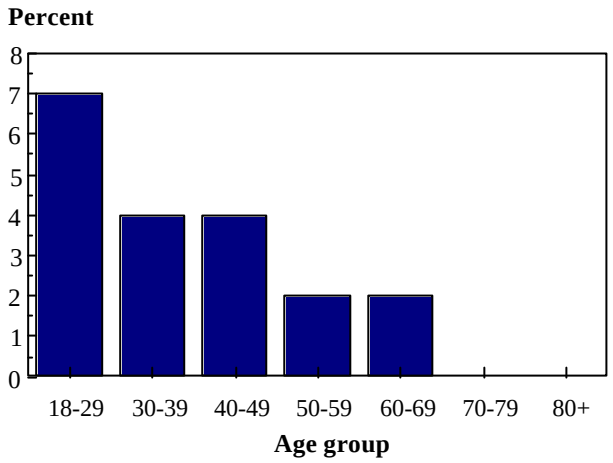
The other significant associations between health and the state of repair of the home concerned depressed respondents. Those reporting any problems on the EuroQol dimension of

anxiety/depression or who were assessed as being depressed on the GHQ-12 scale, were significantly less likely to live in a home in a good state of repair and more likely to live in a home in a poor state of repair than other respondents. Both of these differences were highly statistically significant ($p < .001$ for both variables). When asked to rate their own health using the EuroQol VAS scale, respondents living in homes in a poor state of repair rated their own health worse (mean VAS score 66.3) than those living in homes in an adequate state of repair (mean score 77.2) or a good state of repair (mean score 77.6).

A number of different problems with accommodation were mentioned by respondents. The most frequently mentioned problem was that of a shortage of space, reported by a quarter (25%) of all respondents. Fourteen percent said that there was nowhere to sit outside and approximately one in ten mentioned that the accommodation was damp (11%), had inadequate heating (9%), rot in window frames (9%) or mould (8%). Smaller percentages reported that their accommodation was too dark (4%), had a leaking roof (3%), required them to share a bathroom or toilet (5%) or share cooking facilities (1%). Of the 10 possible problems with accommodation, over a half of the respondents (58%) had no problems at all and a few respondents had nine different problems. The mean number of problems was 0.88 for all respondents and this was associated with state of health. The mean number of problems was 0.7 for those who described their health during the past year as 'good'; 1.0 for those who described their health as 'fairly good' and 1.3 for those whose health was 'not good'.

When asked directly if their own health problems or those of anyone in their family had been made worse by their housing situation, the majority of respondents (96%) reported that it had not. There was no difference in this by sex or marital status but there was by age group, with those in the younger age groups more likely to report health problems made worse by their housing problems (Figure 3.4). There were no respondents in the oldest age groups who associated worsening health problems in anyone in their household with their housing situation.

**Figure 3.4: Percentage of respondents by age group, who reported that the health problems of someone in their household were made worse by their housing situation**




In general, the pattern was that those in better health, as measured in a variety of ways, were the least likely to report that they, or anyone in their household, had any health problems made worse by their housing situation. Only 2% of those describing their health over the past year as 'good' reported such problems, compared with 6% of those describing their health as 'fairly good' and 6% of those reporting it as 'not good'. Of those reporting no long-standing illness, only 3% said that the health problems of anyone in their household had been made worse by their housing situation, compared with 5% of those with some long-standing illness. The only EuroQol dimensions where there were any significant differences between those with and without problems were those of pain/discomfort and anxiety/depression but the pattern remained the same. Those reporting any problems with pain/discomfort or anxiety/depression were significantly more likely to report that the health problem of anyone in their household was made worse by their housing situation, than those reporting no problems.

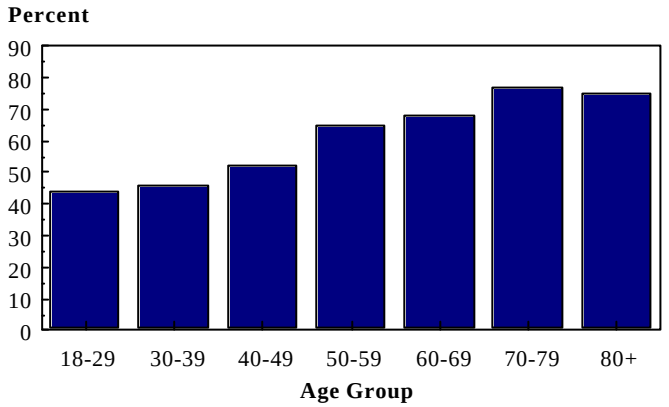
Similarly, those assessed as depressed using the GHQ-12 were also more likely to report that their housing situation affected the health of someone in their household. Overall, the mean EuroQol VAS score for those who said that the health problem of anyone in their household was affected by their housing situation was 66.9, compared with a mean score of 77.4 for those who said that it was not.

**Neighbourhood**

The JHS asked a number of questions about the neighbourhoods in which people lived. When asked how satisfied they were with the area as a place to live, over half of all respondents (56%) stated that they were 'very satisfied', with a further third (33%) saying that they were 'fairly satisfied'. Just 4% of respondents (n = 79) were either 'fairly dissatisfied' or 'very dissatisfied'. There was no significant difference between men and women in satisfaction in their neighbourhood

but there was by marital status and age. Single people were considerably less likely to be 'very satisfied' with the area in which they lived than (46%) than those who were widowed/divorced/separated (57%) or living as a couple (60%) ($p < .001$). Further, the proportion of respondents who reported being 'very satisfied' with the area in which they lived increased with age up to the eldest age group - when it dropped slightly (Figure 3.5).

**Figure 3.5: Proportion of respondents reporting themselves to be 'very satisfied' with the area in which they live, by age group**




There was some association between satisfaction with the neighbourhood and different measures of health. Of those describing their health in the past year as 'good', 60% were 'very satisfied' with the area in which they lived, as were 57% of those who described their health as 'not good'. By contrast, only a half (50%) of those who said that their health had been 'fairly good' were very satisfied ($p < .01$). There were no significant differences in satisfaction where the respondent reported a long-standing illness. A clue to the reason for this pattern may lie in the reporting of problems on the EuroQol dimensions. Respondents reporting problems of self care were significantly more likely to be satisfied with the area in which they lived (73%) than were those with no problems with caring for themselves (56%). However, those reporting problems of anxiety/depression were significantly less likely to be very satisfied (44%) than those reporting no problems. Thus, it appears that those in poor physical health and requiring help with personal care were generally very satisfied with the area in which they lived but those in better physical health but poorer mental health were far less satisfied with their area.

The significant association between poor mental health and lack of satisfaction with the neighbourhood was borne out by analysis of the GHQ-12 scores. Fewer than half (46%) of those assessed as depressed using the GHQ-12 were very satisfied with the area in which they lived, compared with over a half (58%) of those assessed as not depressed ($p < .001$).

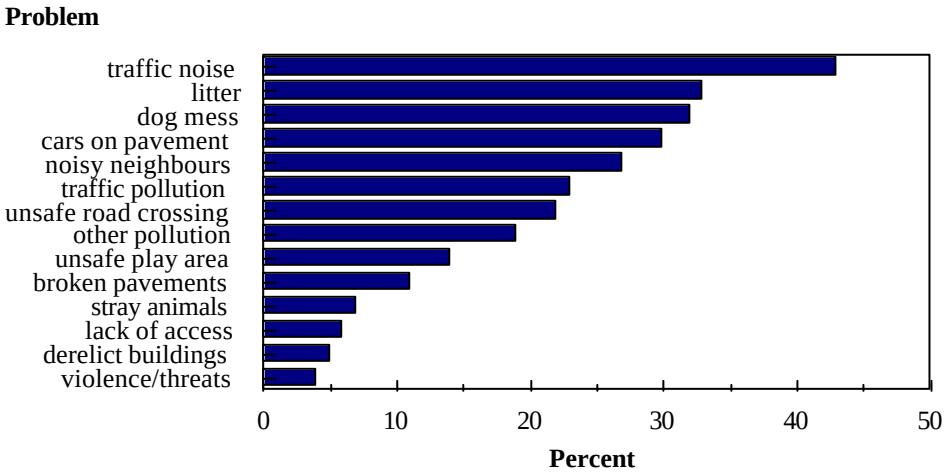
An indication to possible reasons for dissatisfaction with the neighbourhood can be found by exploring the list of possible problems in their neighbourhood that respondents were asked to consider. Respondents were asked if they had experienced any of 19 possible problems during the

past year. The problems that they were asked to consider ranged from noise, pollution, burglaries, nuisances and unsafe aspects of the environment through to violence or abuse. A third of respondents (33%) reported no such problems during the past year and a further fifth (21%) reported just one problem. However, one in ten respondents (11%) reported that they had experienced five or more problems in the past year and the maximum number of problems experienced was 12. The number of problems experienced did not differ between men and women but couples and single people reported more problems than those who were widowed/divorced/separated ($p < .01$). In addition, the proportion reporting three or more problems decreased with age ($p < .001$) with 37% of those aged 18-29 and 41% of those aged 30-39 experiencing three or more problems in the past year, compared with 15% of those in the oldest age group.

The number of neighbourhood problems experienced in the past year was also associated with some aspects of health. Over a third (36%) of those who described their health in the past year as not good' had experienced three or more problems in their neighbourhood, compared with 34% of those who described their health as 'fairly good' and 26% of those who described their health as good' ($p < .001$). Significantly, it was those reporting mental health problems who most frequently stated that they had experienced three or more problems in their neighbourhood in the past year. This was the case for 40% of those reporting anxiety/depression on the EuroQol dimension (compared with 27% of those with no anxiety/depression) ($p < .001$) and for 44% of those assessed as depressed using the GHQ-12, compared with 28% of those not depressed ($p < .001$). There was no difference in the number of neighbourhood problems experienced according to whether a respondent had a long-standing illness or not.

Figure 3.6 shows the frequency of reporting of each of the neighbourhood problems. Most frequently reported was that of traffic noise (43%) followed by litter (33%), dog mess (32%), cars on the pavement (30%) and noisy neighbours (27%).

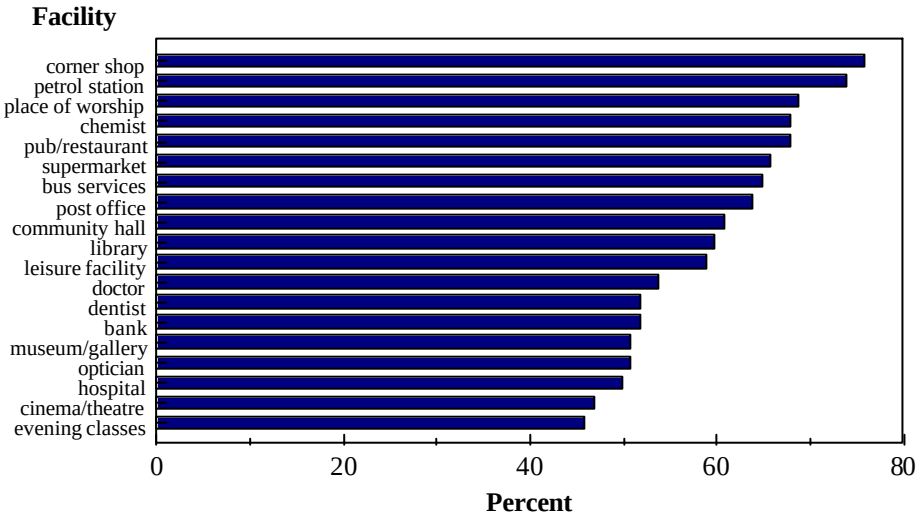
**Figure 3.6: Percentage of respondents reporting each of the different possible problems with their neighbourhood**



**Services**

An important aspect of satisfaction with the environment, which might impact on health, is the degree of ease of access to local facilities. The JHS asked all respondents how easy it would be for them to get to different services if they wanted to. Nineteen different services were specified, and Figure 3.7 shows the proportion of respondents who reported that it was 'very easy' to get to each of them. About three quarters of all respondents reported that it was 'very easy' to get to the corner shop or petrol station and two to three-fifths of respondents reported that it would be 'very easy' to access each of the remaining facilities.

**Figure 3.7: Percentage of respondents reporting that it was 'very easy' to get to different services**




There were significant differences in the ease of access to these facilities by health status. The facility that was reportedly 'very easy' to get to by the largest proportion of respondents was the corner shop. However, the mean EuroQol VAS score of those who found it 'very easy' to get there was 79, compared with a mean VAS score of 63 for those who found it difficult ('fairly difficult' or 'very difficult') to get there. Similarly, those who reported their health during the past year to be 'good' were significantly more likely to be able to get to the corner shop very easily (79%) than those who reported their health during the past year to be 'not good' (64%) ($p < .001$), as were those with no long-standing illness (79%) or a non-limiting long-standing illness (79%) rather than a limiting long-standing illness (66%) ($p < .001$).

Respondents who had a problem on any of the EuroQol dimensions were also significantly less likely to be able to get to the corner shop very easily (Table 3.1).

A similar picture was found when examining facilities that were 'very easy' to get to by a smaller proportion of respondents. The service that was reportedly 'very easy' to get to by the smallest proportion of respondents was evening classes. Here, the mean EuroQol VAS score of those who found it 'very easy' to get there was 81, compared with a mean VAS score of 68 for those who found it difficult ('fairly difficult' or 'very difficult') to get there. Again, those who reported their health during the past year to be 'good' were significantly more likely to be able to get to evening classes very easily (52%) than those who reported their health during the past year to be 'not good' (33%) ($p < .001$), as were those with no long-standing illness (50%) or a non-limiting long-standing illness (48%) rather than a limiting long-standing illness (36%) ($p < .001$). Further, respondents who had a problem on any of the EuroQol dimensions were also significantly less likely to be able to get to evening classes very easily (Table 3.2).

**Table 3.1: Respondents stating that it was 'very easy' to get to the corner shop, by each EuroQol dimension**

| EuroQol dimension | No problem (%) | Any problem (%) | Significance of difference |
|---|---|---|---|
| **Mobility** | 78 | 60 | < .001 |
| **Self-care** | 77 | 38 | < .001 |
| **Usual activities** | 78 | 64 | < .001 |
| **Pain/discomfort** | 78 | 69 | < .001 |
| **Anxiety/depression** | 77 | 68 | < .001 |

**Table 3.2: Respondents stating that it was 'very easy' to get to evening classes, by each EuroQol dimension**

| EuroQol dimension | No problem (%) | Any problem (%) | Significance of difference |
|---|---|---|---|
| **Mobility** | 48 | 28 | < .001 |
| **Self-care** | 47 | 21 | < .001 |
| **Usual activities** | 48 | 32 | < .001 |
| **Pain/discomfort** | 48 | 39 | < .001 |
| **Anxiety/depression** | 48 | 37 | < .001 |

Families were additionally asked how easy it was to get to a number of relevant facilities for them. All families with children were asked about getting child care and to safe play facilities and families with school aged children were questioned about getting to after-school clubs and youth clubs and about public transport to school. Far smaller percentages found these 'very easy' to get to than did adults getting access to local facilities. Thus, only two-fifths found public transport to school (42%) or safe play facilities (40%) 'very easy' to get to, the proportions dropping to 36% for youth clubs, 24% for child care and 20% for after-school clubs. Correspondingly, a greater proportion of families reported that these facilities were difficult to get to (either 'fairly difficult' or 'very difficult'). When these responses were analysed by different measures of health status, a similar picture emerged – it was those in poorer health who tended to find it difficult to get to the facilities. Table 3.3 summarises these details, showing the percentage of respondents who found it difficult to get to each of the facilities, by different measures of health.

**Table 3.3: Percentage of families who found it difficult to get to each of the facilities, by different measures of health**

| Health measures | Safe play facilities | Child care | After-school clubs | Youth clubs | Public transport to school |
|---|---|---|---|---|---|
| | | | | | |
| **Health in past year** | | | | | |
| Good | 9 | 29 | 23 | 15 | 19 |
| Fairly good | 20 | 37 | 37 | 28 | 20 |
| Not good | 34 | 43 | 44 | 32 | 19 |
| *Significance* | *< .001* | *< .01* | *< .01* | *< .01* | *> .05* |
| | | | | | |
| **GHQ-12 score** | | | | | |
| Not depressed | 13 | 30 | 27 | 18 | 19 |
| Depressed | 16 | 40 | 34 | 30 | 20 |
| *Significance* | *< .01* | *< .001* | *> .05* | *> .05* | *< .01* |
| | | | | | |
| **Long-standing illness** | | | | | |
| None | 12 | 31 | 28 | 19 | 17 |
| Non-limiting | 14 | 24 | 24 | 22 | 18 |
| Limiting | 20 | 37 | 31 | 23 | 23 |
| *Significance* | *> .05* | *> .05* | *> .05* | *> .05* | *> .05* |
| | | | | | |
| **Any problem on any EuroQol dimension** | | | | | |
| No problems | 11 | 32 | 26 | 17 | 19 |
| Any problem | 18 | 32 | 31 | 25 | 20 |
| *Significance* | *> .05* | *> .05* | *> .05* | *> .05* | *> .05* |
| | | | | | |
| **Mean VAS score** | | | | | |
| If very easy to get to | 80 | 78 | 78 | 78 | 80 |
| If difficult to get to | 74 | 77 | 78 | 77 | 81 |
| | | | | | |

As Table 3.3 shows, there were significant differences in the ease of getting to different facilities for families, when assessed on health in the past year and the GHQ-12 score for depression. More people, who reported poorer health in the past year, found it difficult to get to safe play facilities, child care, after-school clubs or youth clubs. More people, who were assessed as depressed on the GHQ-12 scale, found it difficult to get to safe play facilities, child care and public transport to school. There were no significant differences in the ease of getting to different facilities for families, when assessed on long-standing illness, any problems on any of the EuroQol dimensions or self-rated health as measured on the EuroQol VAS. Nevertheless, these findings are important for a number of reasons.

Firstly, it suggests that, in general, families find it more difficult to get to facilities for their children than do adults with regard to general facilities. Over a half of all adults found it 'very easy' to get to most facilities, whereas the proportion fell to less than two fifths for families finding it 'very easy' to get access to facilities for their children. Secondly, it suggests that the health of adults is associated with the ability of families to get facilities for their children. This may work in one of

two ways: parents already in poor health might find it more difficult to get to child care facilities than parents in comparatively better health. Alternatively, the lack of access to child care facilities might itself impact on parental health causing it to deteriorate. Poorer self-rated health over the past year and increased depression, as measured by the GHQ-12 questionnaire, were associated with difficulties with getting to facilities for children. Both access to safe play facilities and child care were significant problems for those with less than good health over the past year or those suffering from depression. Finally, approximately a third (32%) of all families with children considered it difficult ('fairly difficult' or 'very difficult') to get to child care and 29% had difficulty getting to after-school clubs. These were by far the largest proportions of respondents who had difficulty getting to any facility. Thus, it would seem that these are two key areas where improvements to ease of access should be considered.

**Transport**

Respondents to the JHS were asked about their use of public and private transport. Over three quarters (78%) of respondents said that public transport was available when they needed it but over a half (55%) never did so. Only a small minority (15%) had no personal use of a car or van. Thus, it seems that private transport was the preferred means of travel even though public transport was available to most people.

There were, however, significant differences by gender, age, marital status and different measures of health. Public transport was available when needed for more women than men ($p < .05$), for younger people rather than for older people ($p < .01$) and for people with no problems on the EuroQol dimension of anxiety/depression rather than those with some problems ($p < .01$). However, public transport was actually used by more women than men ($p < .001$), by widowed/divorced/separated or single people rather than married people ($p < .001$) and by those in the youngest (age 18-29) age group or those aged 60 or over rather than the middle-aged ($p < .001$). It was also used by more people who described their health during the past year as 'fairly good' than it was by people who described their health as 'good' or 'not good' ($p < .05$).

There was a wider range of differences regarding personal use of a car or van. Better access to a vehicle was enjoyed by men ($p < .001$), respondents living as a couple ($p < .001$) and those between the ages of 30 and 60 ($p < .001$). Those who described their health during the past year as 'good' were more likely to have personal use of a car or van than other respondents ($p < .001$) as were those who reported no problems on the EuroQol dimensions of mobility, self-care or usual activities rather than some problems (Table 3.4). The mean EuroQol VAS score for those with personal use of a car or van was 78, compared with a mean score of 69 for those who did not have such access.

**Table 3.4: Respondents who have personal use of a car or van, by the five EuroQol dimensions**

| EuroQol dimension | No problem (%) | Any problem (%) | Significance of difference |
|---|---|---|---|
| Mobility | 86 | 74 | < .001 |
| Self-care | 85 | 70 | < .01 |
| Usual activities | 86 | 77 | < .001 |
| Pain/discomfort | 86 | 82 | > .05 |
| Anxiety/depression | 85 | 82 | > .05 |

**Accommodation and neighbourhood**

Almost a half of all respondents (45%) were 'very satisfied' with both their accommodation and the area in which they lived. Whilst just 2% (n = 42) were dissatisfied with both, approximately four times this many (9%, n = 190) were dissatisfied with either their accommodation *or* their environment. Because of this, we undertook a logistic regression exercise to ascertain whether the health of those who were 'very satisfied' with both their accommodation *and* their environment was significantly better than that of other respondents, when gender, marital status and age were held constant. We found this to be the case on only two of the health measures examined.

Firstly, respondents reporting 'fairly good' health over the past year were significantly less likely than those reporting 'good' health to be very satisfied with both their accommodation *and* the area in which they lived. The odds were 0.7 : 1 ($p < .01$). There was, however, no significant difference in the satisfaction of those reporting 'not good' health compared with those reporting 'good' health.

Secondly, the odds (of being very satisfied with both one's accommodation *and* environment) of respondents reporting problems on the EuroQol dimension of anxiety or depression were only half those of respondents with no problems on this dimension (0.5 : 1) ($p < .001$). The direction of association here, however, is unknown. It may be that living in unsatisfactory accommodation or surroundings precipitates anxiety or depression or it may be that those who are already anxious or depressed move into less satisfactory housing or neighbourhoods. All we can note is the significant association between dissatisfaction with one's home and environment and mental health problems. Aspects that have been found to be likely to contribute to this are dissatisfaction with one's accommodation, one's home being in a poorer state of repair, the health of someone in the household being made worse by their housing situation, dissatisfaction with the area in which one is living, difficult access to a range of facilities and public transport not being available when needed.

**Conclusions**

- The majority of respondents are happy with their accommodation
- The majority of respondents live in a home in a good state of repair
- The majority of respondents are satisfied with the area in which they live
- Over a half of all adults found access to a wide range of facilities very easy
- Only a quarter of families found access to key facilities to be very easy
- Over three quarters of respondents said that public transport was available when needed
- Over half of respondents did not use public transport
- The majority of respondents had personal use of a car or van

# Section 4

# Social Capital

**Introduction**

The importance of social factors to health is, perhaps, less immediately obvious than that of factors such as lifestyle or environment. In recent years, the term *social capital* has increasingly been used in public health research and policy spheres (Mutaner *et al,* 2000) although there are differences of opinion about its meaning and importance to the health of individuals. Social capital has been described as "*…the social, collective, economic and cultural resources available to a family, neighbourhood or community*" (Cooper *et al*, 1999). However, this is a very broad range of factors and the Jersey Health Survey (JHS) focused specifically on the following:

- the nature and extent of social networks
- the availability of informal sources of support and help
- levels of activity in community organisations
- access to and use of a range of health and welfare services

*and*

- the relationship between the above and the physical and mental health of respondents

This analysis enables us to identify how much contact respondents have with families, friends and neighbours, how much help and support they are able to call on in a range of circumstances and how actively involved they are in community life. In short, it enables us to gain a clearer picture of family and social life. There are also areas of overlap between social factors and those covered in other sections of this report and the analyses provided in other sections are, of course, also highly relevant to developing this picture. For example, in Section 3, on *The Environment and Housing*, there is evidence of respondents' ease of access to a range of facilities and measures of their levels of satisfaction with the neighbourhood they live in.

More difficult to measure accurately is the nature of the relationship between such factors and people's health. However, it is also important to bear in mind that the health of a community, such as Jersey, is more than simply the sum of the health of individuals. The links between levels of social inclusion and exclusion are increasingly recognised as important factors in public health and there is increasing reference to these in policy documents. For example, the UK Health Development Agency has set up a Social Action Research Project to develop and evaluate models of community participation with the aim of improving health and reducing inequalities in health. The Jersey Health Promotion Strategy document states that '*to strengthen community participation and action'* is one of its major challenges (Jersey Health Promotion Unit, 1998).

Information about the strengths and weaknesses of social and community ties provide useful data about the quality of life enjoyed by Jersey people that can be used in planning and policy-making. For some, health and welfare services provide a necessary substitute for informal networks when

help is needed. For others, such services complement informal networks of support. The analysis in this section provides details of this complex web of contact, support, help and activity.

**Family and social networks**

Respondents were asked how many members of their family (including all relatives) aged over and under the age of 18 were still living. These two questions give an indication of the extent of people's family networks. Responses indicate that the majority of Jersey residents have extensive family networks, with 43% having 10 or more, 40% having five to nine members and 17% having zero to four family members still living. These figures do not, of course, provide any indication of levels of proximity between family members.

The preliminary household survey carried out in Jersey provides data on the numbers of people living in individual households, including all members of households - not just family members. The results show that the most common household size is two people (31%), followed by one person (22%) and three people (20%). Only 2% of the households have more than five people living in them. The size of people's family networks is, therefore, not reflected in their household composition. It should not be inferred from this that family ties are loose, however, since co-residence is not a pre-requisite of robust family networks.

**Family networks and health**

The relationship between family networks and individuals' health is complex and should not be understood as a causal link. The results suggest that larger family groups are associated with better health. Responses were grouped according to the size of their family networks cross-tabulated with self-reported health. The results suggest that those with small family groups (0-4) are less likely to report good health than are those with medium-sized (5-9) or large family groups (10 or more). The overall picture is given in Figure 4.1.

**Figure 4.1. Size of extended family (grouped) by percentage self reported health status**

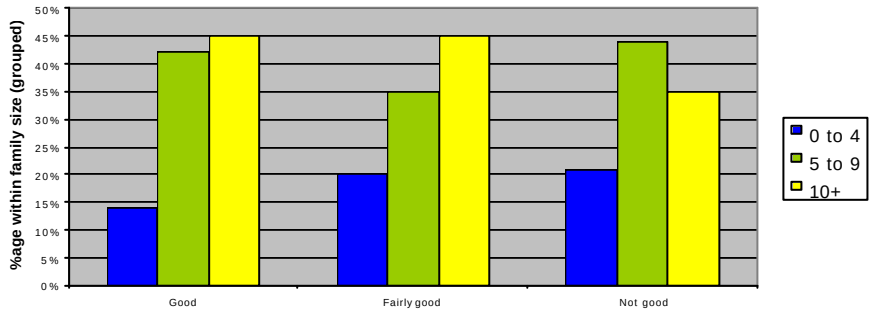


Figure 4.1 shows a mixed picture. Of those who report their health as 'good', most have larger extended family networks. Conversely, a larger percentage of those who describe their health as 'not good' have smaller extended families, although those with families of five to nine members make up the largest percentage of this group.

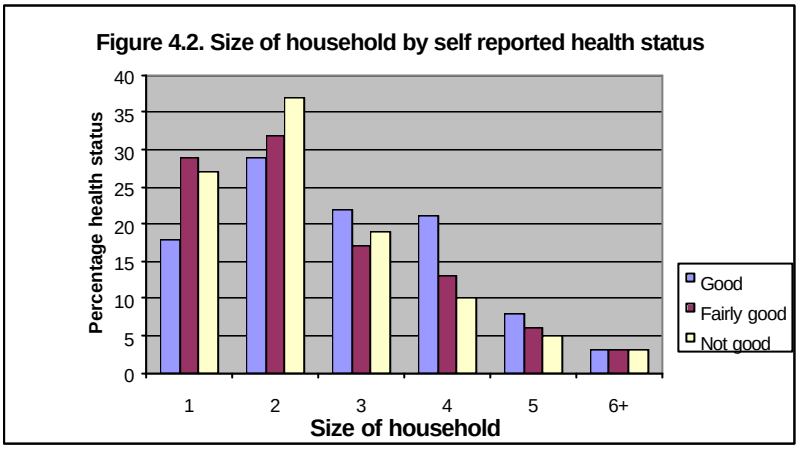



Figure 4.2 shows that in the largest household category of six-plus, the percentages reporting 'good', 'fairly good' and 'not good' health are evenly spread. Within household categories of three, four and five people, there is a higher percentage reporting 'good' health, whilst within single person and two person household category fewer people report being in 'good' health.

**Frequency of social contact**

Taking the analysis beyond size and proximity, an examination of the frequency of contact between people provides further information about the nature of family and social networks. Respondents were asked to identify how frequently they had contact with members of the family, friends or neighbours.

**Frequency of contact with family**

Jersey respondents had, on average, frequent contacts with their family, with 83% of respondents reporting at least weekly contact with a relative (45% had daily contact). However, the frequency of regular contact with family on Jersey is less than in Britain, where 91% of people have at least weekly contact with family members and 59% have daily contact (Gordon *et al*, 2000). Less than 5% of people in Jersey reported having contact with a family member yearly or less (the comparable figure for Britain is 1% of people). Therefore, although the overwhelming majority of people on Jersey have regular contact with family members, this contact is less frequent than for people in Britain. This is probably a result of living an 'island life' rather than choice since family members of Jersey people may be living in other countries thereby making frequent contact more difficult.

**Frequency of contact with neighbours and friends**

Contact with friends is also frequent for the majority, with 31% of respondents having daily and 84% weekly contact with friends. Only 2% reported having contact with friends yearly or less. A somewhat different picture emerges of contact with neighbours. Only 21% of respondents had daily contact with neighbours, 65% weekly and 17% yearly or less. Combining the figures for friends and neighbours, over 92% of respondents have at least weekly contact with friends or neighbours. This is similar to people in Britain in 1999 (Gordon *et al*, 2000) where 92% have at least weekly contact with friends (including neighbours and work colleagues who are friends). Therefore, although people in Jersey may have less regular contact with their families than people in Britain they see their friends just as frequently as people in Britain do.

**Figure 4.3: Frequency of contact with family and friends/neighbours**

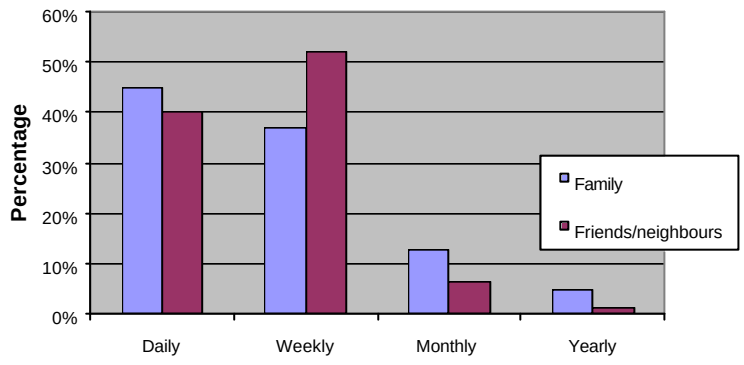



Figure 4.3 compares the frequency of family contact with that of friends and neighbours. This illustrates the pattern of contact in each category expressed as a percentage of the whole cohort. Whilst daily contact with family was most frequently reported, contact with friends was more likely to be on a weekly basis. Very few (1%) had only yearly contact with friends.

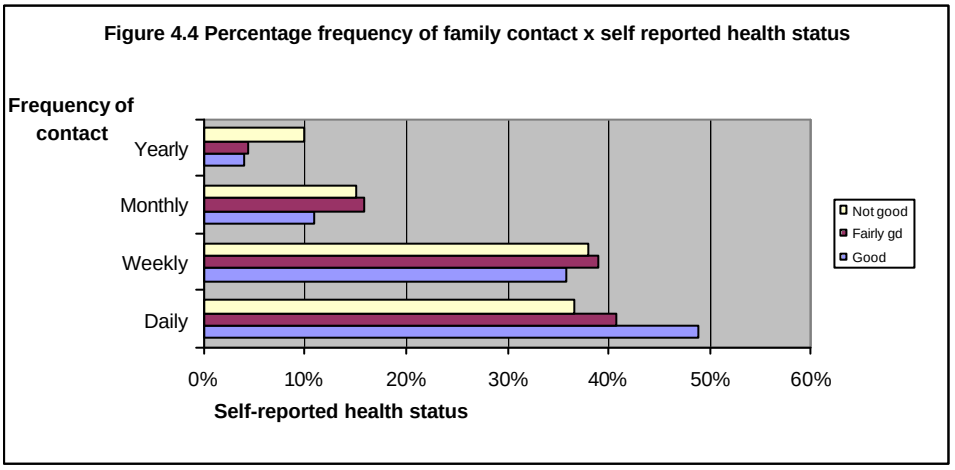
**Frequency of family contact and health**

Table 4.1 shows the relationship between frequency of family contact and self-reported health. Those with daily contact with family members are more likely to describe their health as 'good' than are those with monthly or yearly contact. Of those who reported daily contact with their family, 62% described their health as 'good' with a further 32% describing their health as 'fairly good'. Conversely, those with monthly or yearly contact are more likely to describe their health as 'not good' compared with those with daily contact. Seventeen percent of those who reported yearly or less contact with their family described their health as 'not good'. The results suggest that more frequent contact with family is associated with better health.

**Table 4.1: Frequency of family contact and health status**

| Frequency of family contact | Health status | | | |
|---|---|---|---|---|
| | Good % | Fairly good % | Not good % | Total % |
| Daily | 62 | 32 | 6 | 100 |
| Weekly | 56 | 37 | 8 | 100 |
| Monthly | 48 | 43 | 9 | 100 |
| Yearly or less | 49 | 34 | 17 | 100 |
| **Total** | **57** | **35** | **8** | **100** |

**Figure 4.4: Health status by frequency of contact**

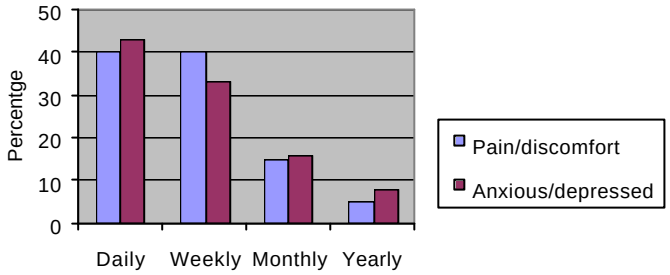



In general, those who have more frequent contact with their families have fewer problems with health. Levels of health are roughly comparable between those who have weekly and those who have monthly contact. The health of those in yearly contact are significantly worse than those who are in daily contact with their families. Health status, as measured by the EuroQol dimensions (pain/discomfort, anxiety/depression, mobility, performance of usual activities, self-care) show a similar relationship with frequency of contact with family and friends.

An important consideration is the frequency of family contact of those who describe their health as 'poor'. Figure 4.5 illustrates the pattern of contact with families of those who are either anxious or depressed or have pain or discomfort. Taking the two most frequently reported health problems in the survey, pain/discomfort (30%) and anxiety/depression (22%), it is clear that, in both cases, family contact is frequent and regular for the majority. Of those who report pain and discomfort, 40% have daily and 80% at least weekly contact with their family, whilst 15% have only monthly

and 5% yearly contact. Of those who are rated as anxious or depressed in the EuroQol dimension, 43% have daily contact with their families but 75% have at least weekly contact. These results are shown in Figure 4.5.

**Figure 4.5: Frequency of family contact of those reporting pain/discomfort or anxiety depression**

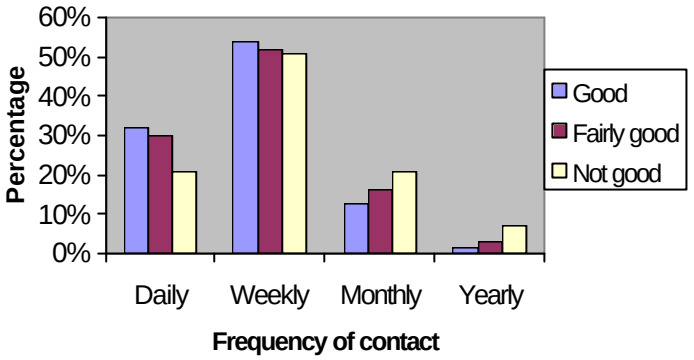



Whilst these are high levels of contact overall, it should be noted that 20% of those who suffer pain and discomfort and 24% of those who are anxious or depressed have only monthly or yearly contact with their families.

**Contact with friends/neighbours and health**

The results demonstrate that more frequent contact with friends is similarly associated with good health. Of those who report daily contact with friends, only 5% describe their health as 'not good' compared with 22% of those who have only yearly contact. The relationship between contact with friends and self-assessed health status is shown in Figure 4.6.

**Figure 4.6: frequency of contact with friends by health status**




Whilst weekly contact remains the most common, this figure indicates an inverse relationship between levels of health and frequency of contact with friends. Less frequent contact is more likely where health is poor.

Of the 20% of the sample that reported anxiety/depression using the EuroQol measure, 23% saw friends daily and 52% weekly. However, 25% saw friends only monthly or yearly. Similarly, taking the 30% of people that reported experiencing moderate or extreme pain or discomfort, 23% of these saw friends on a daily basis and 56% on a weekly basis whilst 21% saw friends only monthly or yearly.

The overall picture of social contacts is therefore healthy, in that most people have family or friends in frequent and regular contact. However, those in poorer health are less likely to have frequent contact with their friends. Specifically, of those that experience pain/discomfort or anxiety/depression, almost a quarter has only monthly or yearly contact with family and a quarter has monthly or yearly contact with friends. This suggests that there are an appreciable number of people in poor health in Jersey who are socially isolated.

**Support from others when needed**

Frequency of contact is an important measure of social support but the survey also attempted to identify the *type* of support available to respondents in particular situations. One indicator of the existence of functioning social relationships and networks is the amount of practical and emotional support potentially available to individuals in times of need (Gordon *et al*, 2000). Respondents were presented with six hypothetical instances:

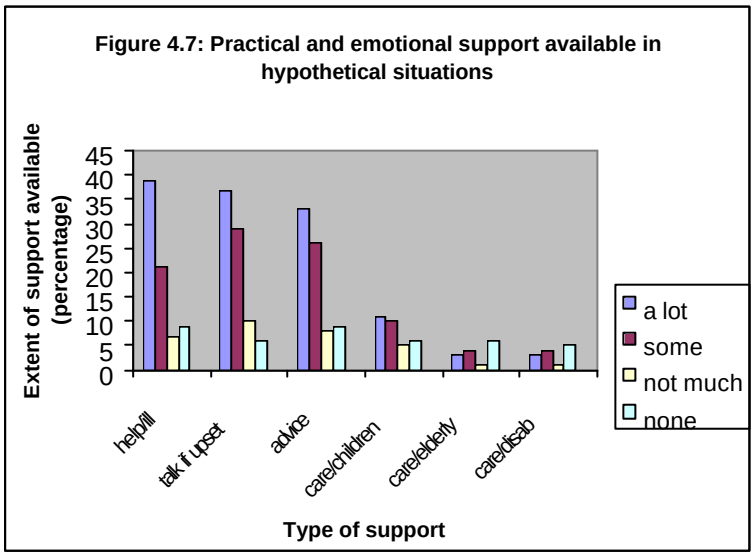
- Help around the home if you are ill in bed

- Needing advice about an important change in your life
- Being upset and wanting to talk to someone
- Needing someone to look after children
- Needing someone to look after an elderly person
- Needing someone to look after a disabled adult.

They were asked how much support they would get if they needed it. For the first three instances (help if sick in bed, advice or support when upset), less than a quarter reported that such support was *not* needed. However, in the last three instances regarding support with caring responsibilities, the vast majority of respondents did report that such support was *not* needed: support with care of children (69%), elderly people (86%) or disabled adults (87%).

Figure 4.7 shows the extent of support available to those who said they might have need in the instances presented.

**Figure 4.7: Practical and emotional support available in hypothetical situations**




The responses show that most respondents, who express a need, are able to call on sources of support - either a lot or some. If the categories 'a lot' and 'some' are combined, 66 % say they would get support if they were upset and needed someone to talk to, 60% say that they would be able to get help around the home if they were ill whilst 59% say they would get support if they needed advice on an important change in their lives.

Of those that report a need for support with caring for a child or an elderly or disabled person, is noteworthy that help with child-care is most readily available. Two thirds of those with child-care responsibilities reported that they would get support if needed. The 14% of respondents that referred to their need for support with caring for a disabled or elderly relative were almost equally

divided between those who considered that they would get 'a lot' or 'some' support and those who said they would get 'not much' or 'none'.

Table 4.2 compares the potential support for Jersey respondents and British respondents in 1999 who indicated that they might need some help in three hypothetical situations.

**Table 4.2: Proportion of respondents having potential support in three hypothetical situations**

| Type of support | Not much/none (%) | | A lot/some (%) | |
|---|---|---|---|---|
| | **Jersey** | **Britain** | **Jersey** | **Britain** |
| Advice | 23 | 13 | 77 | 87 |
| Home help during an illness | 21 | 11 | 79 | 89 |
| Talking to if depressed/upset | 20 | 9 | 80 | 91 |

There appear to be large differences in the levels of potential support between Britain and Jersey, with twice as many respondents in Jersey having 'none' or 'not much' support. However, these results need to be interpreted with some caution as the question wording in the JHS and the *Poverty and Social Exclusion Survey of Britain* (PSE) were somewhat different. In particular, in the JHS, respondents had the option of stating that help was not needed and this may in part explain the difference in the results.

A number of factors need to be taken into consideration. Respondents were asked to envisage situations where they might need support. The results therefore reflect the kind of support people feel able to call upon and what demands they might be willing to place on family and friends, rather than a measure of actual support given.

In addition, it should be borne in mind that there is a qualitative difference between asking for support at times of individual crisis (as in the first three instances) and help over the longer term (as in the last three instances). Research has shown consistently over the past twenty years that carers of disabled adults are unlikely to receive ongoing support, although they might be able to call on friends or extended family for one-off support such as gardening or providing transport (Parker and Lawton, 1994). Research on carers has also demonstrated that many find their social networks are much reduced by their caring responsibilities (Twigg and Atkin, 1994). The implication of this finding is that support for carers of disabled and elderly relatives is not uniformly available within people's own family and social networks.

**Social support and health status**

The relationship between levels of support and health status has been analysed through cross-tabulation of responses to the question on sources of support and to the questions on particular aspects of health status. This enables analysis of the support available to those who

might be assumed to have greater need. For example, those who report their health as 'not good' are more likely to need help around the house if they are in bed. Similarly, those who are anxious or depressed are more likely to need someone to talk to. These results are shown below in Tables 4.3 to 4.6.

**Table 4.3: Extent of help around the house if sick in bed by health status**

| Extent of help | Health status | | |
|---|---|---|---|
| | **Good** | **Fairly good** | **Not good** |
| | **(%)** | **(%)** | **(%)** |
| A lot/some | 60 | 62 | 57 |
| Not much/none | 11 | 22 | 31 |
| Not needed | 29 | 16 | 12 |
| **Total** | **100** | **100** | **100** |

Table 4.3 shows that, where respondents envisage an instance of being sick in bed and needing help around the house, those in good health are more able to draw on sources of support than those who are not in good health. Nearly one third of those currently not in good health say they would receive little or no help in this situation. Again, this may reflect people's expectations of what they can demand of their friends and extended family. Those in poorer health may feel less able to ask for support because their need is ongoing rather than sporadic.

A similar analysis can be made of the levels of support for those who are anxious/depressed (in the EuroQol dimension) when they are upset and need to talk to someone. This is shown in Table 4.4.

**Table 4.4: Extent of support when upset and needing someone to talk to by anxiety/depression measure (EuroQol dimension)**

| Level of support | Anxiety/depression | | |
|---|---|---|---|
| | **Not anxious/ depressed** | **Moderately anxious/ depressed** | **Extremely anxious/ depressed** |
| | **(%)** | **(%)** | **(%)** |
| A lot/some | 66 | 62 | 61 |
| Not much/none | 14 | 30 | 32 |
| Not needed | 20 | 8 | 7 |
| **Total** | **100** | **100** | **100** |

Levels of support for those who are upset and need someone to talk to reduce with increasing levels of anxiety/depression, as measured on the EuroQol dimension. Conversely, the more anxious/depressed someone is, the less likely it is that they would get a lot or some support.

Another example is the level of support in caring for an elderly person cross-tabulated by the health status of the carer. This is shown in Table 4.5, where the figures for those who reported no need have been disregarded.

**Table 4.5: Help with the care of an elderly person by self-reported health status of respondent**

| Level of support | Health status | | |
|---|---|---|---|
| | Good | Fairly good | Not good |
| | (%) | (%) | (%) |
| A lot/some | 56 | 46 | 29 |
| Not much/none | 44 | 54 | 71 |
| **Total** | **100** | **100** | **100** |

Table 4.5 shows that half of those respondents who expressed a need for help with caring for an elderly relative report that they would be able to get such help, as indicated previously. However, it also demonstrates that those in poorer health are less likely to get such help than those in good health. This reinforces the need to take account of the needs of carers for support from health and social care agencies, since carers in poorer health are less likely to be able to call on informal sources of support.

Table 4.6 shows the levels of support available to those with child care responsibilities cross-tabulated with health status.

**Table 4.6: Help with care of children by self-reported health status of respondent**

| Level of support | Health status | | |
|---|---|---|---|
| | Good | Fairly good | Not good |
| | (%) | (%) | (%) |
| A lot/some | 72 | 57 | 50 |
| Not much/none | 28 | 43 | 50 |
| **Total** | **100** | **100** | **100** |

Table 4.6 shows, again, how levels of support decline as the health status of respondents worsens. Although two-thirds of respondents who express a need for help are able to get it, this help is unevenly distributed between groups with varying health status.

**Social and community activities**

Respondents were asked: *'Do you regularly take part in activities with any of the following groups or types of organisations?'* The aim of this question was to identify how actively involved Jersey residents are in their local community life. Respondents were asked to tick all boxes that applied to them. The scores for each box are shown in Table 4.7 which also give some comparative figures collected for *The Poverty and Social Exclusion Survey of Britain* in 1999 (Gordon *et al*, 2000)

**Table 4.7: Current activities and involvement in civic organisations**

| Type of group | Jersey (%) | Britain (%) |
|---|---|---|
| Sports or leisure clubs | 26 | 18 |
| Church | 13 | 12 |
| Voluntary organisation | 12 | 8 |
| School | 11 | 6 |
| Social club | 10 | 10 |
| Adult education | 8 | |
| Parish | 6 | |
| Youth club | 3 | |
| Environmental interest group | 2 | 3 |
| Trades Union | 1 | 10 |
| Political party | | 2 |
| Tenants associations | 1 | 9 |
| Other | 5 | 11 |
| None of the above | 43 | 41 |

Over half the respondents to the JHS (57%) are actively engaged with community organisations, with by far the most frequent activity being the use of sports or leisure clubs which a quarter of the population use. In both Jersey and Britain in 1999, just over two fifths of the population did not participate in any civic organisation, however, the pattern of activity showed interesting differences. There is comparatively much greater involvement with trades unions, tenants associations and political parties in Britain than in Jersey. Conversely, in Jersey there is greater involvement in sports and leisure, schools and voluntary organisations.

Good health is associated with activity in community organisations but there is no evidence that good health is an effect of such activity. Indeed, one explanation for the association is that it is more difficult for those in poorer health to be active in community organisations. Of those who describe their health as 'poor', 64% are active in *none* of the listed organisations compared 38% of those who describe their health as being 'good' and 47% of those who describe their health as 'fairly good'. Of those who describe their health as 'not good', 36% are active in at least one of the listed organisations. This compares with almost 63% of those who describe their health as 'good' and 52% of those who describe their health as 'fairly good'. This is shown in Table 4.8 below.

**Table 4.8: Involvement in number of community activities by health status**

| Number of activities | Health status | | | Total |
|---|---|---|---|---|
| | Good (%) | Fairly good (%) | Not good (%) | (%) |
| None | 38 | 48 | 64 | 43 |
| 1 | 35 | 29 | 24 | 32 |
| 2+ | 28 | 23 | 12 | 25 |
| **Total** | **100** | **100** | **100** | **100** |

However, the difference in levels of activity calculated by other measures of health is less stark. For example, in Table 4.9 below, levels of community activity are cross-tabulated with self-reported long-standing illness.

**Table 4.9: Involvement in number of community activities by self-reported long-standing illness**

| Number of activities | Long-standing illness | | | Total |
|---|---|---|---|---|
| | Limiting long-standing illness (%) | Long-standing illness (%) | No illness (%) | (%) |
| None | 47 | 43 | 42 | 43 |
| 1 | 28 | 32 | 33 | 32 |
| 2+ | 25 | 25 | 25 | 25 |
| **Total** | **100** | **100** | **100** | **100** |

Table 4.9 shows smaller variation between those with different levels of long-standing illness in respect of their level of community activity. It is still *less* likely that a person with limiting long-standing illness or long-standing illness will be engaged in one activity and *more* likely that they will be engaged in none. However, respondents with limiting/long-standing illness are just as likely as respondents with no illness to be engaged in two or more activities.

Ease of access is an important aspect of community activity, particularly if the aim is to promote social inclusion. Table 4.10 shows the picture when mobility is taken into account.

**Table 4.10: Involvement in number of community activities by levels of mobility**

| Number of activities | Mobility | | Total |
|---|---|---|---|
| | I have no problem in walking about | I have some problems in walking about | |
| | (%) | (%) | (%) |
| None | 41 | 54 | 43 |
| 1 | 33 | 23 | 32 |
| 2+ | 26 | 23 | 25 |
| **Total** | **100** | **100** | **100** |

This table demonstrates that those with mobility problems are less likely than those with none to be active in community organisations. A similar picture is evident when measures of anxiety/depression (EuroQol dimension) are taken into account. Those who are either moderately or extremely anxious/depressed are equally divided between those who are active in no organisation and those who are active in more than one. Those who have no anxiety/depression are divided between 59% that are active in one or more organisation and 41% active in none.

The overall picture for community activity is that 57% of the population are active in at least one community organisation. Activity is associated with good health although the relationship between such activity and health status is impossible to assess. Those who report poorer levels of health on a number of different measures are less likely to be involved in activities. This raises questions about the ease with which disabled or less healthy people can access community organisations such as those listed in the survey.

**Use of health services**

The provision of health services can be regarded as an aspect of social capital in a number of ways. First, it provides an essential safety net for those who are unable to call on informal networks of family and friends. Second, the provision of services can be an important stimulus to new informal networks. For example, attendance at ante-natal classes may lead to increased contact and support between mothers of young babies. Third, the ability to access publicly funded services is vital to the health of poorer people. In the JHS, people were asked how many times in the past 12 months they had used any of the nine health services listed below:

- GP at the surgery
- GP at own home
- Hospital casualty
- Hospital outpatients
- Dentist
- Pharmacy
- Optician
- Private doctor other than GP

· Nurse care other than hospital

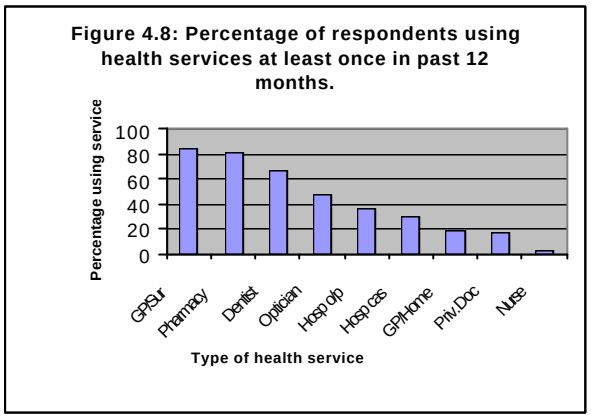



Figure 4.8 shows the number of respondents who used the services at least once during the past 12 months. The GP is most likely to have been used, with 85% of respondents reporting at least one visit to the surgery. Respondents were much less likely to call the doctor to their own home. Only 18% of respondents had called the doctor to their home in the past 12 months. The pharmacy was most likely to have been visited on more than 10 occasions (20% of respondents).

Visits to the dentist were regular for the majority, with 67% having visited the dentist at least once in the past year. From a health promotion perspective, it should be noted that 32% of respondents reported that they had not visited the dentist at all in the past year, although just over 50% of respondents reported that it is 'very easy' for them to get to the dentist (see Figure 3.7 in Chapter 3). However, these figures compare favourably with the UK as a whole. The 1995 General Household Survey showed that only 54% of people aged 16+ said that they still attended the dentist regularly.

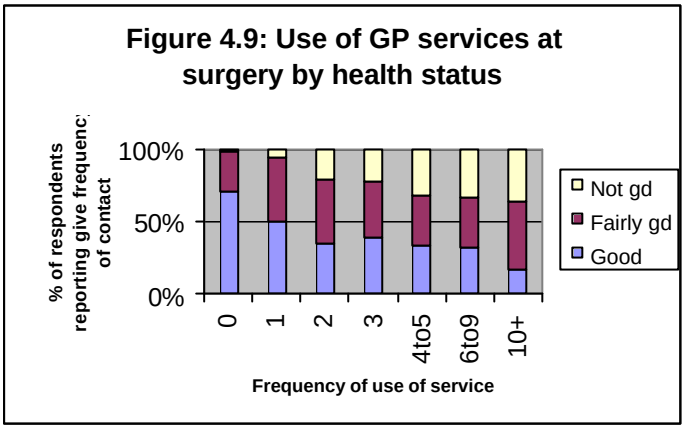
Another noteworthy figure is that 29% of respondents had visited the hospital casualty department at least once in the past year. The use of hospital casualty services in Jersey is relatively high and can be attributed to the numbers of residents who are ineligible for health insurance, the cost of GP services and the range of services available at GP surgeries.

**Use of services and health status**

The figures for use of different services can be measured against people's own description of their health status.

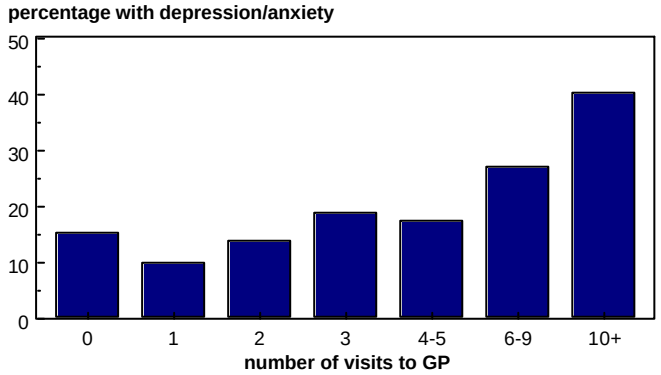
The use made of the GP surgery can be analysed as follows. Of the 58% of respondents who describe their health as 'good', 18% had not visited the GP surgery at all, 40% visited once or twice and only 27% had visited on four or more occasions. As might be expected, the trend for the 8% of respondents whose health is described as 'not good' is the opposite. In this case, 81% said they

visited on four or more occasions whilst only 4% did not visit the GP surgery at all. These results are set out in Figure 4.9.




Other measures of health provide a similar picture. For example, Figure 4.10 shows the numbers of visits to GP surgeries of those who are anxious/depressed, as measured by EuroQol dimension.

**Figure 4.10: Visits to GP surgeries by the anxious/depressed**




With regard to those suffering from pain and discomfort, the results show that 61% have visited the GP surgery four times or more in the past 12 months compared with 34% of those who do not.

The use of hospital outpatients is, again, as might be expected, far more frequent for those whose health is 'not good' compared with those whose health is 'good'. Only 6% of those in good health used the outpatients department on four or more occasions compared with 41% of those whose health is 'not good'.

**Use of other services**

Respondents were asked to identify any of a second list of services they had used in the past 12 months. The overall results were as follows:

| | |
|---|---|
| Social Security benefits | 39% |
| Physiotherapist | 32% |
| Chiropodist | 23% |
| Health Visitor | 11% |
| Domestic help | 10% |
| District nurse | 8% |
| Psychologist/counsellor | 8% |
| Parish welfare services | 6% |
| Nursing auxiliary | 4% |
| Other nurse | 4% |
| Home care assistant | 3% |
| Social worker | 3% |
| Occupational therapist | 3% |
| Incontinence service | 2% |
| Speech therapist | 2% |
| Voluntary worker | 2% |
| Mental health nurse | 2% |
| Night sitting service | 1% |
| Meals on wheels | 1% |

Social Security benefits (received by 39% of respondents) can be broken down into individual types of benefit (note some people were receiving more than one type of benefit so the figures below do not sum to 100%):

| | |
|---|---|
| Sickness Benefit | 45% |
| Old Age Pension | 19% |
| Disability Benefit | 10% |
| Family Allowances | 7% |
| Invalidity Benefit | 6% |
| Maternity Allowance | 6% |
| Widows Pension | 5% |
| HIE | 3% |
| Other (unspecified) | 11% |

The five most frequently used services cross-tabulated with self-reported health status produces the following result:

**Table 4.11: Use of a range of services by self-reported health status**

| Use of services | Health status | | | Total |
|---|---|---|---|---|
| | Good | Fairly good | Not good | |
| | (%) | (%) | (%) | (%) |
| Social Security | 36 | 41 | 23 | 100 |
| Physiotherapist | 41 | 17 | 42 | 100 |
| Chiropodist | 39 | 14 | 47 | 100 |
| Health Visitor | 38 | 8 | 54 | 100 |
| Domestic help | 34 | 46 | 19 | 100 |
| **JHS Total** | **57** | **35** | **8** | **100** |

This table shows a mixed picture, which can probably be attributed to the differences in the type of services described. Some services, such as physiotherapy and chiropody, are available privately as well as through the Health and Social Services Department. It is also important to bear in mind that services such as those listed have a preventive function and it should not be assumed that those who use such service are necessarily those in poor health.

For example, Health Visitor services are used by most parents of babies and young children, not necessarily by those in poor health. Physiotherapy services may be used by people who have occasional sports injuries as well as by people who have long-term illnesses. Similarly, domestic help services may be used by people who have good health but who lack time to do their own housework.

When different benefits are taken into consideration, we see that, unsurprisingly, all those claiming invalidity benefits have a long-standing or limiting long-standing illness. Another important figure is that 79% of those claiming Old Age Pension have long-standing or limiting long-standing illness as do 69% of those claiming widows benefits.

It is also important to examine the level of support available to those who might be assumed to be in need. For example, only 7% of those who report a long-standing or limiting long-standing illness receive any domestic help and only 3% have a home care assistant. When mental health is considered, the results show that that only 8% of those who are either moderately or extremely anxious or depressed anxious, as measured by the E5D, use the services of a psychologist or counsellor and only 2% those of a mental health nurse.

The results have a limited use as a basis for establishing the effectiveness of service provision since they are so variable and because the numbers of people using many of the services listed are very low indeed. However, they do suggest that many respondents with health (including mental health) problems or disabilities do not make use of services that might be beneficial. A number of explanatory factors might apply here. First, potential service users might prefer to look for support within the family. Second, the services may not be sufficiently well developed to reach all those that might be in need. Thirdly, services might be under-utilised for reasons of cost or access.

**Conclusion**

Family and friendship networks in Jersey appear, for the majority, to be extensive and strong. Most people enjoy social networks that provide them with regular and frequent contact and support when needed.

However, for a minority, these informal networks do not appear to be available. Moreover, those who might be considered to be in greater need of support from family or friends are less likely to have such support. There are pockets of isolation within the population where need is not met. In particular, those needing support with caring for children, elderly or disabled relatives are lacking in such support. This is a particularly important issue, given the apparent strength of family networks. If families are to be able to continue with caring responsibilities, additional support will need to be provided. The UK government has recently developed such a strategy, which includes the provision of regular short breaks for carers, information and advice on services, financial benefits (including pension provision for some carers) and a focus on carer-friendly employment policies to ease the stress experienced by employed carers (DoH, 1999b).

Community activity is relatively strong, with over half of respondents being active in at least one community organisation. Again, there are people who are less able to be involved in community activities and this raises questions about the extent to which disabled people or people in poorer health are able to be involved in the life of the community.

The survey suggests that some people make use of some health and welfare services extensively whilst others have low levels of utilisation. In addition, the use of services that could supplement and support family care (for example, night sitting services) is low. Patterns of use of services reflect particular conditions that apply in Jersey. For example, the hospital A&E department performs functions more usually associated with health care centres in the UK.

Social capital is an elusive concept in relation to people's health. The results of the survey suggest that there is a generally active and robust community in Jersey that is associated with good health. However, the development of supportive services and of partnerships between government and community organisations could strengthen and extend informal community networks to embrace the minority that is currently isolated and excluded.

# Section 5

# Health and Poverty

**Introduction**

An individual's health is not just influenced by their genetic make up and behaviours but also by their standard of living and life experience. In particular, it has long been known that poverty and deprivation can make people 'sick'. The evidence that poverty and inequality in material well-being underlie inequalities in health is now overwhelming. Evidence which has accrued over the past two decades lends further support to the conclusion of the Black Committee on Inequalities in Health in 1980 that:

"*While the health care service can play a significant part in reducing inequalities in health, measures to reduce differences in material standards of living at work, in the home and in everyday social and community life are of even greater importance*".

There is wide international recognition of these facts. The 1995 World Health Report (WHO, 1995) states that the world's most ruthless killer and the greatest cause of suffering on earth is listed in the latest edition of WHO's International Classification of Diseases, an A to Z of all ailments known to medical science, under the code Z59.5. It stands for extreme poverty.
Globally, poverty is the main reason why babies are not vaccinated, clean water and sanitation are not provided, curative drugs and other treatments are unavailable and why mothers die in childbirth. Poverty is the main cause of reduced life expectancy, of handicap and disability and of starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse.

Poverty wields its destructive influence at every stage of human life from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it (see Gordon and Spicker, 1999).

The governments of 117 countries agreed on two definitions of 'absolute' and 'overall' poverty at the World Social Summit in Copenhagen in 1995 (UN, 1995). Absolute poverty was defined as *"a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services."*

Overall poverty takes various forms, including *"lack of income and productive resources to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments and social discrimination and exclusion. It is also characterised by lack of participation in decision-making and in civil, social and cultural life. It occurs in all countries: as mass poverty in many developing countries, pockets of poverty amid wealth in developed countries, loss of livelihoods as a result of economic recession, sudden poverty*

*as a result of disaster or conflict, the poverty of low-wage workers, and the utter destitution of people who fall outside family support systems, social institutions and safety nets."*

The UK government agreed to draw up a national poverty eradication plan based upon these definitions of poverty. Since the UK government represents Jersey's interests at the UN this agreement is potentially applicable in the States of Jersey.

However, Jersey is one of the richest societies on the planet (in terms of average household income) and there are no problems of severe poverty on Jersey that compare with those in some developing countries. Extreme poverty and deprivation, malnutrition and starvation may be entirely absent but relative poverty does exist. Even milder forms of relative poverty can affect health and severe deprivation in childhood has been demonstrated to have potential long term consequences. Childhood and adult social and economic circumstances make independent contributions to the risk of death and disease (Davey Smith *et al*, 1997; Davey Smith and Gordon, 2000).

This is particularly relevant to Jersey as, in 1944, during the Occupation, the Channel Islands were cut off from receiving supplies for several months after the invasion of Normandy. Conditions on Jersey deteriorated and there were severe shortages of food, fuel and other necessities of life. Some idea of the kind of conditions suffered by the population and their health impact can be gained from the following extract from Nan Le Ruez *Jersey Occupation Diary* entry for 11th November 1944:

"*Nov 11th Our grandparents are getting to be a great trial now– so much washing and we can't get things really clean without soap. It is so sad. And young people are dying every day. This week, the husband of someone we know has died of TB aged only 37. Also, we are sad to hear of a few farmers who are selling foodstuffs at high prices to the Germans, whilst their own countrymen are near starvation. The love of money is, indeed, the root of all evil. More thieving; this time 12 boxes of potatoes have been taken from our big shed and Dad's axe and wood-splitter from the wood-shed. I'm afraid the rest of my rabbits will get stolen. Joyce says four more young men escaped last night. There is said to have been an important meeting between the two Commandants, but no surrender*."

Her grandparents died shortly after this entry was written. The conditions she and others have described are analogous to those of extreme poverty and deprivation and it is intended that a detailed analysis of the data collected in the Jersey Health Survey and from other sources will be used to determine if there have been any long term health consequences from the German Occupation. Research conducted into the effects of the Dutch Hunger Winter of 1944 has shown that children born during this period suffered from higher rates obesity and glucose intolerance in adult life than would be expected (Raveilli *et al*, 1976, 1998; Lumey *et al*, 1993; Stein *et al*, 1995).

**Life experience and stress**

It is not just the current material and social conditions that can affect a person's health. Their life history and experiences can also have an impact. Stressful events can have long term consequences. JHS respondents were asked about a list of major life changes that had happened to them during the past 12 months. The results are shown below:

**Table 5.1: Major life changes during past 12 months**

| | Jersey (%) |
|---|---|
| Change in financial state | 28 |
| Death of a close family member | 23 |
| Change in health of a family member | 22 |
| Change to a different kind of work | 19 |
| Moving house | 17 |
| Personal injury or accident | 15 |
| Gain of new family member | 15 |
| Death of a close friend | 14 |
| Business re-adjustment | 12 |
| Pregnancy | 6 |
| Marriage | 5 |
| Lost your job | 5 |
| Divorce | 4 |
| Marital separation | 3 |
| Retirement | 3 |
| Death of a partner or spouse | 2 |
| Jail term | 0.5 |
| Marital reconciliation | 0.5 |

Seventy percent of respondents had experienced one or more of these major life changes during the past year. Over a quarter had a change in financial status and more than a fifth experienced the death of a close family member or a change in the health of a family member. The most infrequent major life events were jail terms and marital reconciliation which had happened to fewer than 1% of respondents.

It would be expected that, the more major changes that happen to a person, the more stress this might place upon them. If a person suffers from too much stress, this can affect their health. Table 5.2 shows the cumulative effect that the number of major life events has on respondents' perceptions of their health as recorded on the EuroQol VAS (thermometer) scale. As previously described, on this scale, 100 represents the best imaginable health state and 0 represents the worst health state.

**Table 5.2: Number of major life events and average EuroQol VAS Score**

| Number of life events | Average thermometer score | GHQ-12 depressed (%) |
|---|---|---|
| None | 77 | 6 |
| 1 | 79 | 9 |
| 2 | 78 | 14 |

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| | | |
|---|---|---|
| 3 | 76 | 16 |
| 4 | 73 | 22 |
| 5 | 72 | 23 |
| 6 or more | 69 | 31 |
| | | |
| **Total** | **77** | **12** |

It is clear from Table 5.1 that there is little difference in respondents' perceptions of their health for those who experienced none, one or two major life changes during the past year. However, there is a clear decline in the average VAS score for respondents who have had three or more major changes. The greater the number of life changes above three a year, the worse the respondent's perceived health state. There is also a clear trend in the percent of respondents who are assessed as likely to be depressed on the GHQ-12 scale. Those who had experienced six or more major life changed were five times more likely to be depressed than those who had experienced no changes during the past year. Similar trends were evident using the other health status measures in the JHS.

**Poverty and standard of living**

Although the population of Jersey have, on average, a much higher standard of living than people in most other European countries, this does not mean that no poverty exists on the Island. Jersey has a less comprehensive welfare system than some European countries and it is possible that people may have fallen through the 'safety net' and sunk into relative poverty. Respondents were asked "*Do you think you could genuinely say that you are poor now?*" and given the option of answering 'All the time', 'Sometimes' or 'Never'. Table 5.3 shows the percentage of respondents who gave each answer and how these compare with responses gathered in 1999 for *The Poverty and Social Exclusion Survey of Britain* (Gordon *et al*, 2000).

As would be expected, there were fewer respondents in Jersey who considered they were poor than in Britain as a whole. However, over a fifth of Jersey respondents said they were genuinely poor either 'all the time' or 'sometimes'.

**Table 5.3: Perception of 'genuine' poverty in Jersey and Britain**

| **Are you genuinely poor?** | **Jersey 1999 (%)** | **Britain 1999 (%)** |
|---|---|---|
| All the time | 2 | 7 |
| Sometimes | 20 | 20 |
| Never | 78 | 74 |

In order to examine the effects of poverty on standard of living, respondents were asked about a list of items they have personally gone without during the past year due to a lack of money. The items in this list were chosen to provide a wide range of indicators of standard of living, from necessities of life such as food and heating to more luxury activities such as 'going out' and 'holidays'. The results are shown in Table 5.4 below:

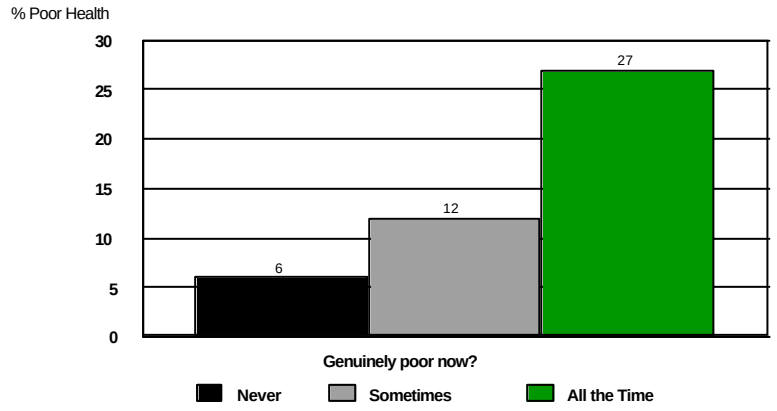
**Table 5.4: Items respondents have gone without personally due to a lack of money during the past year**

| | All year/often | Sometimes | Never |
|---|---|---|---|
| Clothes | 14 | 26 | 60 |
| Shoes | 12 | 21 | 67 |
| Food | 2 | 8 | 90 |
| Heating | 3 | 10 | 87 |
| Telephoning friends or family | 3 | 18 | 79 |
| Going out to celebrations for family & friends | 9 | 29 | 62 |
| A hobby or sport | 11 | 22 | 67 |
| Going out *eg* cinema, theatre, nightclub | 13 | 32 | 55 |
| Visits to the pub | 13 | 30 | 57 |
| A holiday | 23 | 28 | 49 |
| Cigarettes | 7 | 21 | 72 |

The results are somewhat surprising as there appear to be large numbers of people on Jersey who are having difficulty in paying for even the necessities of life. For example, 10% of respondents said they had gone without food at some point during the year and 13% had gone without heating. Fourteen percent of respondents had not been able to afford to buy clothes for most of the year and 12% could not afford shoes. Similarly, a third of Jersey residents could not afford to pursue their hobbies or leisure activities on occasion during the year due to insufficient funds. There appear to be appreciable levels of real poverty in Jersey (though not as high as in Britain) and this is affecting people's standards of living.

It would therefore be expected that relative poverty in Jersey would have a negative impact on respondents' health. Figure 5.1 shows the proportion of respondents who reported their health as 'not good' on the general health question (see Section 1).

**Figure 5.1: Proportion of respondents reporting 'not good' health by perception of poverty**



It is clear that over a quarter of respondents who said they were poor 'all the time' also suffered ill health. This was more than four times the rate of ill health of those who said that they were 'never' poor. Table 5.5 shows a comparison of health status by reported experience of poverty.

**Table 5.5: Comparison of health status by reported experience of poverty**

| | Genuinely poor? | | |
|---|---|---|---|
| **Health question** | **All the time** | **Sometimes** | **Never** |
| | **(%)** | **(%)** | **(%)** |
| *General health* | | | |
| Good | 18 | 36 | 63 |
| Fairly Good | 56 | 51 | 30 |
| Not Good | 27 | 12 | 6 |
| *Long-term illness* | | | |
| Yes -Limiting | 55 | 34 | 21 |
| Yes – Not limiting | 12 | 12 | 13 |
| No | 33 | 54 | 66 |
| **EuroQol dimensions** *(any problem)* | | | |
| Pain | 54 | 42 | 16 |
| Anxiety/depression | 62 | 33 | 15 |
| Mobility | 34 | 22 | 12 |
| Usual activities | 44 | 19 | 14 |
| Self care | 13 | 3 | 3 |
| Average VAS score | 56 | 71 | 79 |

Table 5.5 clearly shows that those few unfortunate people who consider themselves to be poor 'all the time' suffer from very high rates of ill health across all the different health measures. They are twice as likely to suffer from a long term illness compared with the 'never' poor group, three times more likely to suffer pain and discomfort, four times more likely to be depressed, four times more likely to have problems of self-care, have three times the amount of limitation on usual activities and are more than twice as likely to suffer from mobility problems. The survey data gives an indicative figure of 1350 adults in this category. There is a clear need to target health (and other) resources at the low income households in Jersey.

**Poverty in the past**

As previously discussed, it is not just current levels of poverty that can affect health but also the cumulative effects of poverty across the life span. Respondents were asked "*Looking back over your life, how often have there been times in your life when you think you have lived in poverty by the standards of the time (including the occupation period)?"*. Interviewers have reported in other studies that many people and, in particular, elderly respondents, often think long and hard before giving an answer to this question. Table 5.6 below shows a comparison for Jersey respondents with those who answered this question in the 1999 *Poverty and Social Exclusion Survey of Britain*.

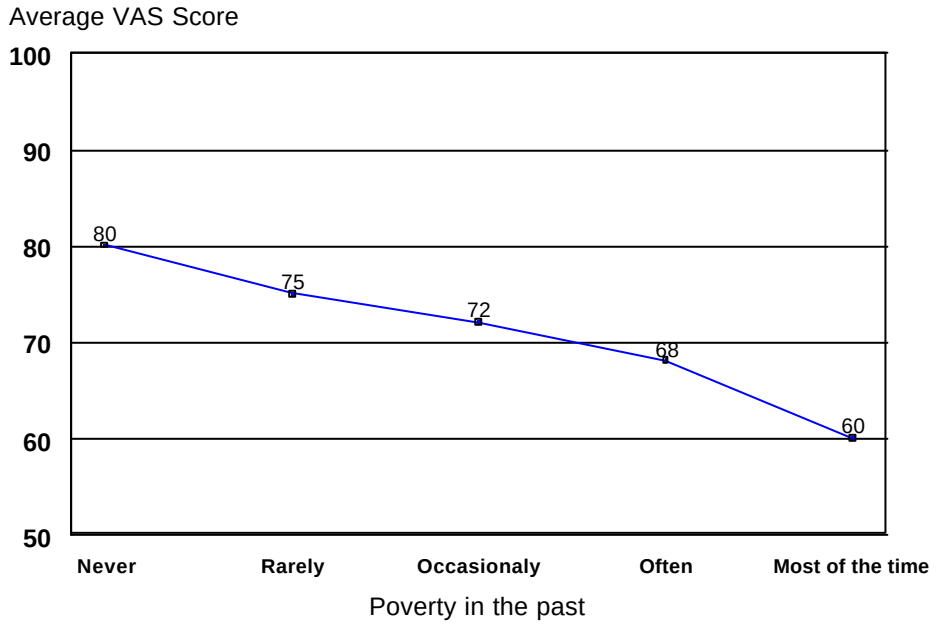
**Table 5.6: History of poverty in Jersey and Britain**

| Have you ever lived in poverty? | Jersey 1999 (%) | Britain 1999 (%) |
|---|---|---|
| Never | 61 | 59 |
| Rarely | 16 | 13 |
| Occasionally | 18 | 19 |
| Often | 4 | 7 |
| Most of the time | 1 | 2 |

The results are again fairly similar to those of Jersey, having slightly fewer people who have been poor at some point in the past than Britain, as would be expected. Nevertheless, a large minority in Jersey (two fifths) have experienced poverty at some point in their lives.

Again, it is to be expected that there will be a causal relationship between a respondent's frequency of experiencing poverty in the past and their current health status. Figure 5.2 shows the average EuroQol thermometer score by respondent's history of poverty. There is a clear linear gradient between the frequency of poverty in the past and average VAS score. Those who reported 'never' having been poor score 20 points higher on average than those respondents who say they have been poor 'most of the time' in the past.

**Figure 5.2: History of poverty by average EuroQol VAS score**



Similar gradients are also found with the other measures of health status. Thus, 66% of respondents who have 'never' been poor reported that they had 'good health' compared with only 20% of respondents who have been poor 'often' or 'most of the time' in the past. Over half of respondents with long histories of poverty reported having a limiting long-term illness compared with 19% of the 'never' poor. The frequently poor were between two and three times more likely to be depressed on the GHQ-12 scale as the 'never' poor. Clear gradients of ill health were present on all these measures, which indicates that increasing frequency of poverty in the past leads to increased rates of current ill health.

**Conclusion**

Both poverty and the stress caused by the cumulative effect of major changes in peoples lives are causes of ill health in Jersey. It is hard for health services to intervene to prevent major life changes although counselling and similar services can be of benefit. However, the situation with regard to poverty is quite different since poverty is relatively easy to prevent, particularly for a relatively 'rich' society like Jersey. There seems little point in letting people sink into severe poverty and then having to pay for expensive health and social care in order to alleviate the resulting ill health. It would probably be less expensive in the long term to provide an adequate social safety net so that poverty can be alleviated and abolished. This would likely result in significant health improvements for the population.

# Policy Context

**Introduction**

This section provides an outline of key issues in the policy context of the health survey. It identifies policies in the four spheres considered in this report that influence people's health and well-being: economic, environmental, lifestyle and 'social capital'. *The Health Promotion Strategy: Towards 2000 and Beyond* identifies three aims:

- To increase the length of our lives – adding years to life
- To increase the years we spend able to live life to the full – adding life to years
- To increase the opportunities for a healthier and longer life for the many as well as the few – ensuring health for all

Jersey has great potential to enhance the health of its population, including a good standard of living and an attractive physical environment. However, its economic prosperity also creates particular stresses on the environment and on people's sense of well-being. For example, the buoyant jobs market is associated with population growth which, in turn, places pressure on housing and the natural environment. There is widespread recognition amongst policy makers of the importance of interrelationships between spheres of policy and their effect on the health and well-being of the population of the island. *The Health Promotion Strategy: Towards 2000 and Beyond*, acknowledges that *"….individuals wishing to adopt a healthier lifestyle may be prevented from doing so by environmental and socio-economic factors which are often beyond their control."* (p.15).

In September 1995, the States of Jersey adopted the following objectives with reference to social policies:

- to ensure that all individuals living in the Island are adequately housed but with priority given to those with residential qualifications
- to ensure that every individual has the opportunity to reach their full potential through education and training
- to provide for the physical and mental health of all individuals
- to minimise material deprivation through ensuring that adequate assistance is given to those in greatest need
- to make better provision for those with a disability, and
- to provide for better employment protection

and, with reference to the quality of life of the people of Jersey:

- to generally enhance the sense of community within the Island
- to support the role of the family
- to reinforce the Parish identity
- to seek to ensure that all sections of the community benefit from the Island's economic well-being

- to pursue policies providing for equality of opportunity, freedom from discrimination and freedom of information
- to seek to reduce the cost of living in the Island

There is, therefore, a general commitment to policy objectives that have significant potential for improving people's health and well-being. What of the policy context in relation to the four spheres considered in the 1999 Health survey?

**Economic**

A summary of contemporary policies on the economic well-being of the people of Jersey is contained in the 1995 Strategic Policy Report, *2000 and Beyond*. This includes the following objectives, which are particularly relevant to economic well-being:

- the full employment of Island residents and the full development of their skills and talents
- a standard of living comparable with that enjoyed in neighbouring countries
- a standard of social services comparable with that to be found in neighbouring countries

There is also a commitment to promoting equality of opportunity in the Island:

- to seek to ensure that all sections of the community benefit from the Island's well-being

Access to paid employment is the primary source of economic security for most people. Relative ease of access to paid work in Jersey is one of the Island's strengths in terms of its potential for health promotion. However, it also creates particular challenges. Jersey's employment policies are closely bound up with immigration issues. As the 1997 *Strategic Policy Review and Action Plan* points out, full employment results in pressure to recruit people from outside the Island. This pressure necessitates careful population planning which, in turn, has implications for a range of social and environmental issues, including housing. The consultation document *Jersey in the New Millennium: A Sustainable Future* argues that continued population growth threatens the achievement of environmental sustainability. A major thrust of the 1997 *Strategic Policy Review and Action Plan* is to develop ways of increasing the productivity of local labour. This, in turn, has implications for access to paid work for women with children and for people over normal retirement age as well as for education and training services, which will be needed to address any skills gaps (see below under Social Capital).

Full employment does not necessarily result in a good standard of living or financial security for all. The Citizens' Advice Bureau argues that there is a need for better employment laws that are effectively policed. They also point out that the relatively high cost of living means that it is difficult for low paid workers to make ends meet. The result, in their view, is a polarisation between those who can live a comfortable lifestyle and those who are at risk of social exclusion (*Jersey Citizens' Advice Bureau: Annual Report 1999)*.

For those who are unable to work, access to adequate social security benefits is essential for good health. The minimisation of material and social deprivation is a core policy aim as is securing a standard of living comparable with that enjoyed in neighbouring countries. The Employment and

Social Security Committee has decided to combine a range of welfare benefits into one single low income, means-tested benefit. This is intended to cut the cost of administering welfare and make welfare benefits more easily accessible by people in need.

**Environmental**

In 1998, the Policy and Resources Committee published its Framework Consultation Document *Jersey in the New Millennium: A Sustainable Future*, which contained the following mission statement:

> *"The States will promote the conservation and sustainable use of resources and will minimise environmental pollution in all its own activities. It will seek, through its influence, the achievement of the same objective by other sectors of the community. The States will review all of its policies, programmes and services and undertakes to act wherever necessary to meet globally accepted environmental standards."* (p.12)

Following an intensive consultation, the key issues that emerged included population control, adequate housing provision, management of land, reducing traffic congestion and avoiding pollution from waste production and potential nuclear risks. These issues require not only policy and strategic action but also ongoing education programmes and awareness raising to encourage people to change accepted habits and lifestyles. For policies on sustainability to work effectively, public participation in decision-making is essential, as acknowledged by the Framework Consultation Document.

In the 1998 Budget, Jersey's Planning and Environment Committee identified a number of pressures, including those related to the growth in the island's economy and to increased public concern about environmental protection. However, the Committee is placed in a difficult position, being required to address a range of sometimes contradictory demands whilst operating from *"a policy and legislative base in need of updating"*.

The Health Promotion Strategy, *Towards 2000 and Beyond*, notes that "*homes that are safe, warm, dry, secure and affordable"* are an essential prerequisite for health. Nevertheless, housing remains a major challenge for policy makers in Jersey. The Citizens' Advice Bureau's *Annual Report, 1999* draws attention to the need to secure greater rights for tenants in private rented accommodation and to deal with the growing number of homeless people sleeping rough.

The housing policy context is, as already poin ted out, inextricably linked with that of employment and migration. Policies aimed at improving levels of productivity among resident workers so as to stabilise the population will inevitably take some time to produce results. In the meantime, there

are serious housing problems that pose a challenge to policy makers. The 1997 *Strategic Policy Review and Action Plan* identifies a range of policies to which the Housing Committee is committed in order to tackle the imbalance between demand and supply. On the supply side, the aim is to work with the Planning and Environment Committee to increase the number of sites available for housing development both in the short and long term. In addition, there is a commitment to working with housing associations to develop affordable, rented housing. On the demand side, there are strategies aimed at facilitating access to housing for lower income residents, including revisions to rent and loan subsidy scheme. The quality of housing in the public sector also received attention in the *Strategic Policy Review and Action Plan*, with a range of schemes for development, modernisation and repairs, with an emphasis on heating, insulation, weather protection and security.

Whilst there are longer-term policies and medium-term strategies in place, the 1998 Budget identified a number of short-term difficulties. For example, there are pressures on the rent abatement scheme for States' tenants and the rent rebate scheme for private tenants. However, the Housing Committee is mindful of the need to maintain these since *"tougher measures would save money by penalising the poorest members of our society, which the committee finds unacceptable."* (p.39). There are also difficulties in maintaining housing stock in good repair because of cuts to the budget allocation in recent years.

Decisions on migration that favour those who already have rights of residence on the island run the risk of creating a two tier housing market, to the detriment of the health of casual labourers who have no right to reside. For example, the Citizens' Advice Bureau's *Annual Report, 1999* recommends prompt action on unfair rents, safe guarding of rental deposits and security of tenure for lodgers.

**Lifestyle**

The *Health Promotion Strategy: Towards 2000* acknowledges that the primary causes of premature death and preventable disease are linked to unhealthy behaviours and lifestyles. However, the necessary socio-economic and environmental factors must be in place in order to enable individuals to adopt a healthy lifestyle. A key policy objective of the Public Health Services in the last three years of the twentieth century was "*To support people in positively improving their health, by providing guidance on maintaining a healthy lifestyle."* (*Health and Social Services: Towards 2000*, p.49).

Reducing levels of cancer and heart disease on the island is a core policy aim, since these are the major causes of death. However, promoting a healthy lifestyle is not only about preventing illness and premature death. Jersey's Health Promotion Strategy identifies specific strategic aims on preventing accidents, tackling alcohol and drug related problems, reducing levels of smoking, raising awareness of cancer, coronary heart disease, sexual health and mental health, raising the uptake of screening and immunisation services, promoting healthy eating and physical activity and positive ageing.

Maintaining a strong focus on preventive strategies and services in the context of rising demand and limited resources for health care is a challenge for policy makers and service managers. Of the £83.5 million budget for the year 2000, only £2 million was allocated to Public Health Services for

disease prevention and health promotions, while over £40 million was allocated to General and Acute Services and £29 million to Community and Social Services. The pressure to target services on those in most urgent need may impede progress in health promotion. For example, the upgrading of renal services, recently approved by the Policy and Resources Committee, is to be financed from existing funds, resulting in delays in other projects (Jersey Government Press Release 9/7/2000). Thus, the strategic aim *"to encourage a shift in the balance of health and social services towards health promotion and disease prevention"* is hard to realise in practice.

However, the principles of health promotion, outlined in *Towards 2000 and Beyond*, are clearly not regarded as the responsibility of Health and Social Services alone. A key theme that runs throughout the strategy is that the key determinants of health are often outside the health sector. The integration of the concept of 'health gain' into all public policies is crucial to the Health Promotion Team's strategy. Restricting smoking in public places, and including education on sexual health into school curricula are just two examples of how health promotion is the business of a wide range of policy makers.

The concept of partnership in health promotion embraces the idea of working together with the public to raise awareness of the benefits of healthy lifestyles. For example, changing attitudes towards ageing is an important aspect of health promotion for older people, and this requires a cultural shift at a wider level. Whilst policy-makers have a part to play in addressing the health implications of their decisions, it is also necessary to ensure that the general public understands and participates in the process of decision-making so that health gain is more widely understood.

**Social Capital**

Broadly, the term social capital refers to a diverse range of goods, facilities and services and networks that enhance the quality of life of Jersey's population. These might include sports facilities, libraries, arts and cultural activities but, importantly, also include informal networks of support, within families and communities. Adding life to years, the second of the three aims of the 1997 Health Promotion Strategy, requires a solid investment in social capital to enable people to live life to the full.

A key question is the degree to which such social capital is accessible to the public in general and poorer sections of the population in particular. For example, how accessible are sports and leisure facilities to those on low incomes? Is public transport available to people who do not have a car? Is education available to adults who may have missed out on opportunities at school? Can older people who live alone gain access to social facilities? Are such goods and services distributed equitably in different parts of the island? The third of the three aims of the Health Promotion Strategy, ensuring health for all, requires that inequality in access to goods and services is tackled. The PricewaterhouseCoopers Review of Health and Social Services noted that "*some families with young children, the elderly, those with low incomes, people with mental health problems or learning disabilities and the Portuguese community"* might be less able to get the services they need.

The 1997, *Strategic Policy Review and Action Plan* of the Policy and Resources Committee noted that the Committee's role is to *"monitor and co-ordinate the implementation of policies that need*

*to be pursued to minimise material and social deprivation."* (p.19). Specific objectives of particular relevance to the sphere of social capital include the following:

- providing education and training services that enable individuals to reach their full potential
- provision for the physical and mental health of all individuals
- provision for disabled people
- enhancing the sense of community in the Island
- supporting the role of the family
- reinforcing the Parish identity
- ensuring that all sections of the community benefit from the Island's economic well-being
- ensuring equality of opportunity and freedom from discrimination and freedom of information
- reducing the cost of living in the Island

Education services are vitally important to promoting material well-being and social inclusion. The provision of adult education can enhance people's employment prospects and is an important aspect of the population control strategy outlined above. In order to ensure equality of opportunity in employment, education services need to take into account issues of accessibility. For example, mothers of young children will require support in the form of nursery provision and after-school care if they are to take full advantage of employment opportunities. Recent States Policy has been focused on making child care more available to low income families, in order to ease the population problem as well as to help eradicate social and material deprivation (Employment and Social Security Committee, April 1999).

Promoting equality of opportunity and a commitment to tackling discrimination has been specifically addressed during the past year in discussions following the publication of the 1999 *Race Relations Working Party Discussion Document*. This document demonstrates that Jersey faces changes in its international obligations. It also argues that, for the anti-discrimination strategy to work, the participation by local people in shaping it is vital to its success. It also asserts that there are wider benefits to the Island of improved relations between different racial and ethnic groups that go beyond those felt by individuals who are able to take action in cases of discrimination.

The majority of people enjoy social contact and support through their own families and friendships. However, a report from the Jersey Citizens' Advice Bureau, *Behind Closed Doors*, reveals that the lack of affordable and accessible transport impedes many older and disabled people from getting out to enjoy a full social life. The provision of health and social services, either directly by government departments or through independent agencies, can do much to enhance informal networks, and for some may be an essential substitute.

The PricewaterhouseCoopers Review noted that there is a need to increase support for older people in their own homes through a mixture of informal networks, voluntary agencies, private enterprise and government departments. Up-to-date and reliable information on older people's own networks of support is essential to ensure that services are effectively targeted and meet need in an appropriate way. A commensurate challenge is to ensure that such services are not provided in ways that are felt to be stigmatising by the service user. Tackling social deprivation and exclusion

is equally as important as tackling material deprivation, as acknowledged by the Policy and Resources Committee 1997 *Strategic Policy Review and Action Plan* (p.19).

**Conclusion**

The policy context of improving the health and well-being of the people of Jersey is similar to that of the United Kingdom and beyond. There is widespread acknowledgement of the importance of social inclusion and encouraging active citizenship and of partnerships between government, business, voluntary organisations and local communities. Policy makers in Jersey also face similar challenges as they try to square the circle of rising demand for better facilities and services within the context of restricted budgets.

However, the 'Island factor' gives rise to possibilities and problems that are unique to Jersey. These include the issue of population controls, the history of migration to and from the Island, the degree of economic prosperity coupled with economic inequalities, the environmental resources and the mounting pressure on these, the strong community base provided through the Parish system and particular forms of social exclusion. It is hoped that this report on the health of the population will contribute to a more informed policy process.

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