Health Profile for Jersey 2014

Data for 2010 to 2012 (or most recent)

with comparisons to Guernsey,

English regions and Europe

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M Clarke	Update and checking of local data to include most recent population estimates
J Birbeck	Narrative and agreement on comparable Island data
J Cateroche	EU data from OECD
S Turnbull	Final edit
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Acknowledgements and Contributions

Table of Contents

Table of Contents

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Introduction

This Health Profile for Jersey provides a set of key indicators for the health status of adults and young people in Jersey in 2010 to 2012. There has been close collaboration between the Jersey and Guernsey Public Health Directorates to develop the indicators used and ensure both reports cover similar areas. It provides Channel Island comparisons, where possible, as well as comparisons with the UK and Europe where appropriate.

The report covers data for the period 2010-2012 (or the most recent year available). The indicators have been selected from health indicators used nationally and internationally focusing on population health status or modifiable lifestyles and behaviours. Together they provide a snapshot of the overall health of our population and how we compare with other areas. The indicators presented in this publication have been selected on the basis of their policy relevance, data availability and comparability with other areas.

Statistics on deaths are one of the most widely available, robust and comparable sources of information on health and as such form the bulk of this report.

The profile provides facts about how Jersey compares with other areas. It does not seek to analyse why the figures are as they are or what may need to be done about them, though these will be important questions to consider.

Within the report our local rates are compared with other areas, but where they are significantly higher or lower it is also important to take account of the actual numbers involved. We need to consider which of the indicators have the most impact on the population as a whole and warrant further investigation and focused effort to try to improve them and in turn achieve maximum population health gain.

The comparative data come from official national statistics including:

- Department of Health Public Health Outcomes Framework;
- Health & Social Care Information Centre (HSCIC), formerly the National Compendium of Health Outcome Data (NCHOD);
- Health Profiles produced for England by the Association of Public Health Observatories;
- Organisation for Economic Co-operation and Development (OECD) Health Database;
- World Health Organisation (WHO).

Jill Birbeck

Head of Health Intelligence

Public Health Directorate, Health & Social Services Department, Jersey

Foreword from the Medical Officer of Health

I am pleased to present this, the third comprehensive Health Profile for Jersey which includes comparisons with our sister island Guernsey, as well as with England and beyond. This has been an interesting and valuable piece of collaborative work between the Islands in 2013/14, the latest of a series of joint endeavours.

The goal of public health is to improve the health status of the population. Many factors influence the health status of the population, including a number that fall outside health care systems, such as the social, economic and physical environment in which people live, and individual lifestyle and behavioural factors.

Large variations are observed between countries in life expectancy, mortality, disease incidence and other measures of population health status. Good health is consistently ranked as one of the most valued aspects in people's lives. Good health status also has instrumental value through enhancing opportunities to participate in education, training, and the labour market. Many lifestyle factors and individual behaviours affect population health status, including tobacco smoking, alcohol drinking, and being overweight or obese.

For a large number of cancers, the risk of contracting or dying with the disease increases with age, so we are likely to see an increase in both cancer incidence and deaths in the future. The better news is that modifiable risk factors such as smoking, obesity, exercising, excess sun exposure and environmental exposures are thought to explain more than 90% of all cancers. Prevention, early detection and treatment remain at the forefront of the ongoing battle to decrease the burden of cancer.

This report summarises our current knowledge of comparative health indicators and, as before, will provide the basis for further analysis and targeted action where needed. Where there is variation there is always scope for improvement.

Good Public Health Intelligence is fundamental to good Public Health. My thanks to my excellent Health Intelligence Team and our Guernsey counterparts for all the hard work that has resulted in the completion of this, our latest Jersey Health Profile

Dr Susan Turnbull

Jersey Medical Officer of Health

Public Health Directorate, Health & Social Services Department, Jersey

Overall Findings

Overall, Jersey's statistics are positive in many of the comparisons. Our stillbirth and infant mortality rates have fallen over time and remain low; we have few low birth weight babies, very low teenage conception rates, high coverage for childhood immunisations, high self-reported health status, high life expectancy and decreasing numbers of deaths from heart disease.

However, we should not be complacent as within these positive population level statistics will be sub-populations who may experience poorer health outcomes. Jersey has: comparatively low breast feeding rates; 1 in 6 babies living in homes where they are at risk from passive smoking; suicide rates resulting in many valuable years of working life lost; a high level of liver disease, cancers of the lung, head and neck as well as skin cancers.

Cancers and heart disease remain the major causes of death locally as well as world-wide. The report shows that there are still premature deaths that are preventable, for example much liver and heart disease, many cancers, accidents and suicides.

Our high level of alcohol consumption is reflected in the worst premature death rates from liver disease compared with England, and a high proportion of potential working life lost (YWLL) from chronic liver disease. Smoking causes 1 in 6 of all deaths amongst those aged 35 and over, and lung cancer also accounts for a high proportion of working life lost. The impact of alcohol and smoking related ill-health on our economy is shown by the new YWLL indicator.

Many of the factors known to cause ill health, such as smoking, are decreasing while others, like obesity, are increasing. While our obesity levels are still lower than other countries, obesity continues to increase. Although we compare favourably in terms of physical exercise and eating '5-a-day' we still have a proportion of the population who do nothing active and eat very few fruit & vegetables.

As in many countries world-wide, our gains in longevity at older ages combined with the reduction in fertility rates are contributing to a steady rise in the proportion of older persons in our population. Whether longer life expectancy is accompanied by good health and functional status among the ageing population has important implications for health & social care systems.

Both Channel Islands have produced similar health outcomes for most of the indicators reported on. Differences include the fact that Jersey has a higher incidence of breast and prostate cancer, but lower teenage conception rates and higher reported levels of physical activity and healthy eating than Guernsey.

Key findings by chapter

Demography

- Projected rise in the proportion of older people in our population contributed to by gains in longevity at older ages combined with a reduction in population fertility rates.

Fertility

- Fertility rates in Jersey are significantly lower than England.
- Infant mortality has decreased from 28 per 1,000 population in 1950-1952 to 3.4 per 1,000 in 2010-2012.
- Breast feeding rates are low but 1 in 3 mothers are breastfeeding exclusively at 6-8 weeks.

Self perceived health & life expectancy

- Life expectancy at age 65 is 19 years for men and 21 years for women.
- 85% of the population rate their health as good or better.

Burden of Disease

- The top 3 main causes of death are ischaemic heart disease, stroke and lung cancer.
- Cancers are the main cause of death locally. Cancers and circulatory disease account for >60% of all deaths.
- Most working years of life lost are due to accidents, suicide, lung cancer, liver disease and ischaemic heart disease.
- Deaths from liver disease rank us among the worst compared to regions in England.
- Most commonly diagnosed cancers are: breast, prostate, colorectal, lung and malignant melanoma.
- One in ten (10%) of the population have a long term illness or condition that affects their day-to-day activity.

Mental Health

- Overall population mental wellbeing in Jersey is 'moderate' (rather than high or low).
- 21% of the population reported a low mental wellbeing score.
- 20% of men and 24% of women report moderate or extreme anxiety and depression.

Sexual Health

- Teenage pregnancy rates remain very low compared to other areas.
- Termination rates are significantly lower than in England.
- The Genitourinary Medicine (GUM) clinic has seen activity increase over the last few years, with total numbers seen in 2013 being 59% higher than those seen in 2009.

Disease Prevention

- Jersey has a high coverage for all childhood immunisations.
- HPV vaccine uptake is higher locally than in the UK.
- Breast and cervical screening coverage remain below the NHS target of 80%.

Lifestyle

- 1 in 6 babies born in 2012 are living in households where they are at risk from second hand smoke exposure (passive smoking).
- 1 in 7 Islanders are drinking alcohol at levels that are likely to be causing them health problems or harm now or in the future (higher risk drinkers).
- Obesity levels, at 16%, are still lower than other areas but are increasing.
- 54% of our population are active at the recommended level of 150 minutes of moderate activity a week.
- 1/3 of adults eat 5 or more portions of fruit and vegetables a day.

6

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1.   DEMOGRAPHY

Population

The total population of Jersey at the end of 2012 was estimated to be 99,000, comprising 50,200 females and 48,800 males (Table 1.1).

The resident population estimate for Guernsey in 2012 is 63,100, whilst that of Alderney is 2,100.

Table 1.1: 2012 Jersey end of year population by age and gender

Age group	Males	Females	Total
0-4	2,700	2,700	5,400
5-9	2,600	2,500	5,100
10-14	2,600	2,600	5,200
15-19	2,900	2,600	5,500
20-24	2,900	2,900	5,800
25-29	3,100	3,100	6,200
30-34	3,600	3,600	7,200
35-39	3,600	3,500	7,100
40-44	4,000	4,000	8,000
45-49	4,300	4,300	8,500
50-54	3,700	3,800	7,500
55-59	3,100	3,200	6,300
60-64	2,800	2,800	5,600
65-69	2,300	2,400	4,800
70-74	1,700	1,900	3,500
75-79	1,400	1,600	3,100
80-84	800	1,200	2,100
85+	700	1,300	2,000
Total	48,800	50,200	99,000

Source: States of Jersey Statistics Unit
Numbers independently rounded to the nearest 100.

The structure of the Jersey population is shown in Figure 1.1. Population pyramids provide a visual representation of how a population is distributed across different age groups. The main population bulge in Jersey is currently between 40-49 years. There are a greater proportion of females in the older age groups (65+), which reflects the increased survivorship of women over men at these ages. The Guernsey population shows a similar pattern.

1. Demography

Around 27% of the population are under 25 and 16% of the population are aged 65 and over.

Figure 1.1: Population Structure of Jersey 2012
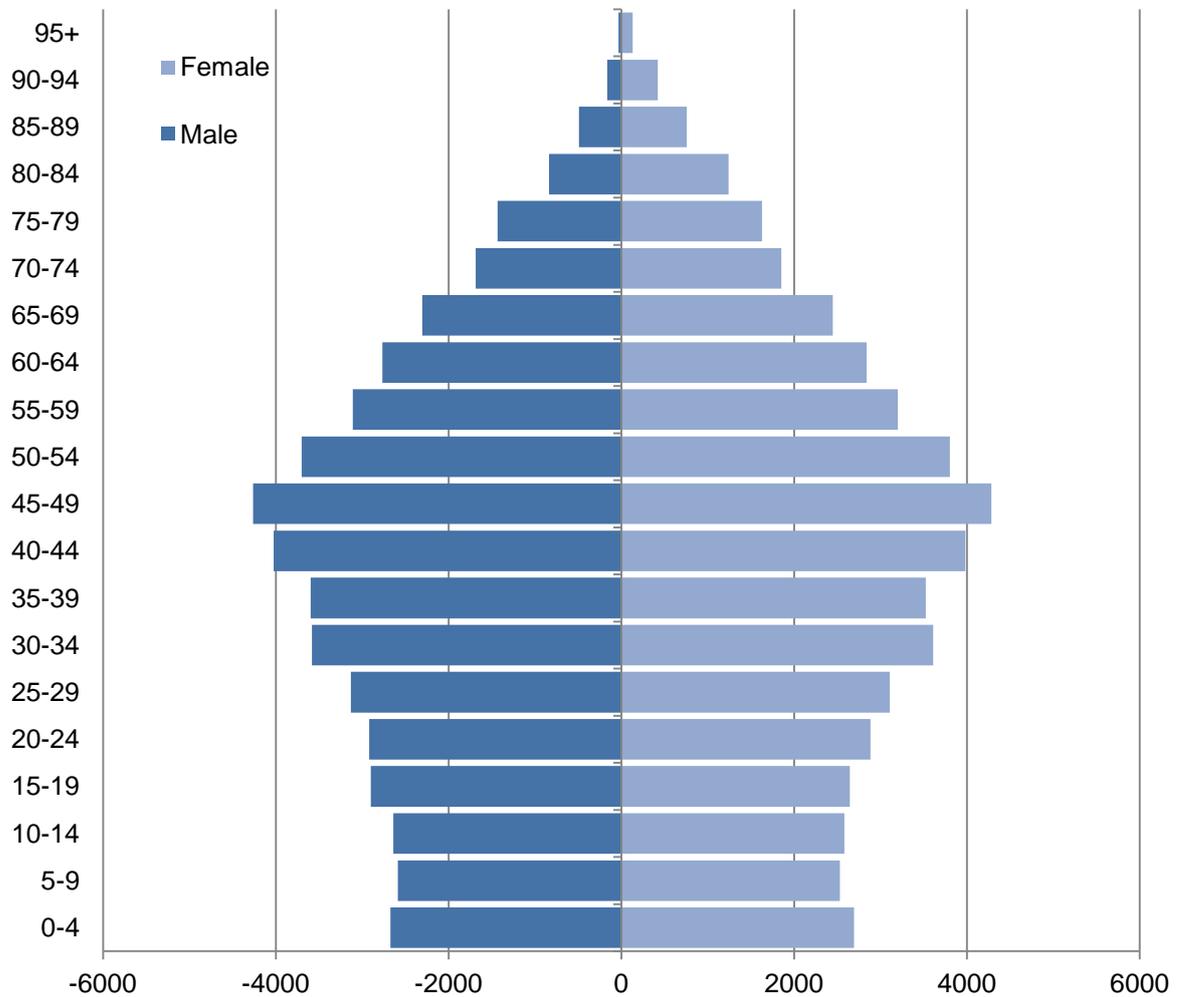
The States of Jersey Statistics Unit estimate that the proportion aged 65 and over in our population will increase over the coming years which will increase demand on local health services. Guernsey predicts a similar increase.

Population Density

Jersey has an area of 119.5 km^2 at high tide. This translates to a population density of 828 people per square kilometre in 2012 in Jersey. This is lower than that for Guernsey, and over double that of England (Figure 1.2), which was around 411 people per km^2 in 2012[1], but lower than Islands like Malta (approximately 1,300 per km^2) and Bermuda (approximately 1,290 per km^2)[2].

Figure 1.2: Population Density (per square km)
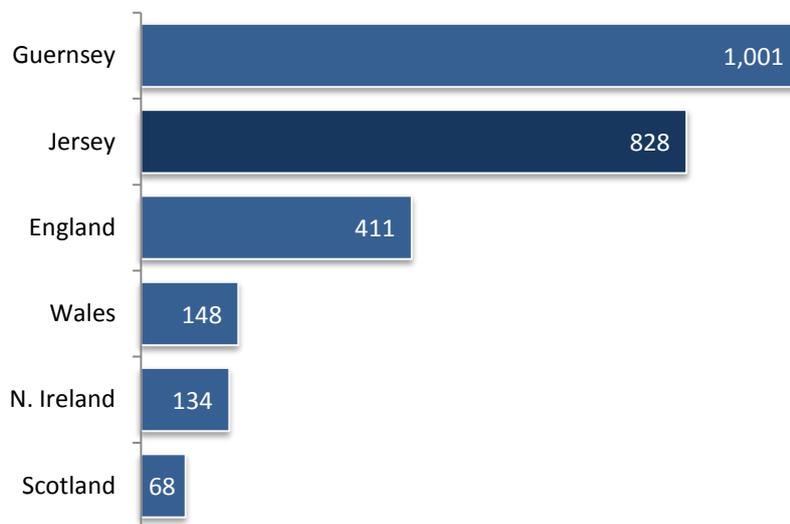
The population density of Guernsey was 1,001 people per km^2 whilst that for Alderney was around 261 per km^2.

Source: ONS Compendium of UK Statistics, States of Jersey Statistics Unit, Guernsey Public Health and Strategy Directorate

Dependency Ratio

The dependency ratio is a measure of the number of people in a population who are dependent (children and people of pensionable age) compared with the number of people of working age. This ratio is used to monitor the burden on the working population.

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[1] Office for National Statistics, Compendium of UK statistics, February 2014
[2] The World Bank (2011 data), data.worldbank.org/indicator/EN.POP.DNST

1. Demography

The Jersey dependency ratio for year-end 2012 was 48% meaning there are 48 dependent children and adults for every 100 of working age. Essentially for every 1 child or person of pensionable age, there are 2 people of working age.

Under a population projection scenario which maintains the current registered population, this ratio will increase to 66% in the medium term (2035). So, in future, Jersey is likely to have a higher proportion of dependent children and adults in our population (66 for every 100 of working age by 2035).

Figure 1.3: Dependency Ratio and Projected Dependency Ratio

Year-end 2012	Year-end 2020	Year-end 2035
48%	53%	66%
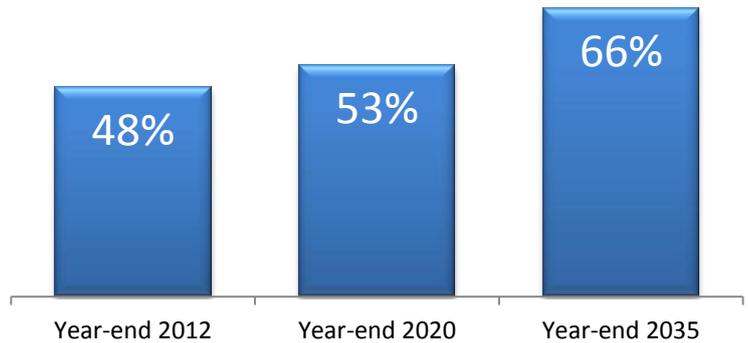
Assuming the 2012 registered population is maintained.
For other projection scenarios please see 2013 Population Projection Report.
Data source: States of Jersey Statistics Unit, Population Projections 2013

2.   FERTILITY

Birth Rate

Crude Birth Rate - the number of resident live births in Jersey for the calendar year per 1,000 total population.

In 2012 there were 1,124 births to resident mothers, giving a crude birth rate of 11.4 live births per 1,000 population. This is similar to the rate of 10 per 1,000 in Guernsey & Alderney, where there were around 625 to 675 births a year between 2010 to 2012, and slightly lower than the birth rate of 12.9 per 1,000 in England and Wales[3] in 2012.

Table 2.1: Jersey birth rates, 2010-2012

	Live births	Population estimate*	Birth rate per 1,000
2010	1,077	97,100	11.1
2011	1,075	98,100	11.0
2012	1,124	99,000	11.4
2010-12	**3,276**	**294,200**	**11.1**

*Year-end population estimates
Source: Jersey Health Intelligence Unit, States of Jersey Statistics Unit

The birth rate in Jersey has remained stable, ranging between 10.7 and 11.7 per 1,000, over the last ten years, although the actual number of births has been increasing since the middle of the decade.

The average age of resident mothers (at the time of birth) was 31 years in 2011 and 2012. The highest number of births over the last twenty years have been to mothers aged 30-34, with the lowest number of births to the under 20's and over 40's.

31

Average age (at birth) of resident mothers in 2012

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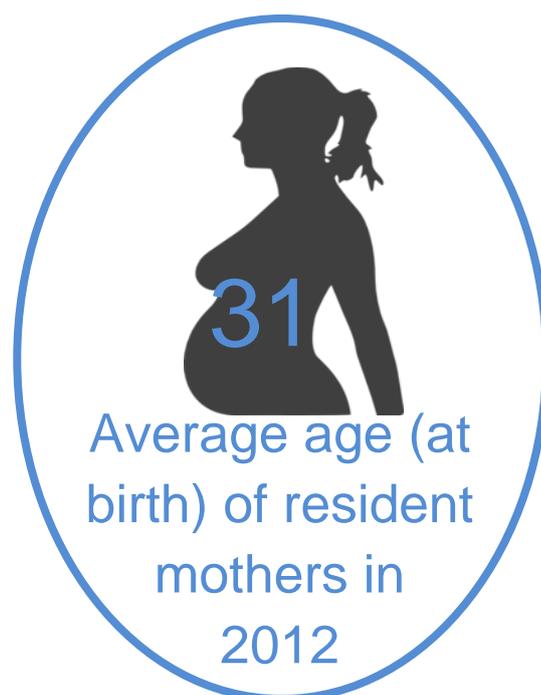
[3]ONS Birth Summary Tables England & Wales 2012, published July 2013, www.ons.gov.uk

2. Fertility

While the number of births to mothers aged 25 to 29 has decreased since 1997 there has been an increase in births to older mothers aged 35 to 39 over the same period. Since 2000, there have been more births to women aged over 40 years than to women under 20 years of age.

General Fertility Rate

General fertility rate (GFR) is defined as the number of live births for every 1,000 females of childbearing age (15-44) in the local population.

Over the period 2010 to 2012, the average general fertility rate for Jersey was 54.9 per 1,000 female population. The rate for Jersey was similar to the fertility rate in Guernsey and both were significantly lower than the England average, as well as the rate for all English regions (Table 2.2).

Table 2.2: General Fertility Rates, Channel Islands 2010-12, England, London and South West 2012

	GFR	95% CI Lower limit (LL)	95% CI Upper limit (UL)
Guernsey & Alderney 2010-2012	50.9	48.7	53.2
Jersey 2010-2012	54.9	53.1	56.7
South West	63.1	62.6	63.6
England	64.9	64.8	65.1
London	67.0	66.6	67.3

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00427

Total Fertility Rate

> Total Fertility Rate (TFR) is defined as the average number of children that would be born to a woman who experienced the current age-specific fertility rates throughout her childbearing years (15-49 years). TFR is used as an estimate of whether a population is replacing itself or not. In Western countries a TFR of about 2.1 is required to maintain long term population levels assuming no migration.

The average total fertility rate between 2010 and 2012 for Jersey was 1.61; this is similar to Guernsey but significantly lower than the England average and the English regions (Table 2.3). The Channel Island rates remain below the level required for population replacement (see definition box above).

Both Channel Island rates are lower than the average rate of 1.8 recorded among high and upper middle income countries globally (Table 2.4).

Table 2.3: Total Fertility Rates, Channel Islands 2010-12 and England, London and South West 2012

	TFR	95% CI Lower limit (LL)	95% CI Upper limit (UL)
Guernsey & Alderney 2010-12	1.58	1.43	1.76
Jersey 2010-2012	1.61	1.49	1.75
London	1.84	1.83	1.85
England	1.94	1.93	1.94
South West	1.96	1.94	1.97

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00428

Table 2.4: WHO Global Average Total Fertility Rate, 2011

Income bracket	Mean TFR
Low income	4.0
Lower middle income	2.9
Upper middle income	1.8
High income	1.8

Source: World Health Statistics 2013

Stillbirth Rate

> The stillbirth rate is defined as the number of stillbirths per 1,000 live and stillbirths. A stillbirth is the birth after the 24th week of gestation of a baby that has died *in utero* (in the womb, or uterus, before delivery). *Still birth (Definition) Act 1992.*

The stillbirth rate for Jersey was 2.1 per 1,000 (2010-12), a decrease from 2.6 per 1,000 in 2008-2010, and is similar to that for Guernsey for the same period. Both Channel Island rates are lower than the most recent comparison data for England, but the wide confidence intervals around the local estimates (because of low numbers) mean the differences are not statistically significant (Table 2.5).

The small number of stillbirths in Jersey & Guernsey means that these figures can be distorted by small fluctuations from year to year.

Table 2.5: Stillbirth Rates, 2010-2012

	Still birth rate	95% CI Lower limit (LL)	95% CI Upper limit (UL)
Jersey	2.1	1.0	4.5
Guernsey & Alderney	3.6	1.4	7.3
South West	4.4	4.1	4.8
England	5.0	4.9	5.1
London	5.6	5.4	5.8

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00468

The stillbirth rate in Jersey has decreased over time (Figure 2.1), a similar decrease has been reported for Guernsey and England and Wales[4]. Locally, rates have decreased from around 15 per 1,000 births in the 1960's to less than 5 per 1,000 in recent years.

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[4] Office For National Statistics, Stillbirth rates 1965-2010, published April 2013, available from www.ons.gov.uk

Figure 2.1: Stillbirth Rates, 3-year averages, 1950-2012
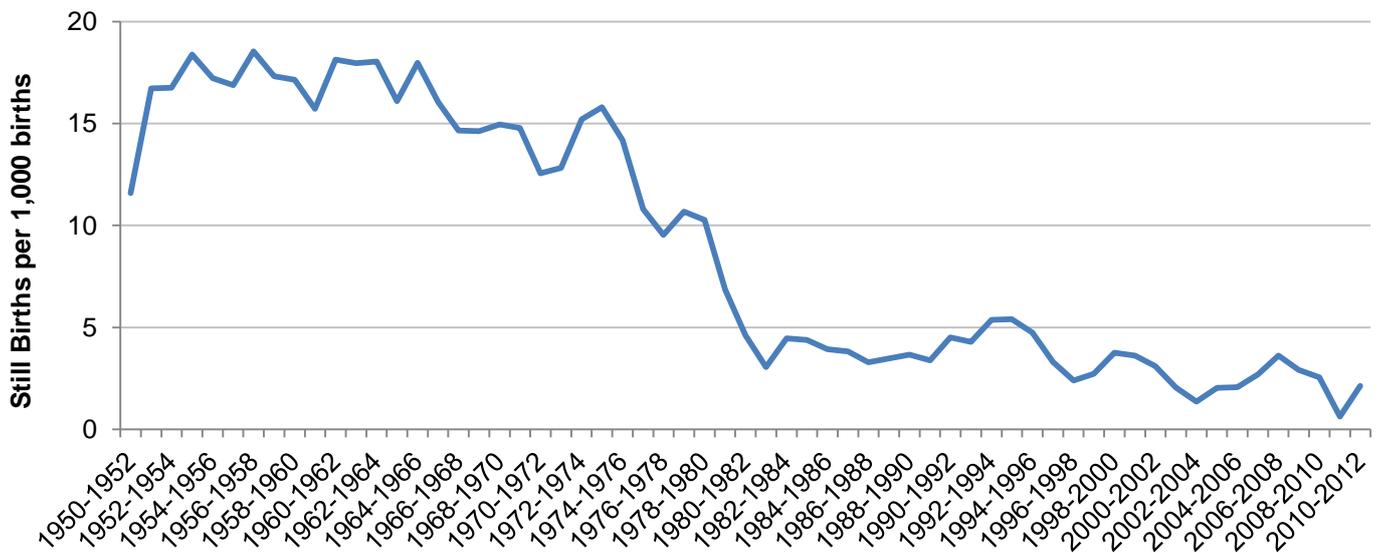
Source: Jersey Health Intelligence Unit

Infant Mortality Rate

> Infant mortality rate is defined as the number of deaths under the age of one per 1,000 live births. The calculation excludes still births.
>
> This indicator reflects the effect of economic and social conditions on the health of mothers and newborns, as well as the effectiveness of health services.

The number of children under 1 year of age that die on the Island is low, between 1 and 6 in any one year (since 2000). Infant mortality in Jersey was 3.4 per 1,000 (in the period 2010-12). This compares with 1 per 1,000 in Guernsey (Table 2.6) but is not significantly different. Both Channel Island rates are lower than the average rate for England (4.3 per 1,000) and the EU 2010 average (4.2 per 1,000[5]). The Jersey rate is not significantly different from these averages, because of the large confidence intervals which are due to our small populations and relatively low numbers of births and infant deaths.

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[5] OECD (2012),*'Infant Health' in Health at a Glance*: *Europe 2012*. OECD Publishing

2. Fertility

Infant mortality rates vary greatly between countries; as seen in the latest Organisation for Economic Co-operation and Development (OECD)[6] data which reveals the range was from 1.6 in Iceland to 47.2 in India.

Table 2.6: Infant Mortality rates, 2010-2012

	Infant Mortality rate	95% CI Lower limit (LL)	95% CI Upper limit (UL)
Guernsey	1.0	0.1	3.7
Jersey	3.4	1.9	6.1
South West	3.6	3.4	3.9
London	4.2	4.0	4.4
England	4.3	4.2	4.4

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00723

The infant mortality rate in Jersey has decreased significantly in the last 60 years (Figure 2.2) from 28 per 1,000 in 1950-1952 to 3.4 per 1,000 in 2010-2012. The OECD reports a similar fall in infant mortality across all OECD countries[7] since the 1970's.

Figure 2.2: Infant Mortality Rates, 3-year averages, 1950-2012
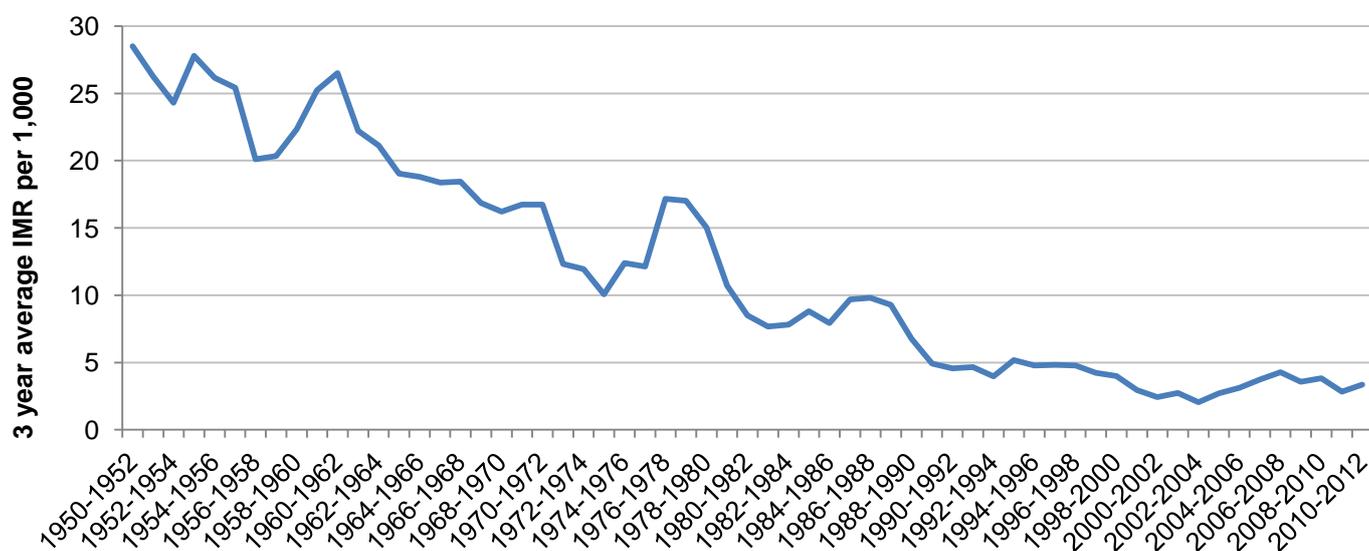
Source: Jersey Health Intelligence Unit

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[6] OECD (2013), *'Infant mortality'* in Health at a Glance 2013, OECD indicators, OECD Publishing
[7] OECD (2013), *'Infant mortality'* in Health at a Glance 2013, OECD indicators, OECD Publishing

Low Birth Weight[8]

> Babies weighing less than 2,500g at birth are considered to have a low birth weight.
>
> Low birth weight is used as a general health indicator for newborns because it is a key determinant of infant survival, health and development

One in fourteen (7%) live births in Jersey over the period 2010-2012 were low birth weight babies. While not directly comparable with UK data this indicates that Jersey has a similar proportion of low birth weight babies.

The low birth weight rate in Guernsey, which is comparable to figures produced for England[9], was lower than the rate in England (6% compared to 7%). In the UK the proportion of low birth weight babies ranges from 8% in the West Midlands to 6% in the South West. In the EU the average was 6.9% low birth weight babies in 2010[10], ranging from 11.7% in Cyprus to 4.2% in Sweden.

Breastfeeding Rates

Breastfeeding has a major role to play in promoting health in both the short and long term for baby and mother. It provides ideal food for the healthy growth, development and protection of infants, and is an integral part of the reproductive process with important health implications for mothers as well as babies.

The global public health recommendation is that infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health, before starting mixed feeding alongside ongoing breastfeeding, where possible.[11]

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[8] The weight of stillborn babies is not routinely collected in Jersey; as a result, it is not possible to compare Jersey to Guernsey and UK measures of the low birth weight rate which includes weight data for stillborns.
[9] HSCIC Indicator P00455, available from www.indicators.ic.uk
[10] OECD (2012), *'Infant Health' in Health at a Glance: Europe 2012*, OECD Publishing
[11] WHO (2001), *The Optimal duration of exclusive breastfeeding. Report of the expert consultation*, www.who.int

Breastfeeding Initiation

Breastfeeding initiation: proportion of babies born in Jersey recorded as being breastfed within the first 48 hours of birth

Jersey breastfeeding initiation rates are around 75% and are in line with the English average and Guernsey (Table 2.7). As the UK has one of the lowest rates of breastfeeding worldwide, Jersey and Guernsey rates are also considered low.

75%

The proportion of births where breastfeeding was initiated within the first 48 hours 2010-2012

Table 2.7: Breastfeeding initiation comparisons, 2010-2012

Area	Percentage
London	87%
South West	78%
Guernsey & Alderney	77%
Jersey	75%
England	74%

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, Department of Health, breastfeeding statistics www.gov.uk

Prevalence of Breastfeeding at 6 to 8 weeks

> Breastfeeding prevalence: the proportion of babies born in Jersey recorded as breastfed at the 6 to 8 week check.

Breastfeeding prevalence in Jersey is calculated on all births with a known breastfeeding status (93% of all births in 2012).

Around one in three (36%) mothers were exclusively breastfeeding at 6-8 weeks in 2012 in Jersey[12]. More than half (53%) were either partially or totally breastfeeding, higher than the England proportion of 49% partially or totally breastfed (Table 2.8).

Table 2.8: Infants partially or totally breastfed at 6-8 weeks, 2012 (percentage of known status)

Area	Percentage
London	71%
Jersey	53%
South West	50%
England	49%

*Jersey data is for cohort born in calendar year 2012. England data is those babies due a 6 week check in 2012
Source: Jersey Health Intelligence Unit, Department of Health, breastfeeding statistics www.gov.uk

No comparable data is available for Guernsey as breastfeeding data is collected retrospectively at the eight month check.

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[12] Jersey data is for cohort born in calendar year 2012. England data is those babies due a 6 week check in 2012.

3.   SELF-PERCEIVED HEALTH AND LIFE EXPECTANCY

Self-perceived health

Asking individuals to rate their health is considered a good indication of current and future morbidity in a population. A question is included in the annual social survey in Jersey.

In 2012, around half (52%) of respondents to the Jersey Annual Social Survey (JASS) rated their health to be 'excellent' or 'very good'. Fewer than one in twenty adults (3%) reported being in 'poor' general health. These proportions have remained similar since 2007[13].

Figure 3.1: Self-perceived health rating, 2012
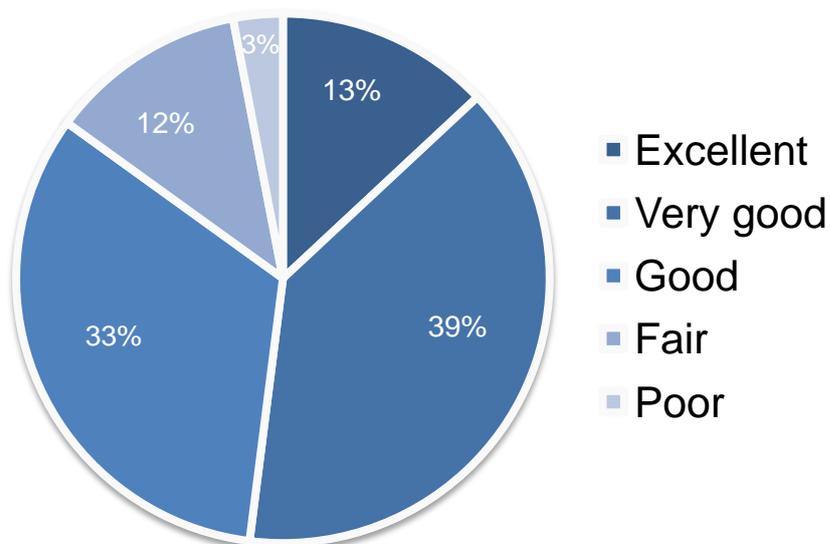
Source: States of Jersey Statistics Unit, Jersey Annual Social Survey 2012

The latest Eurostat[14] data on self reported health status indicates that two-thirds (68%) of Europeans rate their health as good or very good (Table 3.1).

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[13] For further information, please see the report of the Jersey Annual Social Survey 2012, States of Jersey Statistics Unit, published on www.gov.je/statistics
[14] Eurostat indicator hlth_silc_01 available from epp.eurostat.europa.ec

Table 3.1: Proportion of population rating their health as good or very good in 2012

Area	Proportion
UK	75%
Luxembourg	74%
France	68%
EU average	68%
Poland	58%
Portugal	48%

Source: Eurostat indictor hlth_silc_01 2012 data

NOTE: cannot compare to Jersey as Eurostat data is based on a 4-scale question whereas Jersey data is based on a 5-scale question

Jersey Annual Social Surveys in 2012 and 2013 included a question which asked respondents to rate their health on a scale of one to ten (ten being the best imaginable health and one being the worst). On average, adults in Jersey rated their health (on a scale of one to ten) at 7.6 in 2012[15] and 7.4 in 2013[16].

A similar question was asked in Guernsey in 2008, where respondents were asked to rate their health on a scale of 0 (representing the worst imaginable health) to 100 (best imaginable). The average (mean) score was 78. This is similar to the score (if divided by 10 to give the same scale) as that recorded for Jersey respondents.

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[15] JASS 2012, Jersey Statistics Unit
[16] JASS 2013, Jersey Statistics Unit

Life Expectancy[17] at birth

> Life expectancy at birth measures how long on average a baby born today would expect to live, if current death rates did not change. Similarly, life expectancy at 65 is a measure of how much longer a person of that age today could expect to live if they were to experience the current local age-specific mortality rates.

Life expectancy at birth has continued to increase in European[18] countries, reflecting sharp reductions in mortality rates at all ages. These gains in longevity have been attributed to a number of factors including rising living standards, improved lifestyle and better education, and greater access to quality health services.

Figure 3.2: Life expectancy at birth

Life Expectancy at birth

Jersey

79.2 years   83.7 years

Guernsey & Alderney

79.9 years   84.1 years

England

79.2 years   83.0 years

Wales

78.2 years   82.2 years

2010-2012

In Jersey the life expectancy at birth for females is around 4 years longer than for men.

Life expectancy and gender differences are similar in Jersey and Guernsey and in line with the highest English regions.

The average gender gap in life expectancy across EU countries was 5.8 years in 2010-2012[19].

In England and Wales, there is a well-documented socio-economic divide in life expectancy, with individuals living in poorer neighbourhoods or having manual/routine

Source: Jersey Health Intelligence Unit; ONS Life Expectancy at Birth and at age 65 for local areas in England and Wales, 2010-2012, Guernsey Public Health and Strategy Directorate.
Three-year rolling averages, based on deaths in calendar years and proxy mid-year population estimates

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[17] Life expectancy is calculated using life tables, which generate the life expectancy of a hypothetical cohort experiencing the current age-specific mortality rates for each year of their life.
[18] OECD, for more information see www.oecd.org
[19] Eurostat indicator demo_mlexpec average 2010-2012 data, available from epp.eurostat.europa.ec

occupations having, on average, a shorter life expectancy than individuals living in more affluent neighbourhoods or with managerial/professional occupations[20]. Comparative data for Jersey is currently unavailable as our deaths data is not linked to any employment data.

Globally[21], male life expectancy in 2011 varied from 46 to 83 years (median = 70) and female life expectancy was 47 to 86 years (median = 76). Both Channel Islands have life expectancies well above the average for the European region of 77 years for men and similar to the European average of 83 years for women in 2010-2012.

Life Expectancy at 65

Life expectancy at 65 has increased among both men and women over the past decades. These gains in longevity at older age combined with the reduction in fertility rates are contributing to a steady rise in the proportion of older persons in our population, as across Europe.

Currently, women in Jersey can expect to live, on average, an additional 21 years once they have reached 65, while men can expect to live for an additional 19 years (Figure 3.3). This is the same as Guernsey and England and the EU average (2010-2012)[22] for women of 21.2 years and above the EU average for men of 17.7 years.

Figure 3.3: Life expectancy at 65 for Jersey residents 2010-2012, years

	👨	👩	Gender gap
Jersey	18.8	21.4	2.6 years
Guernsey & Alderney	18.6	21.5	2.9 years
England	18.6	21.1	2.5 years
Wales	18.0	20.6	2.6 years

Source: Jersey Health Intelligence Unit; ONS Life Expectancy at Birth and at age 65 for local areas in England and Wales, 2010-2012, Guernsey Public Health and Strategy Directorate.
Three-year rolling averages, based on deaths in calendar years and proxy mid-year population estimates

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[20] For more information, please see *Life expectancy at birth and at age 65 for local areas in England and Wales, 2010-2012, Statistical Bulletin,* Office for National Statistics, October 2013.
[21] World Health Statistics 2013; 58
[22] .Eurostat indicator demo_mlexpec average 2010-2012 data, available from epp.eurostat.europa.ec

The gender gap in life expectancy at 65 for both Jersey and Guernsey (Figure 3.3) are lower than that reported for the EU at 3.5 years in 2010-2012.

Changes in life Expectancy

Since 2000 there has been a small incremental increase in life expectancy for both men and women over time (Figure 3.4). This trend is in line with many other European countries.

The increase for males was larger than that seen for females causing the gender difference in life expectancy to narrow over time. The narrowing of the gender gap has also been seen in Guernsey and England and Wales, as well as in EU countries.

Figure 3.4: Change in Life Expectancy over time

2010-2012
79.2 years — 83.7 years

2005-2007
77.6 years — 83.2 years

2000-2002
76.1 years — 81.3 years

Life Expectancy has increased by 2.4 years for females and 3.1 for males over the last decade.
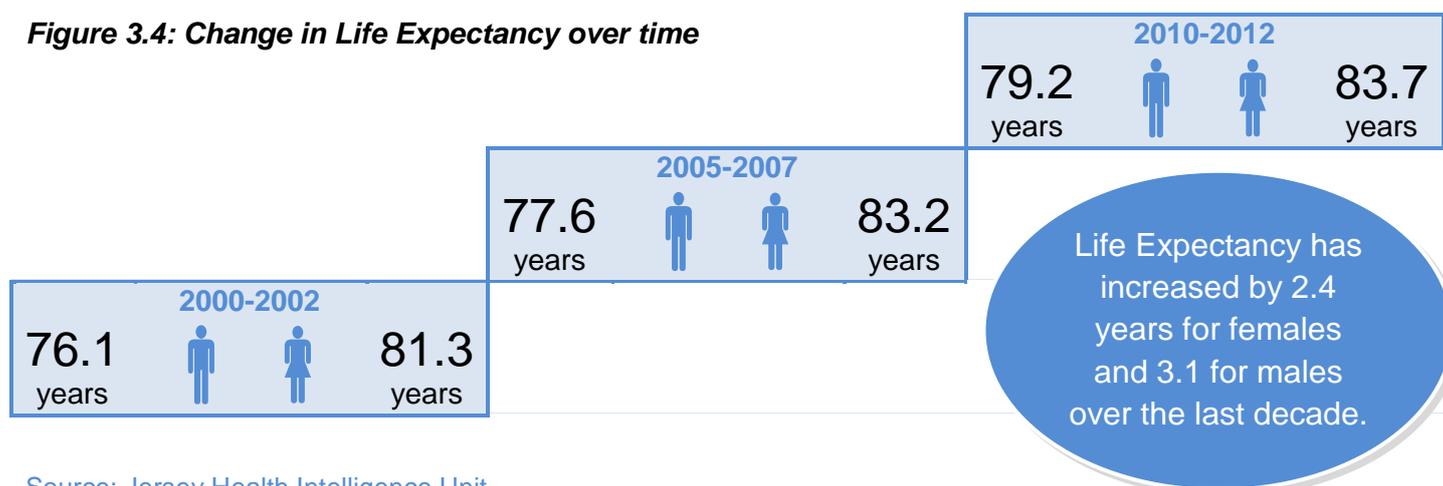
Source: Jersey Health Intelligence Unit
Three-year rolling averages, based on deaths in calendar years and proxy mid-year population estimates

Life Expectancy comparisons

The World Health Organization[23] reported that in 2011, the average life expectancy of birth for the global population is 70, ranging from 60 in low income countries to 80 in high income countries.

The overall life expectancies of 81.6 and 82.3 in Jersey and Guernsey respectively are in line with those in high income countries, as reported in the Central Intelligence Agency (CIA) World Factbook[24].

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[23] World Health Organisation Global Health Observatory, www.who.int
[24] Central Intelligence Agency, World Factbook, www.cia.gov

Both Jersey and Guernsey would rank in the top 10% of countries reported by the CIA (Table 3.2). For 2013, Monaco was ranked top for life expectancy, with residents expected to live 89.63 years, whilst Chad was ranked last with a life expectancy of 49.07. Jersey appears 14th out of 223 countries, whilst Guernsey appears 7th.

Table 3.2 shows the top and bottom 3 countries ranked by the CIA, where Jersey, Guernsey and near-neighbours lie, as well as Poland and Portugal who represent the two largest migrant populations in Jersey.

Table 3.2: CIA World Factbook Life Expectancy rankings, 2013 estimates

Ranking	Country	Life Expectancy
1st	Monaco	89.63
2nd	Macau	84.46
3rd	Japan	84.19
7th	Guernsey	82.32
14th	**Jersey**	**81.57**
15th	France	81.56
30th	United Kingdom	80.29
49th	Portugal	78.85
77th	Poland	76.45
221st	Guinea-Bissau	49.50
222nd	South Africa	49.48
223rd	Chad	49.07

Source: CIA World Factbook

Top 10%

Jersey ranks in the top 10% worldwide for overall life expectancy

4. BURDEN OF DISEASE

4.A. MORTALITY

Population Mortality

In Jersey there were 386 male and 388 female deaths recorded for Jersey residents in 2012, giving a total of 774 deaths. This equates to a crude death rate of 785 per 100,000 population and an age standardised rate (ASR[25]) of 506 per 100,000 in calendar year 2012.

For the period 2010-12 the age standardised rate of 516 per 100,000 was higher than the mortality rate in Guernsey for the same period (Table 4.1).

Table 4.1: Population Mortality 2010-2012

	Jersey 2010-2012			Guernsey 2010-2012		
	Male	Female	Persons	Male	Female	Persons
Deaths	1,146	1,156	2,302	823	878	1,701
Average Age at Death	73	80	77	75	82	79
Crude rate (per 100,000)*	794	779	786	857	889	873
Age-standardised rate (per 100,000)*	624	424	516	595	404	490

* Mid-year population for Jersey, End of March population Guernsey
Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate

When compared to England, Jersey mortality rates are similar to the England average and regions in the south but significantly lower than regions in the North of England (Table 4.2). Guernsey rates are significantly lower than the England average.

The average EU all cause mortality rate was reported as 663 per 100,000 in 2010, ranging from 500 per 100,000 in Spain and Italy to over 900 per 100,000 in the Baltic and central European countries.[26]

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Average (mean) age at death in the period 2010-2012

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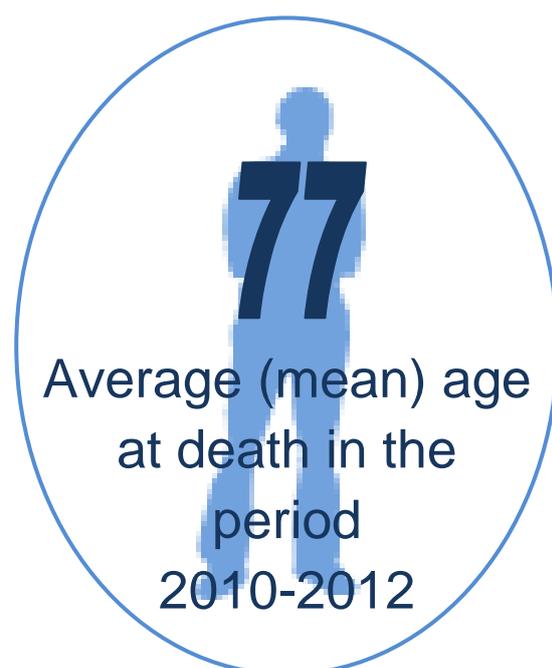
[25] Calculated using the 1976 European standard population. Future publications from the Health Intelligence Unit will use the 2013 European Standard Population.
[26] OECD (2012),'Mortality from all causes' in Health at a Glance: Europe 2012, OECD publications.

Table 4.2: Ranked comparison of England, Wales and English Regions Mortality 2010-2012

	ASR per 100,000	95% CI LL[27]	95% CI UL[28]
North East	598.3	593.9	602.7
North West	596.9	594.2	599.6
Yorkshire & the Humber	568.7	565.6	571.8
West Midlands	544.5	541.6	547.4
East Midlands	535.8	532.7	539.0
England & Wales	531.9	531.0	532.8
England	529.5	528.5	530.4
Jersey	516.3	494.5	538.7
London	503.2	500.5	505.9
East of England	494.1	491.5	496.8
South West	491.5	488.8	494.2
Guernsey	490.0	465.5	515.5
South East	487.8	485.7	490.0

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00339

The ASR for Jersey has reduced slightly in recent years, from 548 per 100,000 in 2008-2010, to 531 per 100,000 in 2009-2011 to 516 in 2010-2012.

Main Causes of Death

Causes of death are categorised and coded according to the International Statistical Classification of Diseases and Related Health Problems, a publication now in its 10th revision and commonly known as ICD-10. Comparing the number of deaths across subcategories of the ICD-10 allows the leading causes of death to be analysed.

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[27] CI LL = confidence interval, lower limit
[28] CI UL = confidence interval, upper limit

4. Burden of Disease

The top three main causes of death in 2010-2012 were cancers (neoplasms), accounting for 32% of all deaths, circulatory diseases (28%) and respiratory diseases (13%). Mental and behavioural disorders (mostly dementia) made up 6% of all deaths while diseases of the digestive system resulted in 5% (see Figure 4.1). In recent years cancers have overtaken circulatory diseases as the main cause of death locally. In the EU and OECD countries mortality from circulatory diseases are still the main cause of death, accounting for 30% and 33% of all deaths respectively, followed by cancers (28% and 26% of all deaths respectively).

Figure 4.1: Main causes of death 2010-2012
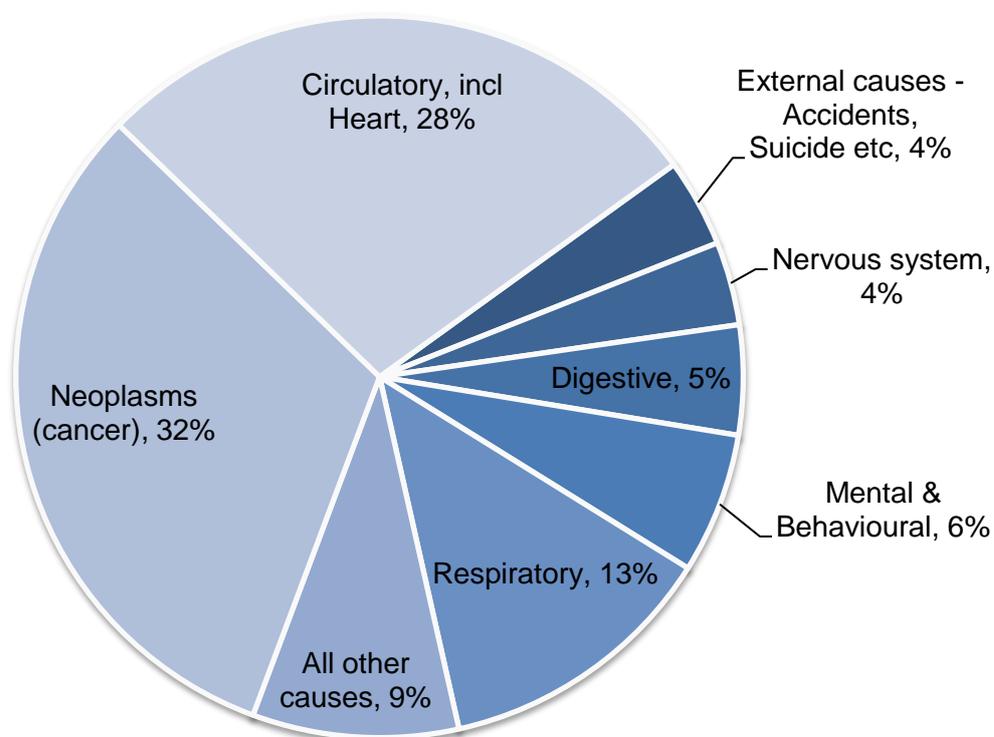
Guernsey shows a similar pattern to Jersey with a similar proportion of deaths from cancers and circulatory diseases, causing 30% and 31% of all deaths and respiratory diseases causing 10% of all deaths.

Deaths from cancers (neoplasms) and circulatory disease account around 60% of all annual deaths in both Channel Islands (Table 4.3) and for 64% of deaths in the EU[29] (2010).

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[29] OECD (2012),'Mortality from all causes' in Health at a Glance: Europe 2012, OECD publications.

Table 4.3: Top causes of death 2010-2012

	Jersey 2010-2012					Guernsey 2010-2012				
	Number	ASR*	95% CI LL[30]	95% CI UL[31]	% of all deaths	Number	ASR*	95% CI LL	95% CI UL	% of all deaths
Neoplasms	728	177.5	164.43	191.33	32%	514	162.4	148.02	177.80	30%
Diseases of the Circulatory System	638	131.4	121.08	142.37	28%	530	141.3	128.86	154.59	31%
Diseases of the Respiratory System	290	61.5	54.39	69.28	13%	174	45.6	38.73	53.26	10%
Diseases of the Digestive System	113	27.7	22.67	33.51	5%	74	21.2	16.38	26.97	4%
Mental and Behavioural Disorders	145	26.6	22.37	31.36	6%	126	28.3	23.46	33.77	7%

Age standardised using the 1976 European Standard Population

Table 4.4: Specific causes of death 2010-2012, all ages

	Jersey 2010-2012				Guernsey 2010-2012			
	Number	ASR*	LL	UL	Number	ASR*	LL	UL
Cancers								
Lung Cancer	164	41.6	35.4	48.7	113	38.9	31.8	47.0
Breast Cancer	59	26.1	19.6	34.1	21	13.6	8.0	21.3
Colorectal Cancer	52	12.6	9.3	16.7	49	15.4	11.2	20.5
Prostate Cancer	41	21.5	15.3	29.2	49	33.0	24.3	43.8
Bladder Cancer	30	6.6	4.4	9.6	20	5.7	3.4	9.0
Malignant melanoma	17	4.5	2.6	7.2	10	4.0	1.8	7.5
Cervical Cancer	5	1.3	0.4	3.1	4	2.6	0.6	6.9
Circulatory Diseases								
Ischaemic Heart Disease	255	54.2	47.5	61.5	209	58.2	50.1	67.0
Stroke	189	37.6	32.3	43.5	162	41.4	34.9	48.7
Respiratory Diseases								
Bronchitis, Emphysema, COPD	124	28.2	23.3	33.8	70	20.2	15.5	25.8
Pneumonia	85	16.0	12.7	19.9	51	11.9	8.7	15.7
Other selected Causes								
Accidents	55	14.9	11.1	19.6	47	17.8	12.7	24.1
Infectious and parasitic diseases	25	5.3	3.4	7.9	20	5.5	3.3	8.7
Chronic Liver Disease incl Cirrhosis	38	11.1	7.8	15.2	12	5.3	2.7	9.2

Age standardised using the 1976 European Standard Population
Sources: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate

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[30] CI LL = confidence interval, lower limit
[31] CI UL = confidence interval, upper limit

Specific Causes of Death

Top five specific causes of death

The greatest numbers of deaths in Jersey are caused specifically by **ischaemic heart disease**, followed by **stroke**, **lung cancer**, **bronchitis, emphysema & COPD** and **pneumonia** (Table 4.4). These top five causes of deaths also cause the most deaths in Guernsey.

Cancers

Cancers are the main cause of death in Jersey accounting for just under a third of all deaths in 2012 (250 deaths). Cancer is not one disease; there are more than 100 different types of cancer each with different risk factors and treatment outcomes.

While lung cancer alone accounts for more than 20% of all cancer deaths (around 55 deaths a year), the most common cancer site was the digestive organs, accounting for 75 deaths (30% of all cancer deaths). In 2012, cancers of the digestive system comprised pancreatic cancer (32%), cancer of the oesophagus (21%), colorectal cancer (19%) and liver cancer (11%), with cancers of the stomach, gall bladder and 'other digestive organs' making up the remainder.

Table 4.5: Top 5 cancers for men and women, 2012

Male			Female		
Cancer Site	ICD Code	Percentage of Cancer Deaths	**Cancer Site**	ICD Code	Percentage of Cancer Deaths
Digestive organs (mainly colorectal, pancreas and oesophagus)	C15-C26	30%	**Digestive organs** (mainly colorectal, pancreas and oesophagus)	C15-C26	31%
Respiratory & Intrathoracic (mainly lung cancer)	C30-C39	22%	**Respiratory & Intrathoracic** (mainly lung cancer)	C30-C39	18%
Urinary tract	C64-C68	10%	**Breast**	C50	17%
Male genital organs	C60-C63	7%	**Malignant neoplasm of ill-defined, secondary and unspecified sites**	C76-C80	7%
Lip, oral cavity and pharynx	C00-C14	6%	**Female genital organs**	C51-C58	6%

Source: Jersey Health Intelligence Unit

Cancer death rates are higher for men than women (in 2010-2012 the ASR for men was 222 per 100,000 compared to 140 per 100,000 for women) and this is reflected in EU data[32] (for 2010).

When individual cancers are considered; lung cancer accounted for the greatest number of cancer deaths among men in Jersey over the period 2010-2012, followed by prostate, colorectal and cancer of the oesophagus. Among women, lung cancer accounted for the most deaths in 2010-2012, followed by breast cancer, pancreatic and ovarian cancer.

Circulatory Disease (also referred to as Cardiovascular Disease)

Circulatory diseases accounted for over a quarter (28%) of all local deaths, 213 deaths in 2012, and are the second leading cause of mortality locally. This is less than the latest reported EU average of 36% of all deaths caused by Circulatory Disease in 2010. The crude death rate for circulatory diseases was 216 deaths per 100,000 population in 2012, maintaining the level seen in 2010 and 2011 (around 220 per 100,000).

Deaths due to diseases of the circulatory system are mostly accounted for by ischaemic heart disease (also referred to as coronary heart disease or heart attack) and stroke (or cerebrovascular disease). Locally, ischaemic heart disease (IHD) accounted for 40% of all deaths from circulatory disease, 11% of all deaths of Jersey residents in 2012. Stroke accounted for 30% of all circulatory deaths, 9% of all deaths. These proportions reflect the latest EU findings: IHD is responsible for 13% of all deaths in the EU; stroke is responsible for 9% of all EU deaths; and 60% of all deaths from circulatory disease are caused by IHD or stroke.

The number of male deaths from ischaemic heart disease exceeds the number of female deaths, while a greater numbers of females than males died from a stroke.

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[32] OECD (2012), *'Mortality from cancer' in Health at a Glance: Europe 2012,* OECD publications.

Suicide

In 2010 to 2012, deaths from suicide in Jersey returned to more expected levels after a peak in 2008 and 2009 (Table 4.6).

The suicide rate was **10.4 per 100,000** in 2010-12 for persons aged 15 and over. This is lower than in previous years when rates ranged between 15 to 17 per 100,000, due to the influence of the particularly high suicide rate observed in 2009.

Table 4.6: Annual number of resident deaths from suicide[33] and events of undetermined intent

Year	2007	2008	2009	2010	2011	2012
Number of Suicide deaths	15	16	26	10	8	11

Source: Jersey Health Intelligence Unit, ICD-10 codes X60-X84 and Y10-Y34

Suicide rates in Guernsey were not significantly different to Jersey in 2010-2012, with a reported rate of 13.2 per 100,000 for suicide and events of undetermined intent.

Suicides rates in Jersey were not significantly different to England and Wales or the South West region of England (Table 4.7) in 2010-2012. Our current suicide rate is also lower than the latest reported EU average of 12.3 per 100,000 in 2010 where rates range from a low of 8 or less per 100,000 in southern European countries to over 17 per 100,000 in the Baltic States and Central Europe[34].

Table 4.7: Suicide ASR compared with England, London and the South West, 2010-2012, persons 15 years and over

	Number	ASR	Lower CI	Upper CI
Jersey	26	10.4	4.49	12.98
England	9,892	7.6	7.48	7.78
London	1,129	5.8	5.47	6.17
South West	1,187	9.1	8.61	9.69

Source: Jersey Health Intelligence Unit, HSCIC indicator P00535 for Suicide only, does not include events of undetermined intent due to availability of comparative data

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[33] Those deaths coded as Intentional self-harm and events of undetermined intent are jointly reported as suicides, this is in line with suicide reporting by the Office for National Statistics for England.
[34] OECD (2012), *'Mortality from suicide'* in Health at a Glance: Europe 2012, OECD publications.

However, suicide rates remain high in men. They are around 3 times higher than the female death rate; with the highest rate among young men aged 30-49. In 2010-12 there was an average of 7 male suicides annually compared with 3 female suicides. Reported suicide death rates across the EU are four to five times greater for men than women.

Figure 4.2: Male and female suicide rates for Jersey compared to England and the Southwest, aged 15 years and over.
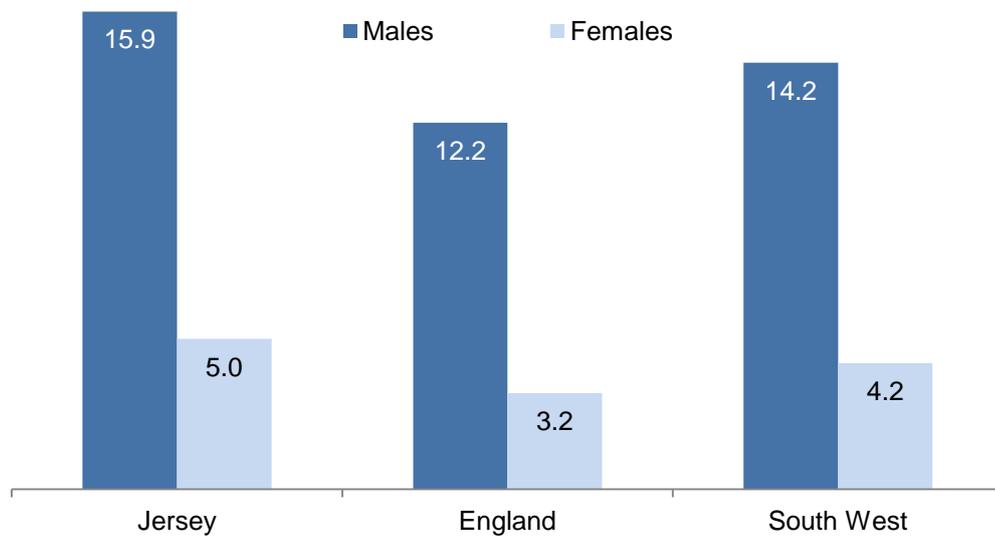

Source: Jersey Health Intelligence Unit, HSCIC indicator P00535 for Suicide only, does not include events of undetermined intent due to availability of comparative data

Preventable Deaths

> The ONS definition of Preventable deaths: a death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) **could be avoided by public health interventions in the broadest sense**.

The quantification of preventable premature mortality is a key focus of the Department of Health Outcomes Framework (2010-2016)[35] which looks at the importance of prevention as well as treatment in reducing avoidable deaths. Preventable deaths include causes that are believed could have been avoided through individual behaviour or public health measures to limit an individual's exposure to harmful substances or conditions.

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[35] Department of Health Outcomes Framework 2010-2016 www.gov.uk

On average, around 160 deaths each year (around 20% of all deaths) in Jersey are to causes considered preventable. Our rate is not significantly different to the rate in England and Wales (Table 4.8).

Table 4.8: Preventable deaths 2010-2012

		Jersey				England & Wales			
		Number of deaths	Rate	LL	UL	Number of deaths	Rate	LL	UL
All Preventable deaths	2010	177	161.1	138.1	186.8	96,786	150.4	149.5	151.4
	2011	158	142.3	120.8	166.6	94,584	145.0	144.1	146.0
	2012	153	135.0	114.3	158.4	-	-	-	-

Rate is ASR per 100,000 population, standardised to the 1976 European Standard Population
LL & UL: lower and upper 95% confidence Intervals
Source: Jersey Health Intelligence Unit and ONS

The average rate for Jersey over the period 2010-2012 is 146.0 per 100,000 (confidence interval 133.3, 159.7). The comparative Guernsey rate for the same period being 120.1 per 100,000 (confidence interval 106.5, 135.0) is lower than Jersey, but not significantly different.

Many of these preventable deaths are smoking and alcohol related.

Smoking-related deaths

Smoking is the primary cause of preventable illness and premature death in the UK[36] and tobacco kills around half of its users[37]. In Jersey, around one in six (17%) deaths of adults aged 35 and over in 2012 are estimated to be caused by smoking[38] and is similar to the estimated 16% in Guernsey. This amounts to around 130 individuals dying annually from smoking attributable causes in Jersey.

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[36] ASH factsheet on Smoking Statistics – Illness and Death, April 2013, www.ash.org.uk
[37] World Health Organisation Tobacco Factsheet No. 339, July 2013, www.who.int
[38] Department of Health and Health and Social Care Information Centre methodology

In recent years the development of Smoking Attributable Fractions[39] (SAFs) for several diseases and causes of death has allowed a better estimate of the impact of smoking on health.

Most smoking-related deaths are from one of three types of disease: lung cancer, chronic obstructive pulmonary disease (COPD, which incorporates emphysema and chronic bronchitis) and ischaemic heart disease (CHD).

Of these, smoking caused: 37% of all respiratory deaths, around 35 deaths a year; 30% of all cancer deaths, around 70 deaths a year; 11% of all circulatory disease deaths, around 23 deaths a year. These are similar to the proportions seen for England[40] and Guernsey (Table 4.9).

Table 4.9: Estimated proportion of Smoking Related Deaths (>35 years) in each cause of death category

Cause (ICD-10 codes)	JERSEY 2010-2012	GUERNSEY 2010-2012	ENGLAND 2011
All causes	17%	16%	18%
Respiratory diseases (J00-J99)	37%	36%	36%
Cancers (C00-C97)	30%	28%	28%
Circulatory disease (I00-I99)	11%	11%	14%

Sources: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, HSCIC 2013, Statistics on Smoking 2013

Smoking attributable deaths are more common in males than females (Figure 4.3) in both Jersey and Guernsey.

- **1 in 6 of all deaths of those over 35 is attributable to smoking**
- **130 people die each year from smoking-related causes**
- **Smoking attributable deaths are more common in men**

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[39] Statistics on Smoking, 2013, Health and Social Care Information Centre
[40] Statistics on Smoking, 2013, Health and Social Care Information Centre

Figure 4.3: Estimated deaths attributable to smoking, as a percentage of all deaths from that disease*, by gender, 2012
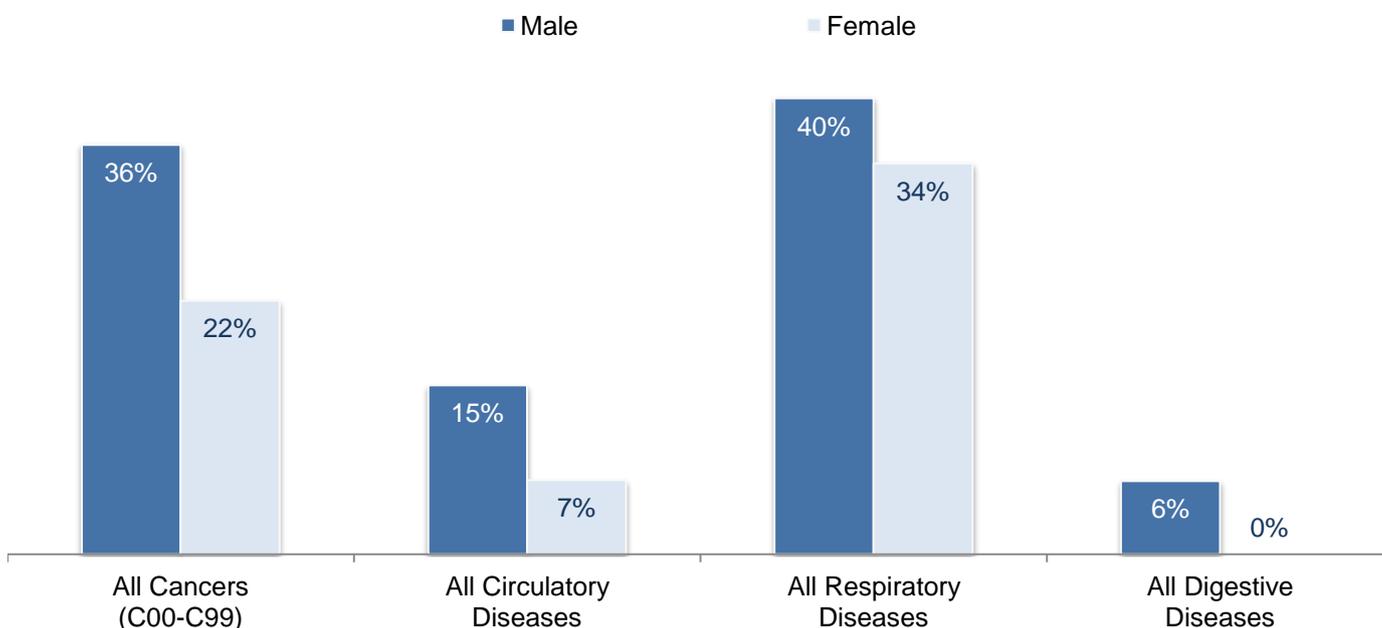
*Among adults aged 35 and over
Source: Jersey Health Intelligence Unit

An estimated 78% of deaths from trachea, lung and bronchus cancer were attributable to smoking; four-fifths (78%) of larynx cancers and four-fifths (82%) of bronchitis and emphysema deaths were also smoking-related. One in ten (11%) of ischaemic heart disease deaths and two-thirds (66%) of head and neck cancers deaths were attributable to smoking over the period 2010-2012.

Alcohol-related deaths

Around 2% of all deaths (around 14 a year) in Jersey are from alcohol-related causes[41], such as alcoholic liver disease and cirrhosis. These deaths account for around 300 years of life lost each year (total years of life lost under the age of 75. See page 37 for further explanation). In Guernsey there are around 6 deaths per year related to alcohol, accounting for 103 years of life lost.

Deaths caused specifically by alcohol have remained stable over the past 5 years (2008 to 2012). Over the period 2010-2012, the age-standardised death rate in Jersey was 13 per 100,000 population. The majority of these deaths were due to alcoholic liver disease, accounting for around three-quarters (77%) of all alcohol-related deaths over the period 2010-2012. Males accounted for

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[41] Alcohol-related disease definition used by the Office for National Statistics; see *Alcohol-related deaths in the United Kingdom, registered 2012*, ONS published February 2014, available from www.ons.gov.uk

approximately 72% of all alcohol-related deaths; a similar proportion to that seen in the UK in 2012[42].

Figure 4.4: Alcohol-related death rates, by region, 2012
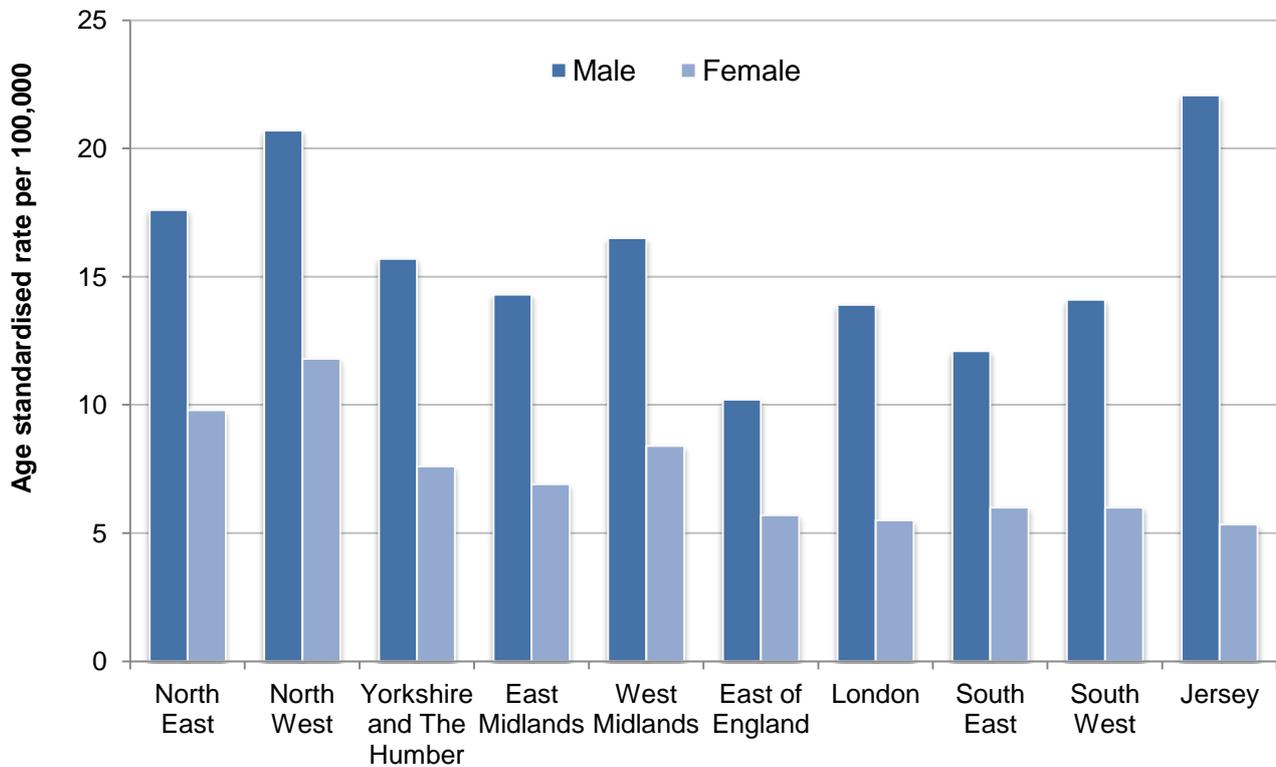
Source: Jersey Health Intelligence Unit, ONS

Premature Deaths – Years of Life Lost under 75

> The concept of years of life lost (YOLL) is used to estimate the potential length of time a person would have lived had they not died prematurely. It is based on the assumption that every individual could be expected to live until the age of 75 and premature death before that age may be preventable.

Years of life lost (YOLL) data can help health planners to identify areas of concern and prioritise resources to try to avert preventable early deaths. The age of 75 is most commonly used as the

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[42] ONS (2014), *Alcohol-related Deaths in the United Kingdom Report*, deaths registered in 2012, published February 2014, www.ons.gov.uk

cut off point in premature death statistics. Causes accounting for the most YOLL do not necessarily cause the most deaths but may be causing deaths at a younger age.

In Jersey more than 250 people a year die before they reach 75, accounting for over 3,700 YOLL annually from all causes of death. Our rate of 380 YOLL per 10,000 is comparable to the England average but higher than Guernsey and the South West (Table 4.10).

Table 4.10: Years of Life Lost (all causes) 2010-2012

Jersey		Guernsey			
Total YOLL (2010-12)	Rate per 10,000 population (95% CI)*	**Total YOLL (2010-12)**	Rate per 10,000 population (95% CI)*	E&W	South West
11,240	**379.8** (372.8 to 387.1)	6,310	**316.8** (308.9 to 324.9)	393.7	363.5

* Rate calculated using the 1976 European Standard Population
Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00332

Cancers accounted for the majority of years of life lost due to deaths under 75 in Jersey followed by circulatory disease and external causes, such as suicide and accidents (Figure 4.5). Guernsey has a slightly different picture with external causes (suicide & accidents) responsible for slightly more YOLL than cancer, followed by circulatory disease.

In particular, deaths from lung, colorectal and breast were responsible for the majority of premature deaths due to cancers in both Islands.

- **835** potential years of life were lost due to intentional self-harm between 2010 and 2012
- **1,030** potential years were lost due to accidents over the same time period

For males, the predominant causes of premature death are cancers of the digestive organs (mostly colorectal and pancreatic cancers), lung cancer (cancer of respiratory organs), suicide and ischaemic heart disease. For females, premature deaths are caused mainly by lung cancer, breast cancer, liver disease and cancers of the digestive organs (mainly pancreatic cancers).

Figure 4.5: Potential Years of Life Lost, annual average 2010-2012
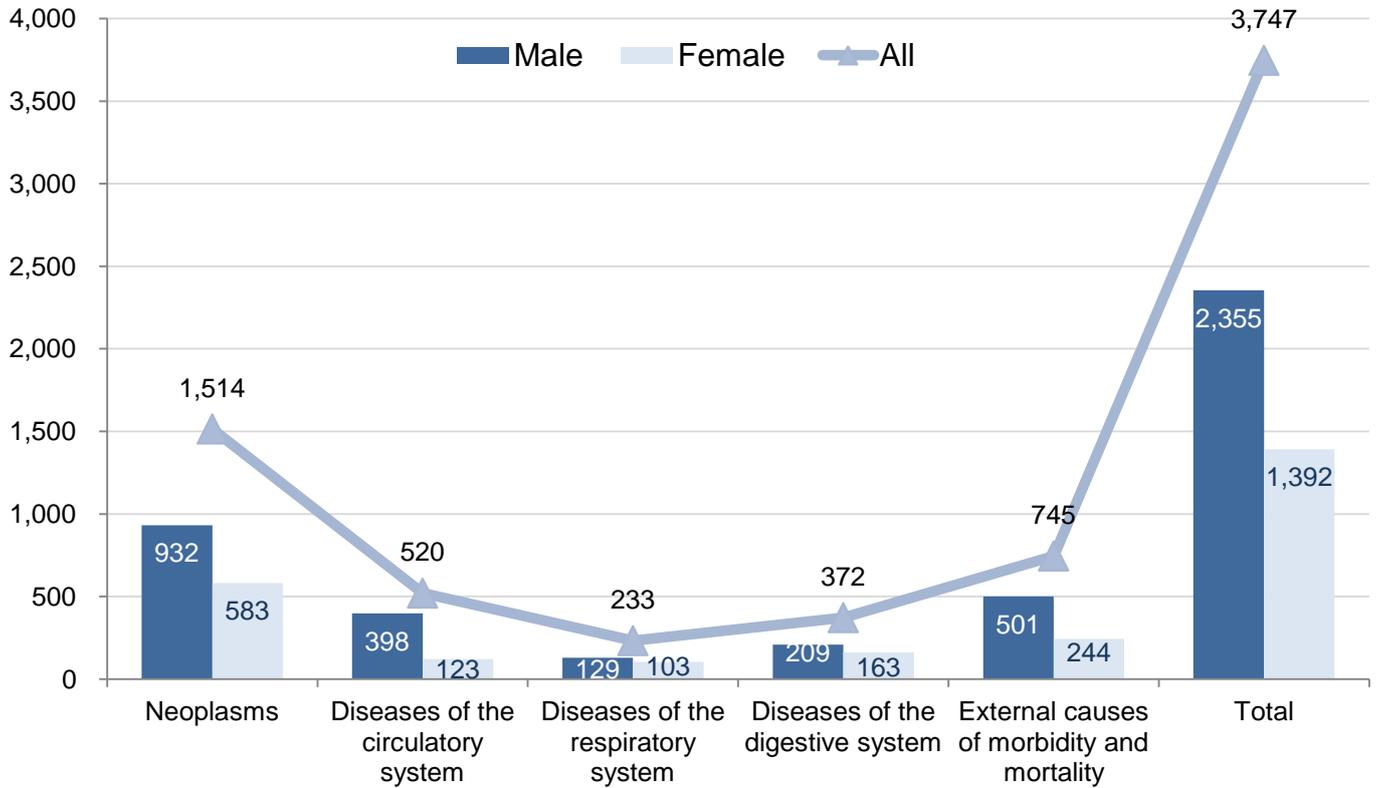
Source: Jersey Health Intelligence Unit

Premature Deaths – Years of Working Life Lost

> The concept of years of working life lost (YWLL) is used to estimate the potential length of time a person would have worked had they not died prematurely. It is based on the assumption that every individual could be expected to live and therefore work until the pension age (65). YWLL provides a measure of the impact of avoidable mortality in a population and the potential effect premature death has on the economy.

In Jersey, 46% of all Years of Life Lost were due to deaths among people of working age (16-64 years) or younger; this is similar to the proportion in Guernsey (43%).

Table 4.11: Potential Years of Working Life Lost 2010-2012

CAUSE OF DEATH	Total YWLL 2010-2012	Average YWLL per death
Accidents	740	28
Suicide and undetermined injury	595	21
Lung cancer	368	8
Chronic liver disease incl. cirrhosis	355	12
Ischaemic heart disease	290	9
Breast cancer	195	11
Colorectal cancer	130	8
Malignant melanoma	100	17
Bronchitis, Emphysema, COPD	80	7
Stroke	60	5
Infectious and parasitic diseases	50	13
Bladder cancer	33	7
Prostate cancer	28	6
Pneumonia	13	4

Source: Jersey Health Intelligence Unit

As for total YOLL, deaths from accidents, suicides & injuries of undetermined intent and lung cancer contributed the most to potential years of working life (YWLL) lost between 2010 and 2012 (Table 4.11).

Conditions with the highest average YWLL are those where death occurs, on average, at younger ages. Thus accidents, suicide and undetermined injury account for more years of life lost per individual death than lung cancer, although it causes more deaths, because these deaths happen in a much younger age group.

A similar picture is seen in Guernsey, with suicides & undetermined injury, accidents and chronic liver diseases including cirrhosis accounting for the greatest potential years of working life lost per death.

Premature Mortality (Longer Lives)

Public Health England published their Longer Lives Tool in 2013 which allows comparison of premature mortality rates across English regions and is designed to be a powerful enabler for change and to facilitate debate on improving health and living longer lives.

Using the same methodology, it is possible to map where Jersey is in the 'longer lives' rankings. A recent revision and update of the tool was published in February 2014 for premature mortality between 2010 and 2012.

More than 250 people a year die in Jersey before their 75th birthday, accounting for more than a third (34%-36%) of all deaths each year. Like England, a child born in Jersey today can expect to live a longer, healthier life than ever before, yet, they still have a one in three chance of dying before they reach 75.

Figure 4.6: Premature Mortality rankings, 2010-2012

- **Premature mortality** was 332 per 100,000 in 2010-2012, this **was better than the English average**
- **Jersey ranks 53rd out of 151 regions, behind York**

- For premature deaths due to **cancer**, Jersey would be 91st out of 151 regions
- The ASR of 154 per 100,000 for premature cancer deaths is **worse than the overall average for England**

- For **heart disease and stroke** deaths, Jersey ranks 11th out of 151 regions, behind Somerset
- The ASR of 61 per 100,000 for these conditions is **amongst the best of the English regions**

4. Burden of Disease

- For **lung disease**, Jersey has a premature mortality rate of 36 per 100,000
- The rate in Jersey is worse than the England average, ranking 81st out of 150 regions

- For **Liver disease*** in 2010-2012 Jersey had a rate of 21 per 100,000, meaning **Jersey is worse than the overall average for England**
- Jersey ranks 88th, behind Ealing

*Includes deaths from liver cancer
Source: Jersey Health Intelligence Unit, Public Health England Longer Lives Tool

Place of Death

Around half of all Jersey deaths occur in hospital; this is the same in Guernsey (49%). A further one in six deaths occurs in private homes, whilst one in four occurs in nursing or residential homes.

Figure 4.7: Place of on-Island deaths 2012

- Hospital, 44%
- Nursing Home, 18%
- Hospice, 13%
- Private Home, 17%
- Other, 1%
- Residential Home, 7%
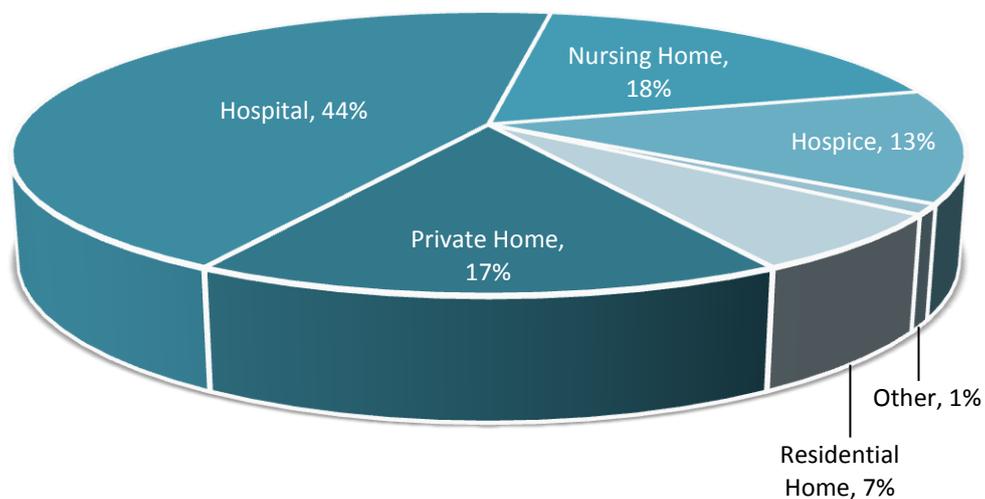
Source: Jersey Health Intelligence Unit

The average proportion of local deaths in hospital for 2010 to 2012 in both islands is similar to that observed in England and Wales (49.7%)[43].

Over the past few years, there has been a drop in the proportion of deaths in hospital and a slight increase in deaths in residential homes and the Jersey Hospice. This is similar to the pattern seen in Guernsey.

Figure 4.8: Distribution of on-Island deaths by place 2008-2012
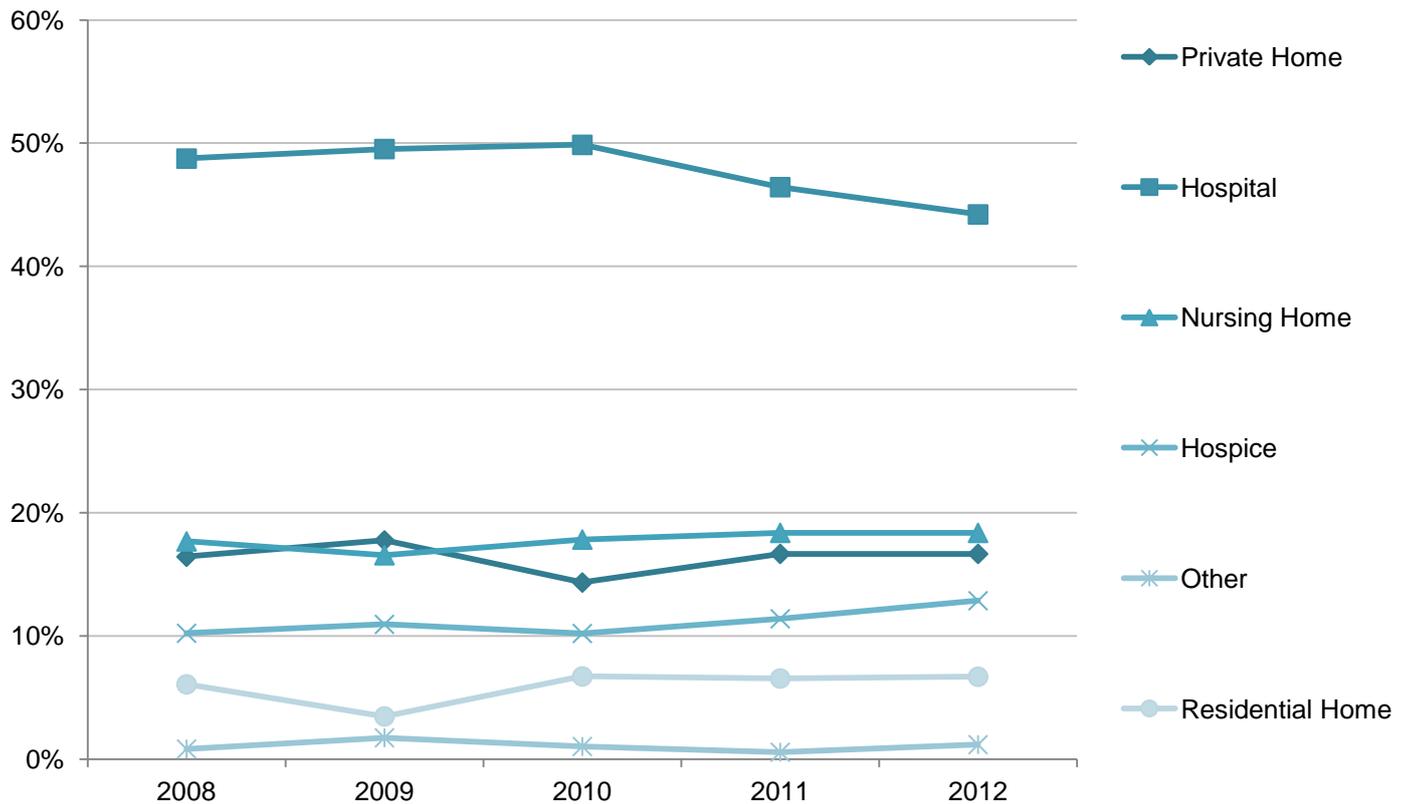
Source: Jersey Health Intelligence Unit

Over half of all deaths from respiratory diseases, circulatory diseases and other causes occur in hospital (Figure 4.9). The pattern for cancer is very different and there are more cancer deaths in hospital in Guernsey (47%) than Jersey (34%), probably because more Jersey cancer deaths occur in Hospice (35% in Jersey compared with around 10% in Guernsey).

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[43] ONS (2013), *Deaths from selected causes by place of death in England and Wales between 1997 and 2012*, 01 November 2013, www.ons.go.uk

Figure 4.9: Distribution of on-Island deaths by place and underlying cause 2010-2012

Legend: ■ Hospital ■ Nursing/Residential Home ■ Private Home ■ Hospice ■ Other

Cause	Hospital	Nursing/Residential Home	Private Home	Hospice	Other
Other	52%	29%	14%		3%
Respiratory disease	56%	28%	16%		
Circulatory Disease	55%	26%	18%		1%
Cancer	34%	17%	15%	35%	
All causes	47%	24%	16%	11%	1%
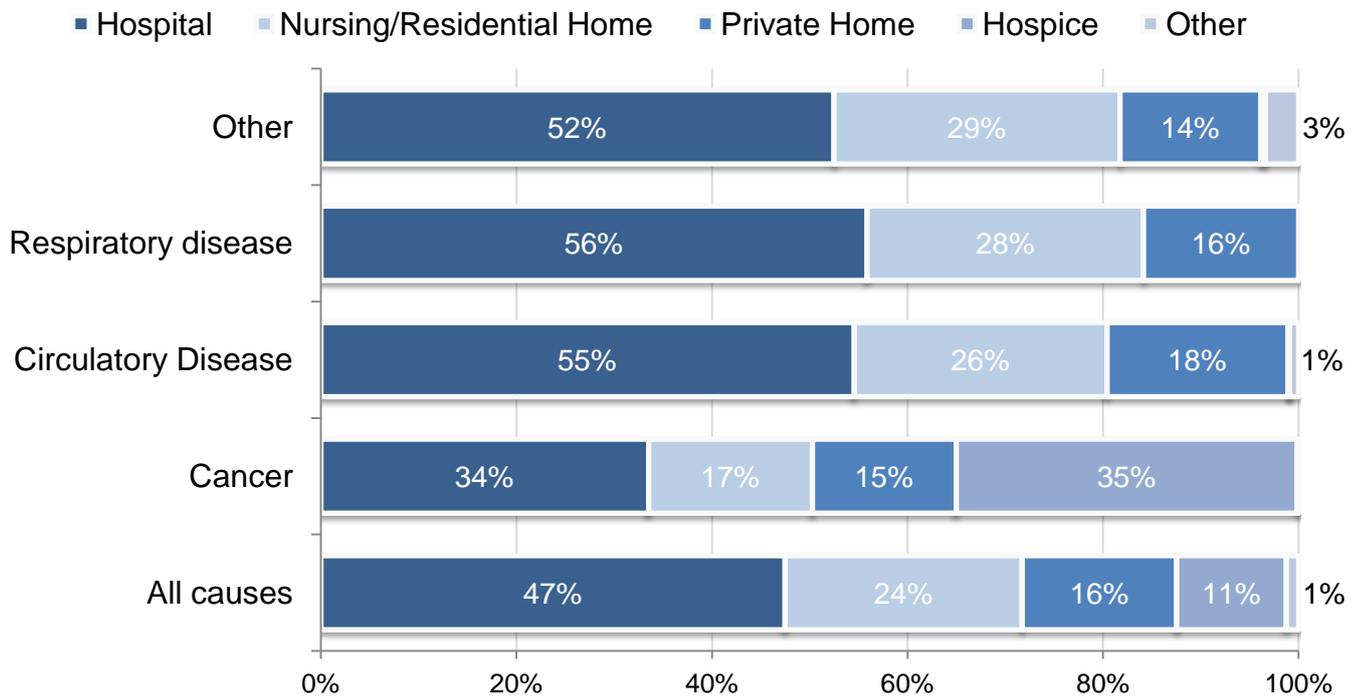
Source: Jersey Health Intelligence Unit

Excess Winter Mortality

England and Wales experience higher levels of mortality in the winter than in the summer and a measure of this increase is provided annually by the Office of National Statistics (ONS). This compares the average number of deaths in the winter period (Dec-Mar) with the average number of deaths in the preceding period (Aug-Nov) and the following period (Apr-Jul).

Using the same methodology, Excess Winter Mortality (EWM) is calculated for Jersey

As seen in other countries, both Channel Islands have more deaths during the winter months than at other times of the year (Figure 4.10). In 2012, using the method of comparison described above, there were over 50 excess winter deaths in Jersey and 30 in Guernsey.

Colder temperatures are considered to play a part in this observed seasonal variation in mortality, but when the average annual winter temperatures are plotted against excess annual winter mortality, there is no significant correlation (Figure 4.10). The same is true for Guernsey. Other relevant factors may include seasonal variation of respiratory infections.

Figure 4.10: Excess Winter Mortality and Average Winter Temperature in Jersey, 2001-2012
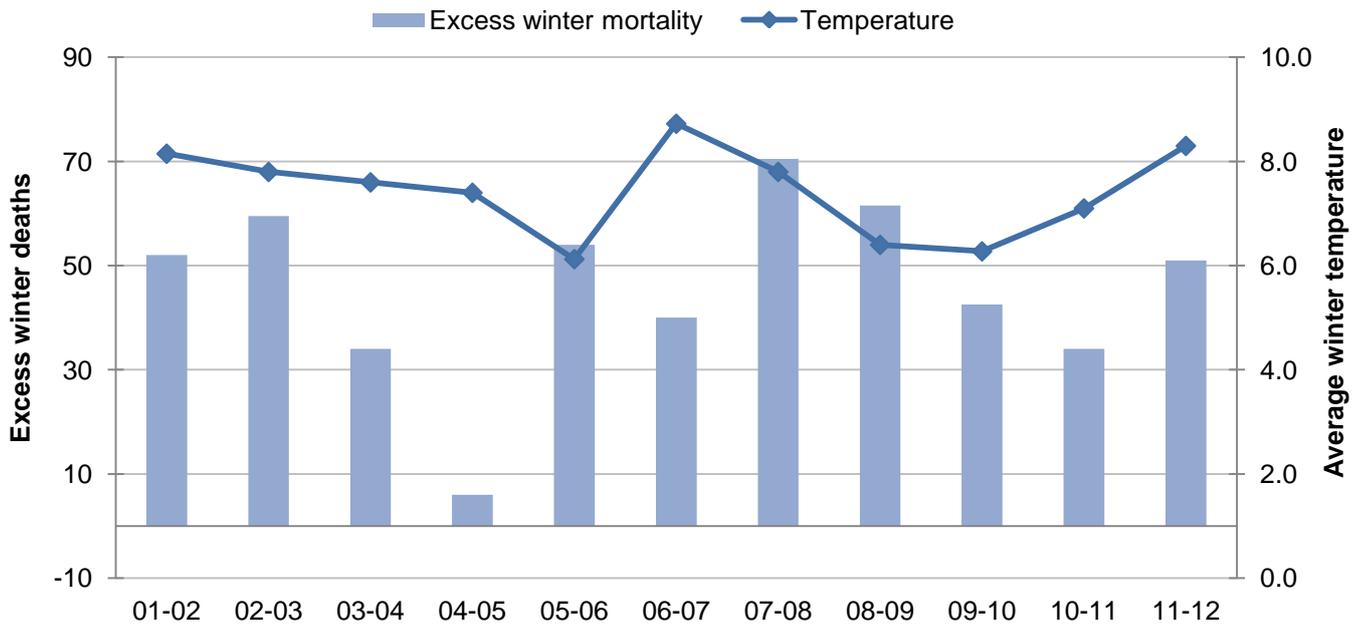
Source: Jersey Health Intelligence Unit and Jersey Met Office

However, **lower monthly temperatures** do seem to correlate with more deaths in the older age groups, aged 75 and over (Figure 4.11) and have much less effect on those under 75 years of age. Guernsey data also reflects this.

Figure 4.11: Monthly deaths and Average Monthly Temperatures in Jersey 2011 to 2012, over 75's
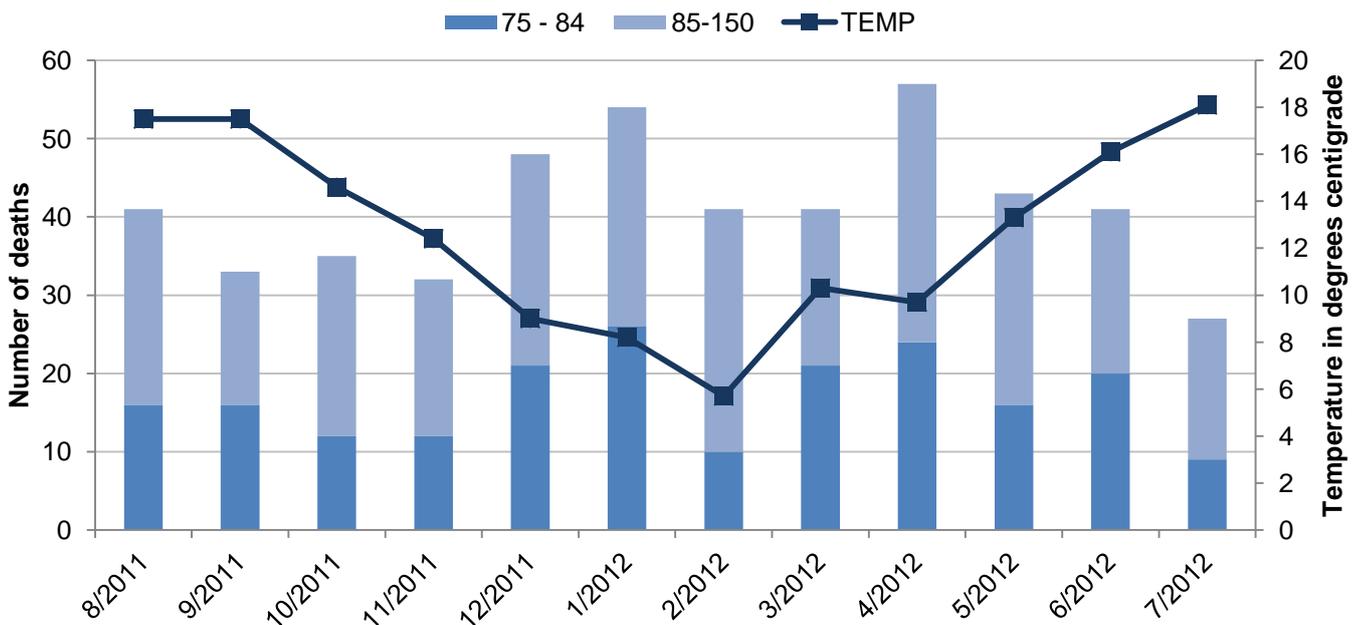
Source: Jersey Health Intelligence Unit and Jersey Met Office

4.B.   DISEASE INCIDENCE & PREVALENCE

Incidence and *prevalence* are both terms that are commonly used to refer to measurements of disease frequency and disease burden in a population.

> The incidence of a disease is the rate at which new cases occur in a population during a specified period. For example, the number of new cases of cancer diagnosed each year or the number of cases of measles per 1,000 people in a given year.

> The prevalence of a disease is the total number of cases (new and ongoing) of a disease in a given population at a specific time, or the proportion of a population that is affected by the disease.
>
> Prevalence is an appropriate measure only for relatively stable, chronic conditions, not for acute or other short-lived conditions, such as flu or measles.

Locally, we have very little information on disease incidence and prevalence as there are no Island-wide disease registers. The best data we have is on cancer incidence in the Island. Local cancer data has been collated and sent to the South West Cancer Intelligence Service for a number of years to be analysed and audited in the same way as UK Cancer Registry data.

Cancer Incidence

The latest cancer incidence report[44] (based on 1999-2011 data) showed that around 800 new cancer tumours were diagnosed each year, around 60% being malignant tumours. If the non melanoma skin cancers (NMSC) are excluded, then there were 488 new cases of malignant cancer diagnosed annually. This gives Jersey an age standardised rate of around 571 per 100,000 population (2009-2011), similar to the rate for the South West region (557.3 per 100,000) and Guernsey & Alderney (558.7 per 100,000) in the same period but higher than the England average (543.6 per 100,000).

The latest report shows that the most commonly diagnosed cancers (excluding NMSC) were **breast, prostate, colorectal, lung** and **malignant melanoma** for 2007 to 2011 (Table 4.12). This is no different to other similar populations. These same cancers account for the highest number of

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[44] Channel Islands Cancer Report 2013, Public Health England Knowledge and Intelligence Team, published January 2014, available from www.gov.je

new diagnosed cases in Guernsey, England and the South West region. In the EU region, the most commonly diagnosed cancers reported were prostate, colorectal, breast and lung cancer.

While breast cancer and prostate cancer account for the largest number of new cases diagnosed each year, deaths from these cancers (on average 20 and 14 annual deaths, respectively, 2010-2012) are much lower than for lung (55 deaths annually 2010-2012) or colorectal cancers (17 deaths annually 2010-2012).

Table 4.12: Five year Cancer incidence in Jersey- excluding NMSC (latest data 2007-2011)

Cancer site	Jersey			Guernsey	South West	England
	ASR*	Average annual number of new cases	Compared with SW	ASR*	ASR*	ASR* (2006-2010)
All malignant cancers (excluding NMSC)	570.7	488	-	558.7	557.3	543.6
Breast (F only)	180.8	77	-	153.0	185.5	176.2
Prostate (M only)	175.9	71	-	134.3	160.7	148.1
Colorectal	65.0	56	-	66.2	68.8	65.6
Lung	62.7	54	Higher	59.9	54.6	65.9
Malignant melanoma	47.9	39	Higher	50.9	30.4	22.4
Head & neck	36.2	28	Higher	31.4	21.5	22.4
Upper GI	34.4	31	-	41.5	35.8	38.7
Lymphoma	26.2	20	-	28.5	26.1	24.1
Paediatric (0-19 only)	23.5	5	-	22.8	15.9	15.0
Uterus (F only)	20.7	9	Lower	25.6	29.0	27.5
Bladder	17.9	16	-	31.2	15.4	16.3
Leukaemia	17.7	14	-	18.2	13.8	13.0
Ovary (F only)	17.4	8	Lower	18.2	24.4	23.4
Other F gynaecological	16.8	7	-	21.3	20.1	17.6
M urogenital (excl Prostate)	12.0	4	-	11.0	14.0	11.8
Kidney & Ureter	12.4	10	Lower	15.7	16.9	15.2
Hepatobiliary	9.8	8	-	9.3	8.9	9.0
Brain and CNS	7.5	5	-	9.8	9.5	8.8

*Age standardised rate – for population 20 years and over (except for the paediatric cancers) standardised to the 1976 European Standard Population
Source: Public Health England Knowledge and Intelligence Team (South West)

Jersey has significantly higher rates of skin cancers (both malignant melanoma and non-melanoma types), lung and head & neck cancers than in the South West or England. Smoking, excessive alcohol use and UV exposure are the major risk factors for these cancers[45]. Guernsey also has significantly higher rates of skin and head & neck cancers.

In contrast, Jersey has higher rates of breast and prostate cancer than Guernsey, while Guernsey has significantly higher rates of bladder cancer.

The rate of non-melanoma skin cancers in Jersey and Guernsey is higher than the *recorded* rate in the South West or England. However, care must be taken as not all parts of England record non-melanoma cancers comprehensively. The data registration in the Channel Islands and the South West is comparable, so we can be confident that the ASR is genuinely higher than in the South West. The ASR in Jersey is 362 per 100,000 and the rate in the South West is 249 per 100,000. Around 318 new cases are diagnosed each year. The major risk factor is UV exposure through sunlight or sunbeds.

> **Note** High incidence is not necessarily a bad thing. It can indicate that more cancers are being diagnosed or that data collection is better. If high incidence rates are linked with low death rates for a particular cancer it may mean that early detection has allowed successful treatment of the disease.

The 2013 Channel Island Cancer Report[46] and The Cancer in Jersey Report[47] give a more in depth summary of cancer in Jersey and the main risk factors associated with the cancers where we have higher incidence rates. The main conclusion was that the cancers for which Jersey has significantly higher incidence rates are readily explained by exposure to the risk factors that cause most of them: smoking; hazardous alcohol consumption; UV exposure. In other words most of the cancers Jersey has a higher incidence of are preventable.

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[45] For more information on risk factors for these cancers, please see Cancer in Jersey Report, published July 2013, Public Health England Knowledge and Intelligence Team, available from www.gov.je
[46] Channel Islands Cancer Report 2013, Public Health England Knowledge and Intelligence Team, Published January 2014, available from www.gov.je
[47] The Cancer in Jersey Report 2013, Public Health England Knowledge and Intelligence Team, Published July 2013, available from www.gov.je

Disability Prevalence

The 2013 Jersey Annual Social Survey (JASS) indicated that around 10% of the Jersey population had a long-lasting condition or difficulty that significantly affected their ability to carry out normal day-to-day activities (including any condition related to old age)[48].

Table 4.13 gives the approximate prevalence of a range of conditions or difficulties experienced by Islanders.

Table 4.13: Proportion of adults with each condition at a level that has a significant adverse effect on being able to carry out day-to-day activities

	Percent
Blindness or a serious visual impairment	*1%*
Deafness or a serious hearing impairment	*3%*
Physical impairment (e.g. wheelchair user and/or difficult using arms or hands)	*4%*
Learning disability (e.g. autism, Down's syndrome)	*1%*
Mental health condition (e.g. depression, schizophrenia or severe phobia)	*3%*
None of the above conditions	*90%*

Source: JASS 2013

Long-standing illness, disability or infirmity

A recent survey[49] found that one in four Islanders (26%) reported having a long-standing illness, disability or infirmity (LSI) that had lasted, or was expected to last, at least 12 months. This compares with around one in three (30%) Guernsey residents. It should be noted that as JASS is a postal self-completion questionnaire it is likely to under-estimate disabilities and infirmities that might affect a person's ability to complete the form, particularly in single person households where there may not be other household members to assist.

The reported levels of long standing illness or health problems in Jersey are lower than the reported levels in 2010[50] for the EU as a whole (30%), Portugal (30%), UK (35%), France (37%) or Poland (33%) and slightly higher than Luxembourg (22%).

[48] It should be noted that as JASS is a postal self-completion questionnaire it is likely to under-estimate disabilities that might affect a person's ability to complete the form, particularly in single person households where there may not be other household members to assist.
[49] JASS 2013
[50] OECD (2012),'*Self Reported Health & Disability' in Health at a Glance: Europe 2012*, OECD publications.

As might be expected a higher prevalence of LSI was found in the older ages groups .The prevalence of LSI in Jersey ranged from around one in eight of those aged 16-34 years up to half of those aged 65 years or over (Figure 4.12). It can also be seen that in all age groups over half of those with a long standing problem reported that it affects their ability to undertake normal daily activities (a little or a lot).

Figure 4.12: Long-standing illness, disability or infirmity and limit on day-to-day activities by age group
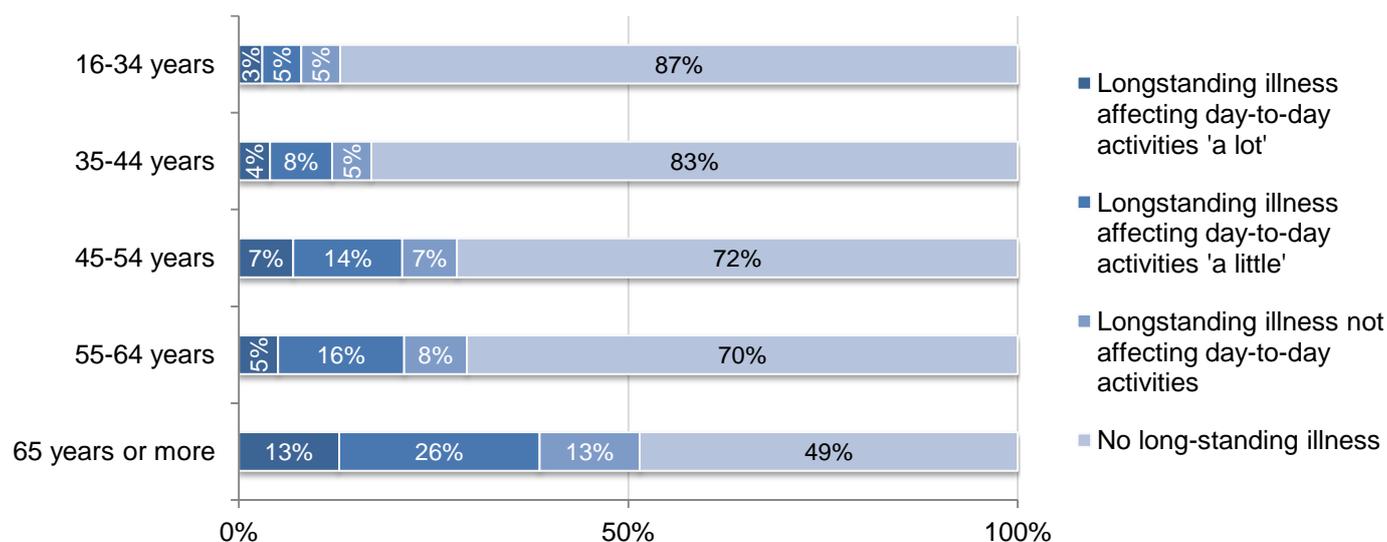
Source: JASS 2012

Three-quarters of those with a long-standing illness, disability or infirmity (75% in 2013) reported undergoing long-term medical treatment for the condition.

Future Disease Incidence and Disease Prevalence Data

With the introduction of a centralised GP computer system in 2014, it is expected that improved anonymised data on disease incidence and prevalence in Jersey will become available across a wide range of medical conditions.

5. MENTAL HEALTH

Population mental wellbeing

A set of questions known as the Short Warwick Edinburgh Mental Wellbeing scale (WEMWBS) were included in the Jersey Annual Social Survey[51] in 2012 and 2013. A person's score on the scale can range between 7 and 35, where a score of 35 represents the most mentally healthy a person can feel.

Overall, most adults in Jersey rate their mental health reasonably high.

The average (mean) score for adults in Jersey was found to be 26 out of 35, with no significant difference between males and females. In Guernsey, a more detailed version of WEMWBS was included in their 2008 Health Lifestyle Survey; the score was 51 out of 70. Classifying both datasets into low, medium and high[52] wellbeing allows a comparison to be made. Guernsey found 16% had low wellbeing, 67% had moderate wellbeing whilst 17% reported high wellbeing in 2008. This compares to 21% low wellbeing, 71% moderate wellbeing and 8% high wellbeing in 2012 in Jersey.

26

Jersey 2012 & 2013 average WEMWBS score

The Jersey mental wellbeing measure correlates with an individual's general satisfaction with life (Figure 5.1). Those who are most satisfied with life are more likely to report better mental wellbeing.

The surveys also showed that those respondents who rated their health as 'excellent' had a higher mental wellbeing score, on average 28 compared with an average score of 22 for those who reported their overall health as 'poor' (Figure 5.2).

The same average (mean) score of 26 was found for the population in 2013, indicating no change in overall population mental health.

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[51] For further information see Jersey Annual Social Survey 2012 and 2013, States of Jersey Statistics Unit, published December 2012 and November 2013, available from www.gov.je/statistics
[52] Low wellbeing score between 7 and 22, Moderate 23-32 and High wellbeing 33-35

5. Mental Health

Figure 5.1: WEMWBS average score by life satisfaction
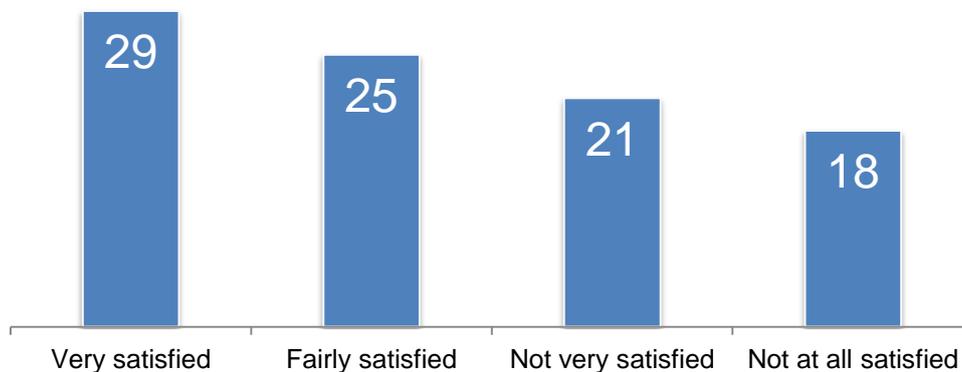
Figure 5.2: WEMWBS average score by health rating
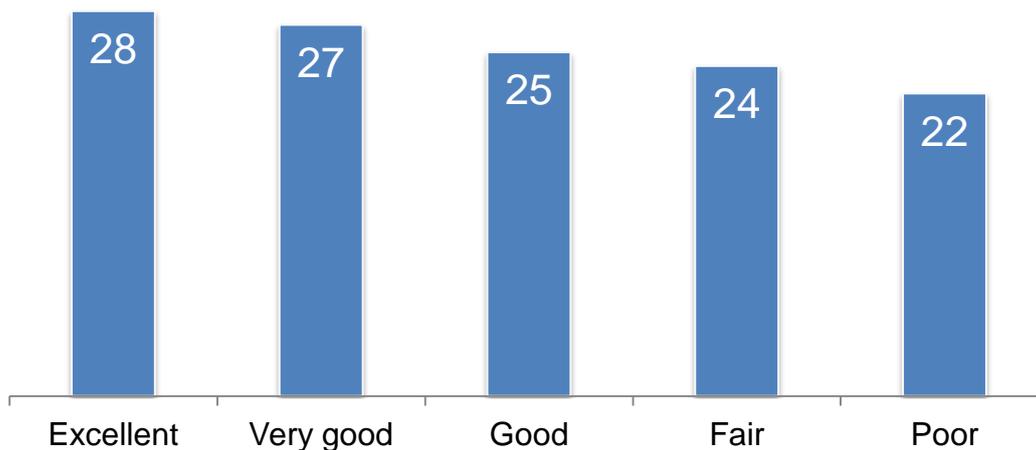
Anxiety and Depression

The levels of anxiety and depression amongst the adult population (aged 16+) on the Island are estimated through questions asked in the Jersey Annual Social Survey (JASS). The EuroQol tool (EQ 5D) is used to measure five aspects of an individuals' quality of life which includes anxiety and depression. Respondents report none, moderate or extreme levels of anxiety and depression.

In 2012, a fifth (20%) of respondents reported feeling moderate anxiety and depression whilst an additional 2% reported extreme anxiety and depression (Figure 5.3). Guernsey estimates of 21% for levels of anxiety and depression in their population are in line with this.

Figure 5.3: Anxiety/Depression rating from JASS 2012, by gender
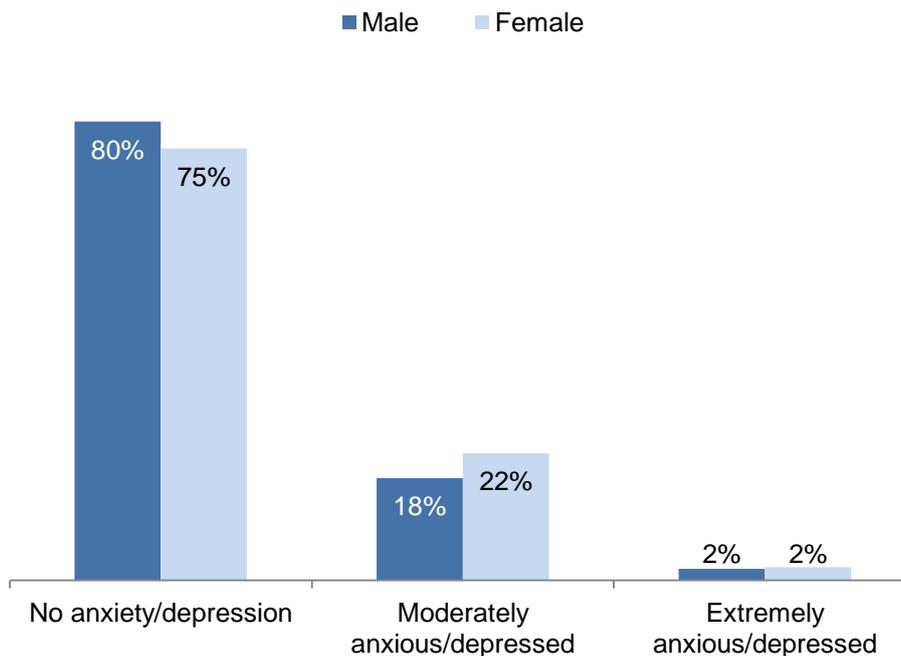
Source: JASS 2012

Small differences were seen in the levels of anxiety and depression by gender; however these differences are not statistically significant.

There was no change in the proportions reporting feeling moderate or extreme anxiety or depression in 2013.

Life Satisfaction

In 2013 the States of Jersey Statistics Unit produced the first Better Life Index[53]. This included a life satisfaction score related to self assessed health based on 2012 data (Figure 5.4).

When asked to rate their general life satisfaction on a scale of 0 to 10, respondents to the 2012 Jersey Annual Social Survey gave an average (mean) score of 7.5. Life satisfaction as measured by a method known as the Cantril ladder appears to be linked to health status. In 2012, individuals who reported their health as either very good or excellent also rated their lives highly on a scale of 0 to 10, recording mean scores above 7.5. In contrast, individuals who reported being in poor health recorded a mean life satisfaction score of less than 5.

Overall life satisfaction, on average, was found to be higher in Jersey (7.5) than in most OECD countries, including the UK (6.9), and was similar to that in Switzerland, the Netherlands and Austria.

7.5

Average life satisfaction score

Figure 5.4: Life satisfaction score by self-assessed health rating
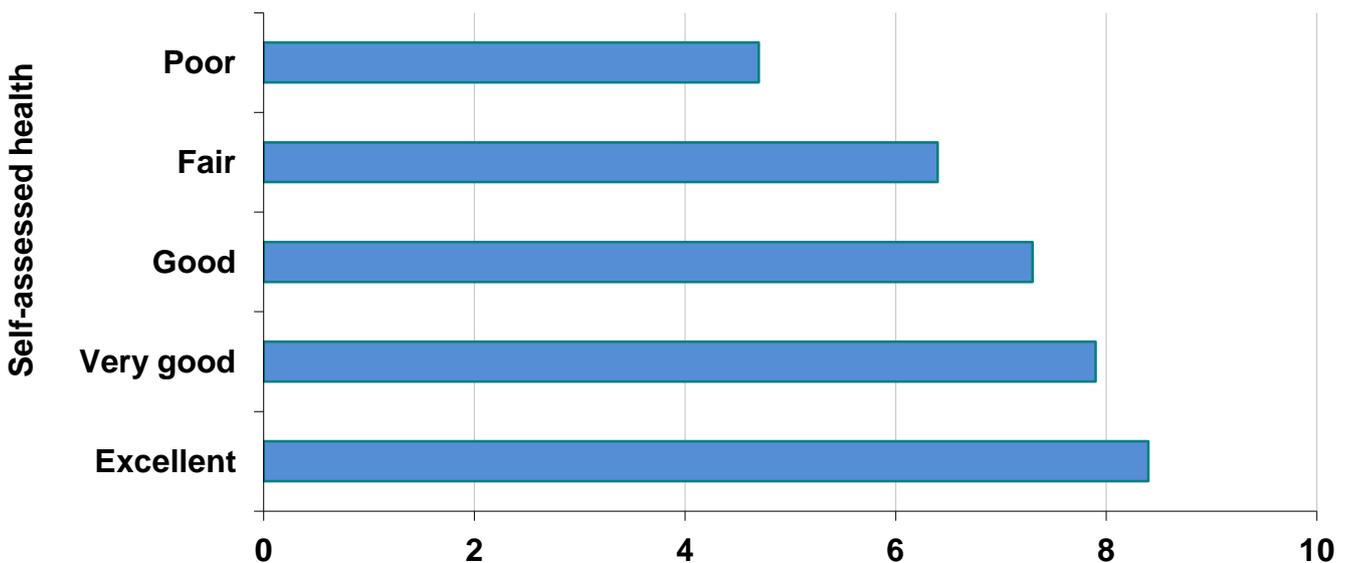
Source: JASS 2012

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[53] For more information see Jerseys Better Life Index Report 2013, States of Jersey Statistics Unit, published March 2013, available from www.gov.je/statistics

Suicide and intentional self-harm

Local data shows that although suicide rates in Jersey have decreased recently, they remain high for men - see the Burden of Disease chapter; section on suicide.

In 2012, there were around 150 discharges from hospital admissions coded as self-harm. This was made up of 130 individuals - 54% female and 46% male. The Emergency Department (ED) recorded around 50 admissions for 'deliberate self-harm'[54] in 2012.

There were more women than men in the numbers for both hospital admissions and ED presentations. Younger women (18 years and under) and older women (55 years and over) made up the highest proportion of admissions, whilst male admissions peaked in the 25-39 age group.

Figure 5.5: Self-harm episodes 2012
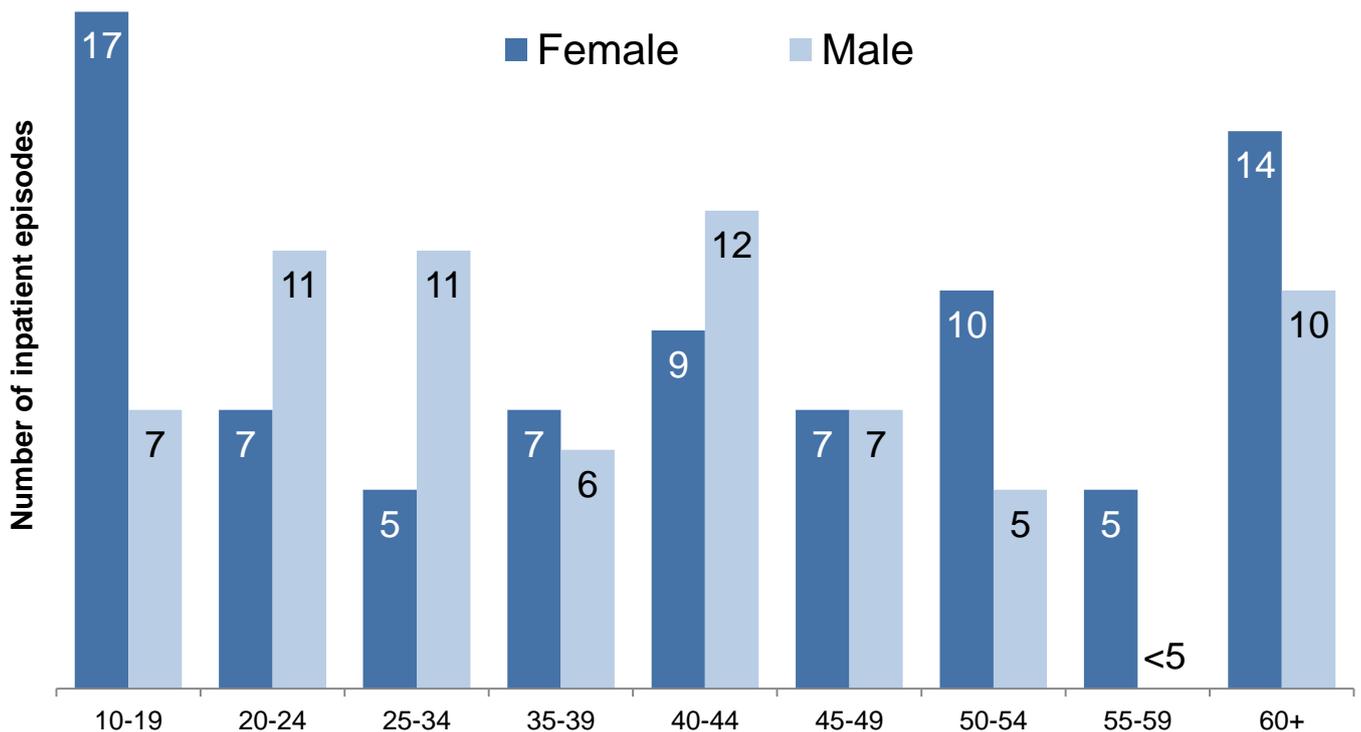
Source: TRAK care system

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[54] Emergency Department Data is coded by front-line staff and is not standardised therefore caution should be taken when interpreting data on emergency admissions.

6. SEXUAL HEALTH

Teenage conceptions (under 16)

There are substantial variations in teenage conceptions and terminations by area in the UK. In populations, such as the UK, with equal access to free contraceptive services, these variations have been shown to be very closely associated with the level of deprivation of an area – the conception rate is higher in deprived areas and the proportion that ends in termination is lower in deprived areas.

> Under 16 Teenage Conception Rate: This is defined as the number of conceptions (live births, stillbirths and terminations) to under 16 year olds per 1000 females aged 13-15.

There were fewer than ten under 16 conceptions in Jersey during the three year period 2010-2012; an average of 3 per year. This gives a rate of 1.7 per 1,000 for 2010-2012, which is lower than that seen in Guernsey and Alderney for the same period (4.3 per 1,000) and three times lower than the English average (Table 6.1). In Jersey, 88% of these conceptions ended in a termination.

Table 6.1: Under 16 Teenage Conceptions 2010-2012

	Conception rate per 1,000	% leading to termination
England	6.1	61%
London	5.5	69%
South West	5.3	63%
Guernsey	4.3	62%
Jersey	1.7	88%

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, ONS Conceptions in England and Wales 2012 Report

Teenage conceptions (under 18)

> Under 18 Teenage Conception Rate: This is defined as the number of conceptions (live births, stillbirths and terminations) under 18 per 1000 females aged 15-17.

The rate of under 18 (teenage) conceptions in Jersey over the period 2010-2012 was 11.4 per 1,000 population of 15 to 17 years olds (based on 54 conceptions) which is significantly lower than the England average (Table 6.2) and significantly lower than the equivalent rate for Guernsey (27.8 per 1,000). The highest rate in England was observed in the North East (39.2 per 1,000) whilst the lowest was seen in the East (26.3 per 1,000).

More than two-thirds (70%) of under 18 conceptions between 2010 and 2012 ended in a termination. This compares to less than half (40%) of teenage conceptions in Guernsey over the same period.

Table 6.2: Under 18 Teenage Conceptions 2010-2012

	Conception rate per 1,000	% leading to termination
England	30.9	52%
London	29.1	65%
Guernsey	27.8	40%
South West	27.4	51%
Jersey	11.4	70%

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, ONS Conceptions in England and Wales 2012 Report

There has been a considerable drop in the rate of teenage conceptions over the last decade, from a high of 25 per 1,000 in 2000-2002 to 11 per 1,000 in the latest period (Figure 6.1). A decrease in the rate has also been witnessed in England and Wales and in Guernsey, over the last 5 years (2008 to 2012)[55].

54% fall in the rate of under-18 conceptions in Jersey over the last decade

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[55] Office for National Statistics, Conceptions in England and Wales, 2012, available from www.ons.gov.uk

Figure 6.1: Under 18 Teenage Conceptions in Jersey, three year averages
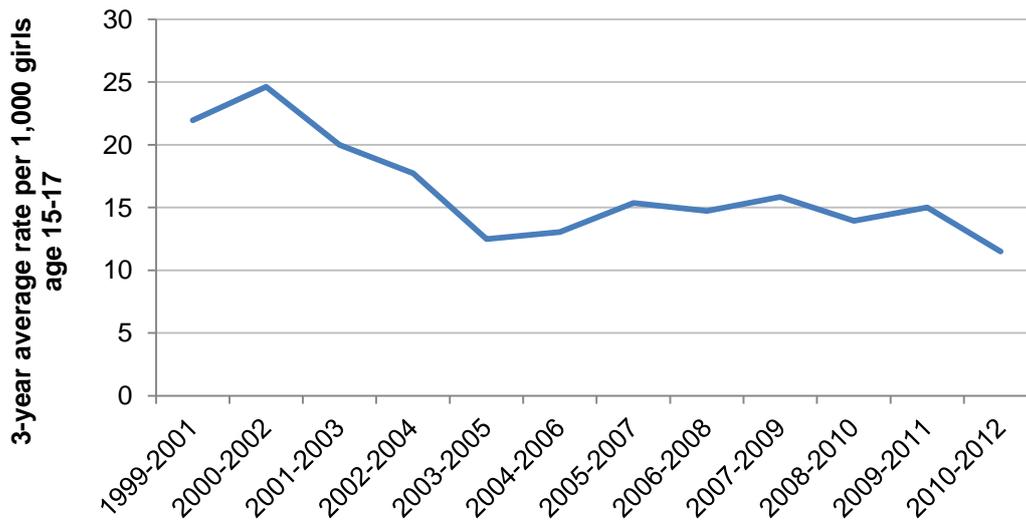
We do not have an age breakdown of the small number of terminations carried out in the UK in 2012 for Jersey residents (less than 10 in the last three years) so the true overall rate may be slightly higher.

Terminations of Pregnancy

> The termination rate is calculated as the number of all terminations per 1,000 females aged 15-44 years of age.

Between 2010 and 2012 there were 619 terminations in Jersey, an average of 206 per year. The rate of termination was 10.3 per 1,000 in Jersey, similar to the Guernsey rate of 10.0 per 1,000. Both Islands have rates that are significantly lower than the England rate for 2012 (16.6 per 1,000).

Over the last decade, the trend in Jersey has declined from 15 per 1,000 females aged 15 to 44 in 2000-2002 to 10 per 1,000 in 2010-2012. This picture is similar to that seen in Guernsey.

Table 6.3: Termination rate (all terminations per 1,000 females aged 15-44) Jersey and Guernsey 2010-2012, England and regions 2012

	Abortion rate per 1,000	95% Confidence Interval LL	95% Confidence Interval UL
London	22.4	22.3	22.5
England	16.6	16.6	16.7
South West	13.1	-	-
Jersey	10.3	9.5	11.2
Guernsey	10.0	9.0	11.0

- Confidence intervals not available

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, Department of Health Abortion Statistics England and Wales 2012

The number of terminations to mothers under 18 years of age in Jersey is low. Jersey has a rate of 8 per 1,000 which is significantly lower than the England average of around 13 per 1,000 and lower than all the English regions.

Table 6.4: Under-18 Termination rate (all terminations per 1,000 females aged 15-17) Jersey 2010-2012, England and regions 2012

	Abortion rate per 1,000	95% Confidence Interval LL	95% Confidence Interval UL
London	14.8	-	-
England	12.8	-	-
South West	11.2	-	-
Jersey	8.0	5.8	10.9

- Confidence intervals not available

Source: Jersey Health Intelligence Unit, Department of Health Abortion Statistics England and Wales 2012

Sexually transmitted infections (STIs)

In 2012, around 1,300 tests were done as part of the Chlamydia Screening Programme, at Brook Channel Islands, the Family Planning Clinic at Le Bas and at the Genitourinary Medicine (GUM) clinic. The majority, (92%) of tests were for females. In total, around 5,400 Chlamydia tests were processed by the Pathology Laboratory System in 2012. In the UK[56], around 26% of the population aged 15-24 years was screened in 2012; comparative data for Jersey shows that 21% of the local population aged 15-24 years were tested during the same period.

The Genitourinary Medicine (GUM) clinic has seen activity increase over the last few years (Figure 6.2 and Figure 6.3), with total numbers seen in 2013 being 59% higher than those seen in 2009.

Figure 6.2: Activity at GUM clinic, annual numbers seen
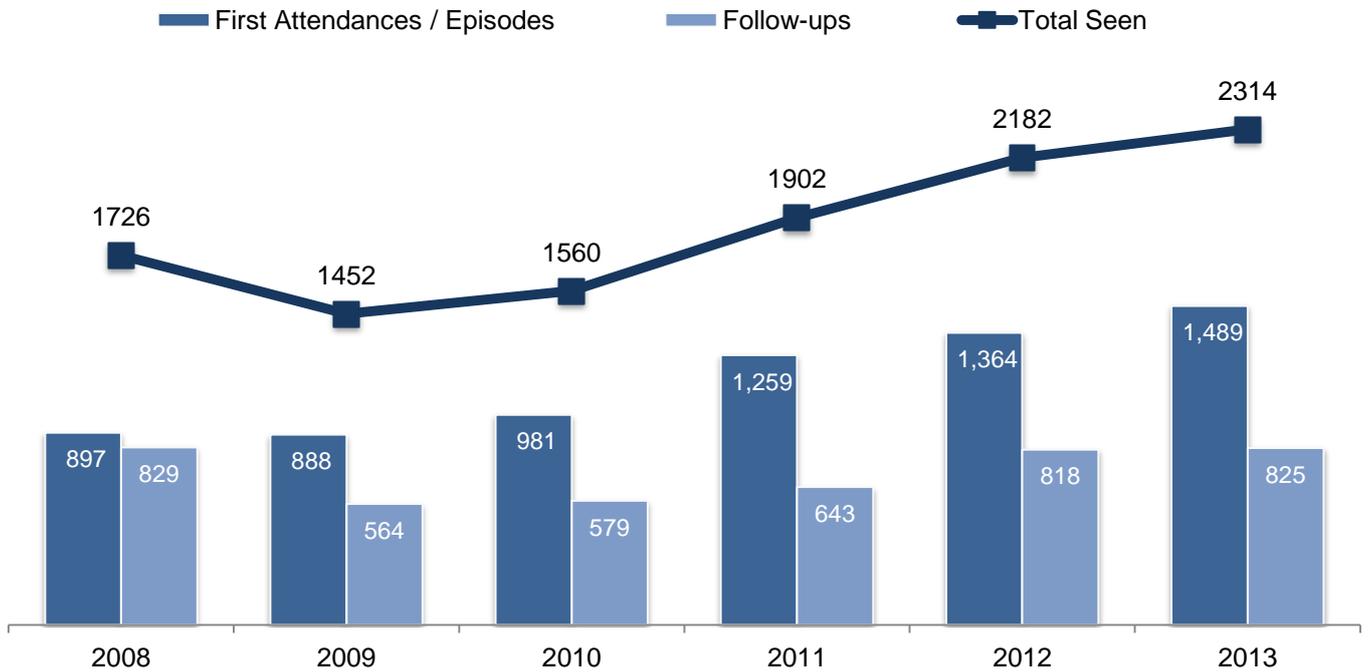
Source: GUM Clinic KC60 forms

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[56] Public Health England, Sexual and Reproductive Health Profiles, 2012 data, available from www.phe.org.uk

Figure 6.3: Activity at GUM clinic, annual numbers telephone calls and emails
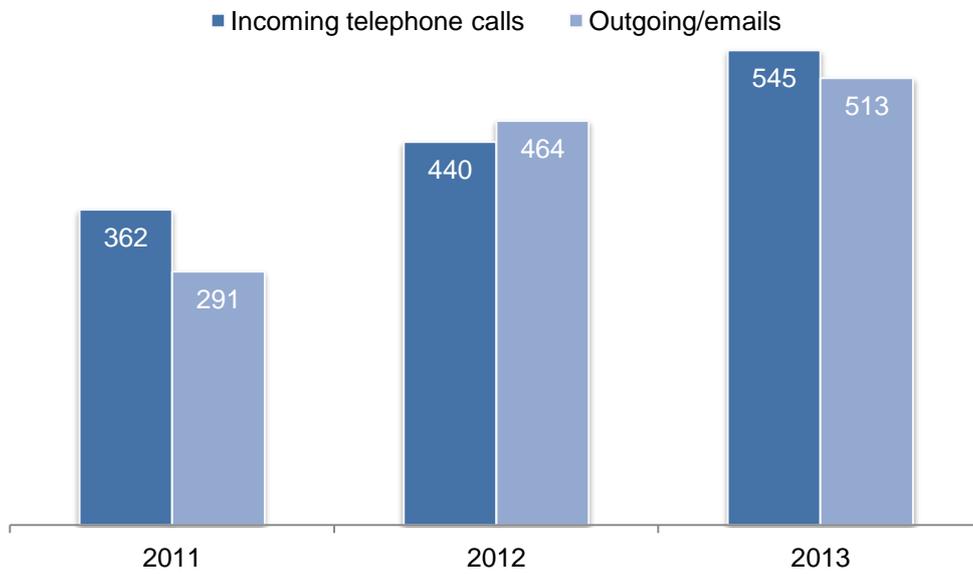
Source: GUM Clinic KC60 forms

It is hoped that improved data on Island-wide STIs will become available from the Jersey Pathology Laboratory system. In future, more robust rates and trends will be identified to allow comparisons with Public Health England's Sexual and Reproductive Health Profiles.

7. DISEASE PREVENTION AND EARLY DETECTION

Childhood Immunisation Coverage

The UK schedule of routine childhood immunisations is followed in Jersey. This includes the DTaP/IPV/Hib or "5-in-1" vaccine (protecting against diphtheria, tetanus, whooping cough, polio and Haemophilus influenza type b), PCV (pneumoccal conjugate vaccine), MenC (meningitis C), MMR (measles, mumps and rubella) and for girls, HPV (Human Papilloma Virus).

Jersey has a high coverage of childhood immunisations (Table 7.1). Our coverage is consistently higher than the average reported for England and, for immunisation given at 2, 3, 4 and 12 months of age, coverage is above the World Health Organization target of 95%. Guernsey coverage is also high but is an estimate and is not directly comparable.

Table 7.1: Coverage of Childhood Vaccination in Jersey and Guernsey compared with England

	Jersey		Guernsey*		England	
	2011	2012	2011	2012	2011/12	2012/13
Infant Immunisations at 2, 3 and 4 months						
DTaP / IPV / Hib (by 12 months of age)	98.4%	98.8%	96%	99%	94.7%	94.7%
MenC (by 12 months of age)	97.5%	98.0%	96%	99%	93.9%	93.9%
Pneumococcal (by 12 months of age)	97.4%	98.2%	96%	98%	94.2%	94.4%
Immunisations at 12 months						
MMR (by 2 years of age)	93.1%	95.4%	93%	95%	91.2%	92.3%
Hib/MenC booster (by 2 years of age)	95.6%	96.8%	97%	98%	92.3%	92.7%
Pneumococcal booster (by 2 years)	94.4%	96.2%	N/A	N/A	91.5%	92.5%
Pre-school boosters at 3 years 4 months						
DTaP / IPV booster (by 5 years of age)	92.3%	92.5%	N/A	N/A	87.4%	88.9%
2nd dose MMR (by 5 years of age)	89.3%	90.9%	N/A	N/A	86.0%	87.7%

*Estimates for Guernsey

Source: Jersey Child Health System; HSCIC NHS Immunisation Statistics 2012-2013 (September 2013), Guernsey Primary Care Company Ltd

HPV vaccination

Since September 2008, 12-13 year old girls have been offered immunisation against Human Papilloma Virus (HPV) to protect them from cervical cancer in the future. Uptake of the complete course of HPV immunisations is consistently higher in Jersey than that achieved in England, Wales or Northern Ireland.

Table 7.2: HPV uptake for 12-13 year old females

	2009	2010	2011	2012*
Jersey	84.0%	88.4%	89.8%	92.5%
Scotland	90.9%	90.1%	91.4%	82.0%
Wales	77.3%	85.5%	89.7%	82.0%
England	76.4%	84.2%	86.8%	86.1%
Northern Ireland	83.4%	84.6%	88.1%	-

* 2012 coverage for Scotland, Wales and England likely to increase as figures shown are provisional
Source: Jersey Health Intelligence Unit, Department of Health Annual HPV vaccine coverage report www.gov.uk, Public Health Agency Northern Ireland Vaccine Coverage www.publichealth.hscni.net, Public Health Wales National Immunisation Data, www.wales.nhs.uk, ISD Scotland Childhood Immunisation statistics www.isdscotland.org

Seasonal Influenza Vaccine Uptake

> Seasonal influenza vaccinations are offered by Jersey GP practices to those aged 65 and over and all patients who are deemed to be 'clinically at risk' due to an underlying medical condition.

Data on seasonal flu vaccination uptake is not yet available from Jersey GP surgeries. It is hoped that the implementation of a centralised GP computer system in Jersey will allow this information to be available in the future on an anonymised basis.

The World Health Organization target for seasonal flu vaccinations in the over 65 age group is 75%. For England, coverage was reported as 74.0% for 2011/2012 and 73.4% for 2012/2013[57]. In Guernsey, the uptake for this age group was 58% over the winter of 2011/2012.

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[57] HSCIC (2013), *NHS Immunisation Statistics 2012-2013*, published September 2013, available from hscic.gov.uk

Screening

Jersey has three population cancer screening programmes. As there is no comparative data for Guernsey, this section summarises what is known of population coverage and uptake in Jersey. An annual screening report will be produced in 2014 by the Public Health Directorate.

> **Screening coverage:** the number of individuals in the eligible age group who attended screening in the relevant screening period as a proportion of all individuals in the eligible age group in Jersey
>
> **Screening uptake:** the number of individuals who attended screening in any one year as a proportion of those invited

Breast Screening

The Jersey Breast Screening Service has been operating since 1990. It offers digital mammography screening on a call-recall basis every two years to women aged 50 and 69. The intention is to detect breast cancer at an early stage when there is a better chance of successful treatment.

Jersey has historically been unable to identify names and addresses of all women as they reach 50 years of age and the service has been reliant on women proactively registering themselves onto the programme to obtain a first appointment.

Jersey coverage is estimated to be 73% of women aged 50 to 69; this is above the NHS Cancer Screening Programmes minimum standard of 70% but below the target of 80%. Of those women who have joined the programme and are subsequently invited for regular screening, over 90% attend a breast screening appointment.

Cervical Screening

In 2012, the screening age range and interval for cervical screening were updated in line with evidence based recommendations from the UK National Screening Committee. Women in Jersey aged between 25 and 49 are recommended to have regular cervical screening (known by many women as a smear test) every three years whilst women aged 50-64 are recommended to have screening every five years (provided they have a previously uncomplicated screening history).

Coverage for the period 2009-2011 is 66% of eligible women.

Colorectal Screening

In early 2013, a colorectal (bowel) screening programme was introduced in Jersey for men and women during their 60th year. The aim is to identify and remove lower bowel benign polyps which have the potential to develop into bowel cancer; once removed this risk no longer exists.

The target age was chosen based on research evidence showing that this is when most benign polyps have developed and so when most cancers can be prevented.

Annual coverage data will be collated and reported on once the programme statistics for the first full year are available.

8. LIFESTYLE

Smoking

> Smoking prevalence in Jersey is estimated from the Jersey Annual Social Survey (JASS).
>
> It is calculated as the percentage of all adults aged over 16 in our population.

The proportion of adults (16+) smoking daily was found to be around one in six (16%) in 2012 and 2013 (Table 8.1). No significant change in the proportion of adults smoking daily has occurred since 2007. Around half of the population of Jersey have never smoked. Similar proportions were found in Guernsey in their 2008 Guernsey Healthy Lifestyle Survey. The proportion of the adult population smoking daily varies greatly across countries, ranging from over 30% in Greece to 14% in Sweden in 2010, giving an EU average of 23% in 2010[58] and an OECD average of 21% in 2011[59].

In Jersey similar proportions of male and females smoke daily (17% and 15%, respectively), as in the UK and Nordic Counties. Smoking prevalence in men is higher in all other EU member states.

Table 8.1: Smoking habits in Jersey

	2005	2007	2008	2010	2012	2013
I have never smoked / I don't smoke	45%	48%	48%	47%	46%	44%
I used to smoke occasionally but don't now	12%	15%	15%	13%	15%	15%
I used to smoke daily but don't now	17%	17%	16%	17%	17%	18%
I smoke occasionally but not everyday	6%	6%	5%	8%	6%	6%
I smoke daily	19%	14%	16%	15%	16%	16%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: JASS 2013

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[58] OECD, (2013) 'Smoking among adults' in Health at a Glance 2013: OECD indicators, OECD publications.
[59] OECD, (2012) 'Smoking among adults' in Health at a Glance: Europe 2012, OECD publications.

An Island-wide smoking ban in enclosed public places and work places was introduced in Jersey in January 2007. The number of cigarettes smoked each day by daily smokers has decreased since 2005. JASS 2012 found the self reported average number of cigarettes smoked a day was 15 for male daily smokers compared with 21 in 2005. A lesser reduction has been seen for female daily smokers from 15 a day to an average of 13 a day in 2012 (Figure 8.1).

One in six (16%) adults in Jersey smokes daily

Figure 8.1: Average number of cigarettes smoked
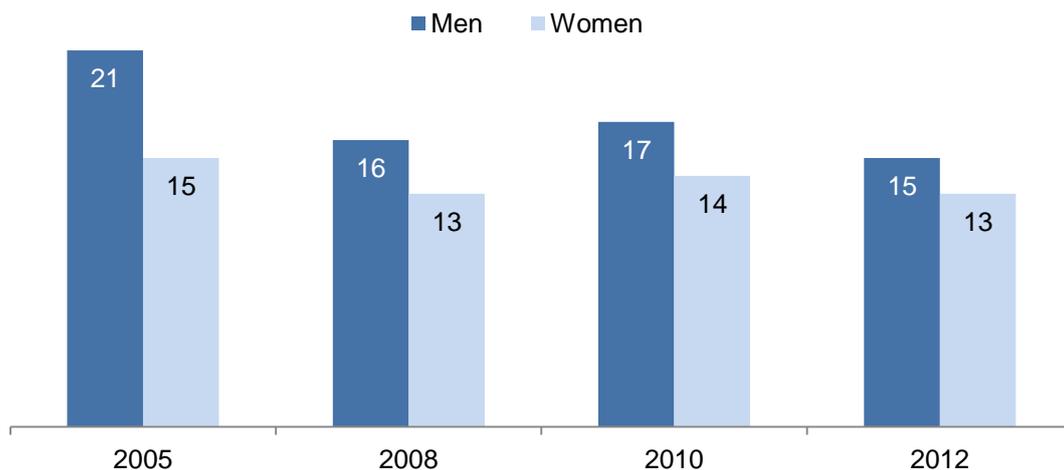
Source: JASS 2005 and JASS 2012

In Jersey, on average 130 deaths of adults aged 35 and over each year are estimated to be attributable to smoking, accounting for around one in six deaths (17%) of all deaths of adults aged 35 and over. It is known that smoking is a cause of much preventable illness and premature death. For more information, see the Smoking-related Deaths in the Burden of Disease chapter page 34.

For information on smoking in childhood, see the Health Related Behaviour Questionnaire 2010.

Passive Smoking risk

At their six week check, babies are assessed as either being at risk of second-hand smoke exposure or not. In 2012, 16% of babies were recorded as being at risk of passive smoking. That means 1 in 6 of all babies born in 2012 were living in a household where they were likely to be exposed to tobacco smoke.

Alcohol

> The Jersey Annual Social Survey is used to estimate the drinking behaviour of Islanders and to estimate the impact alcohol has on their lives. As JASS is self-reported, it is likely that local data is an underestimate of the true picture.

Alcohol has been identified as a causal factor in more than 60 medical conditions, including mouth, throat, stomach, liver, bowel and breast cancers; hypertensive disease (high blood pressure), cirrhosis of the liver, depression and obesity[60]. It is considered to be the third leading risk factor for disease and mortality after tobacco and high blood pressure[61].

The EU region has the highest alcohol consumption in the world with an average of 10.7 litres of pure alcohol per adult (2010), ranging from 13 litres to 7 litres per capita. In comparison, Jersey's per capita consumption, of 12.7 litres of pure alcohol per adult in 2012[62], is also high.

The current Department of Health's[63] guidance is that to avoid detrimental health effects **men should not regularly drink more than 4 units of alcohol a day** and **women should not regularly drink more than 3 units of alcohol a day**. Individuals who exceed the daily recommendations for their sex are considered to be drinking at 'increased risk' (drinking at harmful levels). Drinking alcohol regularly at these levels increases health risks dramatically.

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[60] HSCIC (2011), *Smoking, Drinking and Drug Use Among Young People – England 2010*, published July 2011, www.hscic.gov.uk
[61] OECD, (2012) 'Alcohol consumption among adults' in Health at a Glance: Europe 2012, OECD publications.
[62] States of Jersey Statistics Unit
[63] Department of Health (2013), *Reducing harmful drinking*, policy document published March 2013, www.dh.gov.uk

Men drinking in excess of 8 units per day and women drinking in excess of 6 units per day on drinking days are considered to be drinking at a level conferring a higher level of risk (drinking at hazardous levels).

Local data shows that Jersey has similar proportions of men and women drinking at levels of increasing risk compared to England (Table 8.2). The proportion drinking at higher risk is lower than England, but higher than Guernsey for both men and women.

This means there are likely to be around one in seven Islanders experiencing harm (such as accidents, alcoholic poisoning, hypertension or cirrhosis) as a result of their drinking habits.

Table 8.2: Proportion of population drinking alcohol at levels of increased and higher risk

	Jersey 2010	England 2010	Guernsey 2008
Men drinking at increasing risk	39%	36%	33%
Men drinking at higher risk	18%	19%	10%
Women drinking at increasing risk	32%	28%	21%
Women drinking at higher risk	10%	13%	4%

Source: JASS 2010, Guernsey Public Health and Strategy Directorate, ONS Drinking Habits amongst Adults 2012, published December 2013 www.ons.gov.uk

In 2012, one in seven (13%) people aged 16 and over in Jersey reported never drinking alcohol[64]. A higher proportion of females (17%) than males (10%) never drink. More than half (55%) of men drink alcohol at least twice a week compared with two-fifths (40%) of females (Figure 8.2).

JASS 2012 found that the prevalence of factors that could be indicators of harmful levels of drinking have not significantly changed since the questions were asked in 2010. Around 4% of people reported that a relative, friend, doctor or health-worker had been concerned over the last year about their drinking or had advised them to cut down. Around one in twelve (8%) adults reported having failed to do what was expected of them because of their drinking at least once over the previous year.

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[64] JASS 2012

Figure 8.2: Drinking frequency

	Never	Once a month or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
Male	10%	14%	22%	32%	23%
Female	17%	17%	26%	27%	13%
All	13%	15%	24%	30%	18%
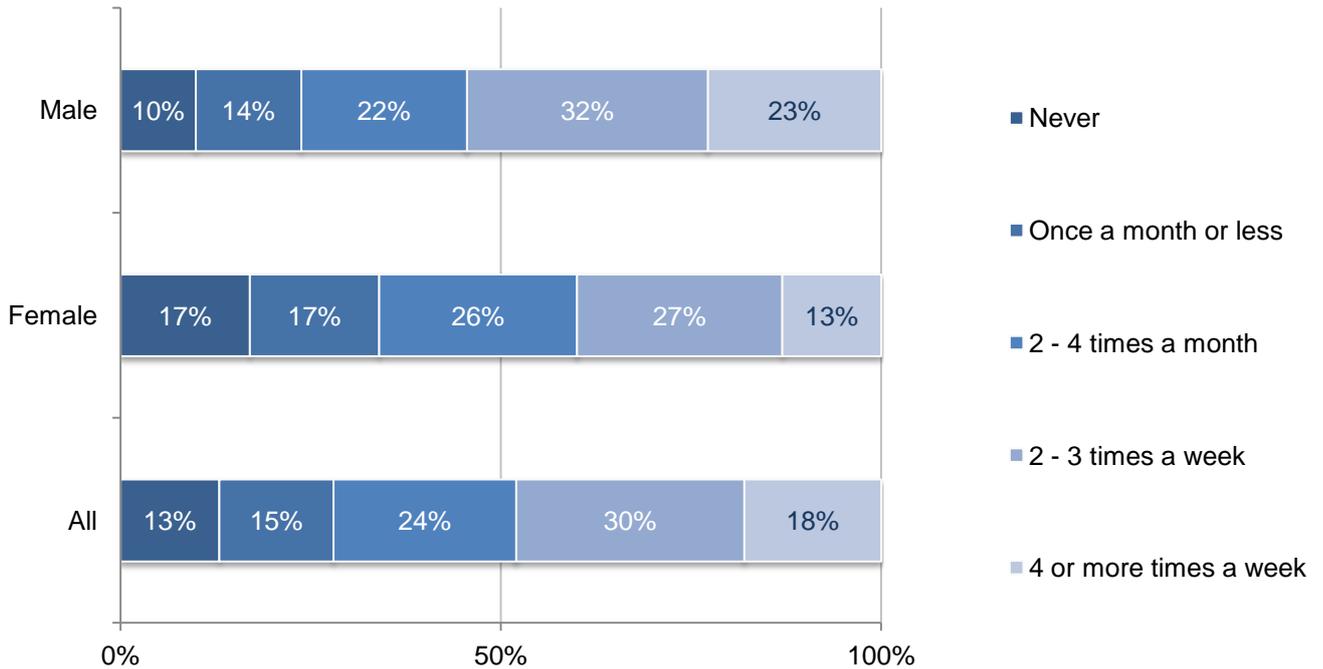
Source: JASS 2012

More detailed alcohol indicators for the Island can be found in the Alcohol Profile for Jersey[65] to be published in 2014. Information on the drinking habits of young people is available in the Health Related Behaviour Questionnaire report 2010[66], the next round of which is running throughout 2014 with results available end of 2014.

Healthy weight and obesity

The weight status of Islanders is currently estimated from the Jersey Annual Social Survey. Respondents to JASS 2013 were asked to state their weight and height from which **Body Mass Index (BMI)[1] is** calculated.

BMI scores are then categorized:

<18.5 = underweight, 18.5-24.9 = healthy weight, 25-29.9 = overweight, ≥ 30 = obese.

Obesity scores can be further divided into obese, very obese and morbidly obese.

Jersey data is **self-reported and will be an underestimate** of the true population level.

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[65] Health Intelligence Unit (2014) Jersey Alcohol Profile, to be published 2014, www.gov.je
[66] Health Intelligence Unit (2010), A Picture of Health Jersey 2010, Reflections on Health-Related Behaviour of young people aged 10-15 years, published 2010, www.gov.je

The increasing prevalence of obesity amongst adults and children in the developed world is recognised as a significant public health challenge. Being overweight or obese can increase the risk of developing a range of other health problems such as ischaemic heart disease (CHD), type 2 diabetes, some cancers, stroke and reduced life expectancy. The consequences of obesity are not limited to the direct impact on health. Overweight and obesity also have adverse social consequences through discrimination, social exclusion and loss of earnings, and adverse consequences on the wider economy through, for example, working days lost[67].

The latest available data (JASS 2013) shows that the overall distribution of Islander's BMI has not changed significantly since 2008. Currently around 16% of the adult population are likely to be obese with an additional 32% overweight. Guernsey data shows a similar proportion of adults overweight and a greater proportion obese than in Jersey in 2008.

Table 8.3: Distribution of BMI category by year

Classification	2013	2010	2008	Guernsey 2008
Underweight (< 18.5)	2%	2%	3%	1%
Normal weight (18.5 - 24.9)	51%	48%	53%	46%
Overweight (25.0 - 29.9)	32%	34%	32%	35%
Obese (30.0 – 34.9)	11%	11%	9%	12%
Very obese (35.0 – 39.9)	4%	4%	2%	4%
Morbidly obese (≥ 40)	1%	1%	1%	2%

Source: JASS 2013, Guernsey Public Health and Strategy Directorate, England Health Survey for England 2012

These data show that the proportion of our population that are obese or overweight is less than the latest reported data for England and similar to the EU average. The 2012 Health Survey for England[68] reported that around a quarter (~25%) of adults were obese and 42% of men and 32% of women were overweight. In the EU, data indicates that more than half (52%) of the adult population of the EU are overweight or obese with around 17% being obese in 2010[69].

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[67] Public Health England, National Obesity Observatory www.noo.org.uk
[68] HSCIC (2013), Health Survey for England 2012, published December 2013, available from www.hscic.gov.uk
[69] OECD (2012) 'Overweight & obesity among adults' in Health at a Glance: Europe 2012, OECD publications.

- Half (51%) of adults in Jersey have a normal weight BMI score

- One in three (32%) are overweight

- One in six (16%) are obese, very obese or morbidly obese

Around three-fifths (59%) of all women and around two-fifths (44%) of all men had a normal BMI (Figure 8.3). Similar proportions of men and women were obese, very obese or morbidly obese. A greater proportion of men were reported to be overweight than women.

The proportion of men and women with a BMI greater than 25 (overweight, obese, very obese or morbidly obese) was higher in those aged 35 years and over (Figure 8.4).

In Guernsey, the distribution of the BMI was found to be similar to that of Jersey, with more men in the overweight category and more women obese.

Figure 8.3: Percentage weight status by sex of respondents


Source: JASS 2013

72
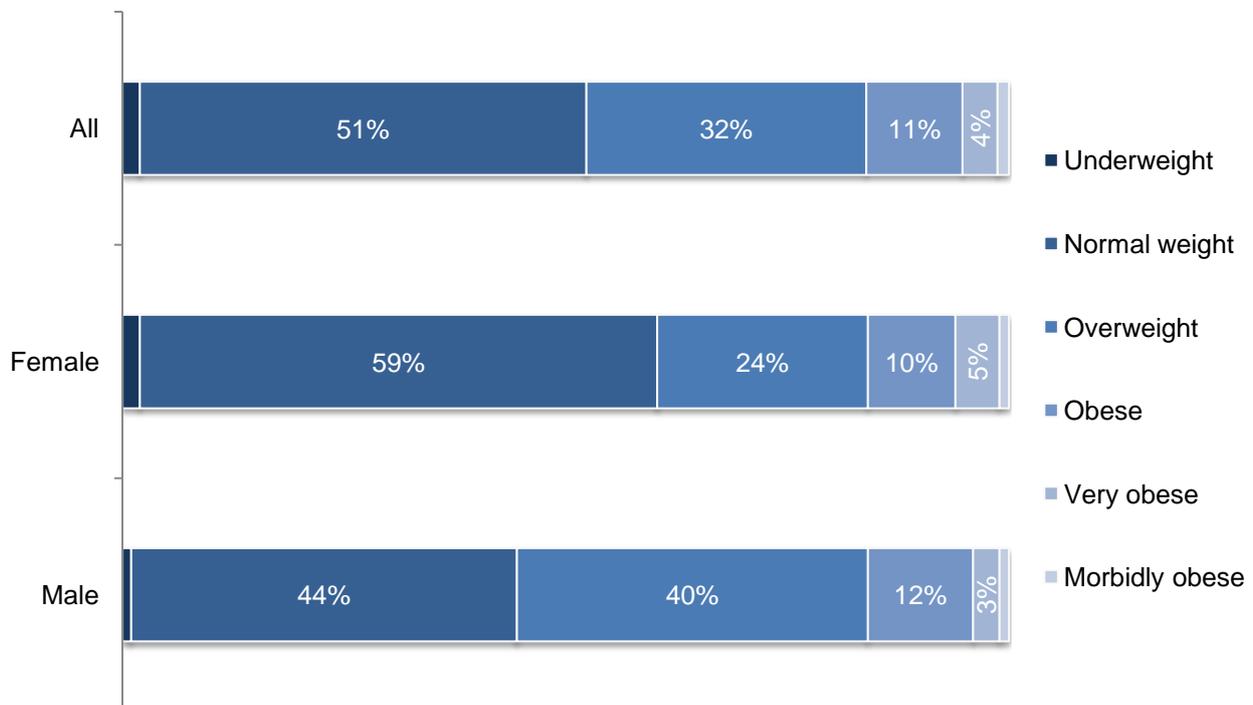
Figure 8.4: Overweight and obese persons by age and gender

Legend: ■ Male ■ Female

- 16-34 years: Male 40%, Female 25%
- 35-44 years: Male 55%, Female 46%
- 45-54 years: Male 67%, Female 43%
- 55-64 years: Male 63%, Female 47%
- 65 years or more: Male 65%, Female 51%
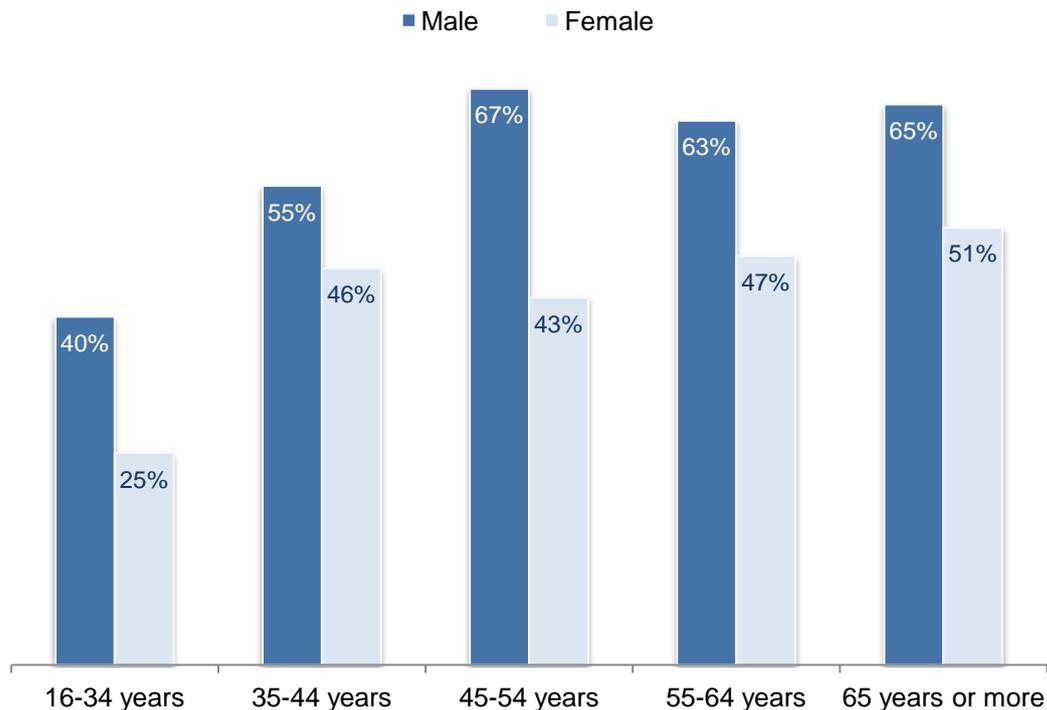
Source: JASS 2013

Healthy Eating

In the UK, public health experts have recommended that adults and children eat five or more portions of fruit and vegetables each day *(http://www.nhs.uk/livewell/5aday/pages/5adayhome.aspx)*.

The latest data shows that two-thirds (64%) of adults in Jersey eat less than this recommended daily amount of fruit and vegetables (JASS 2013). Similar proportions were observed in 2010 (66%); 2008 (65%) and 2007 (59%). However, we appear to be doing better than our neighbours.

Overall, 36% of all adults (16+) in Jersey reported eating the recommended 'five-a-day' (28% of men and 43% of women). This is higher than reported figures for Guernsey where 28% of women and 17% of men reported eating the recommended number of portions of fruit and vegetables. The Jersey figures are also higher than the latest available

⅓

of Jersey adults eat 5 or more portions of fruit & vegetables each day

73

figures for England and Scotland, but similar to Wales. In England, 24% of men and 29% of women were consuming at least 5 portions of fruit and vegetables a day[70], compared with 19% of men and 21% of women in Scotland[71] and 32% of the population in Wales[72].

Women continue to be more likely to be eating five or more portions of fruit and vegetables a day than men.

Information on the eating habits of young people is available in the 2010 Health Related Behaviour Questionnaire which will be updated in the 2014 Jersey Schools Health Survey Report.

Physical activity

An unhealthy diet and a sedentary lifestyle are known risk factors for the three leading causes of death in adults: cancer, stroke and cardiovascular disease.

The recommended level of physical activity for adults

5 sessions of 30 minutes a week

Moderate-intensity aerobic activity

AND muscle-strengthening activities on 2 or more days

Recommended by the UK Department of Health, www.dh.gov.uk

Half (51%) of adults in 2013 reported being active enough to meet the recommendation of five or more half hour sessions of moderate physical activity within a normal week. This compares to 29% of adults in Wales in 2011 and around a quarter (26%) of adults in Guernsey in 2008.

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[70] HSCIC (2013),*Statistics on obesity, Physical Activity and Diet England 2013*, published February 2013 www.hscic.gov.uk
[71] Scottish Government (2013), *Scottish Health Survey 2012: Volume 1*, published September 2013, www.scotland.gov.uk
[72] Welsh Government (2013), *Welsh Health Survey 2012*, published September 2013, www.wales.gov.uk

Figure 8.5: Frequency of weekly moderate intensity sport of physical activity for 30 minutes or longer
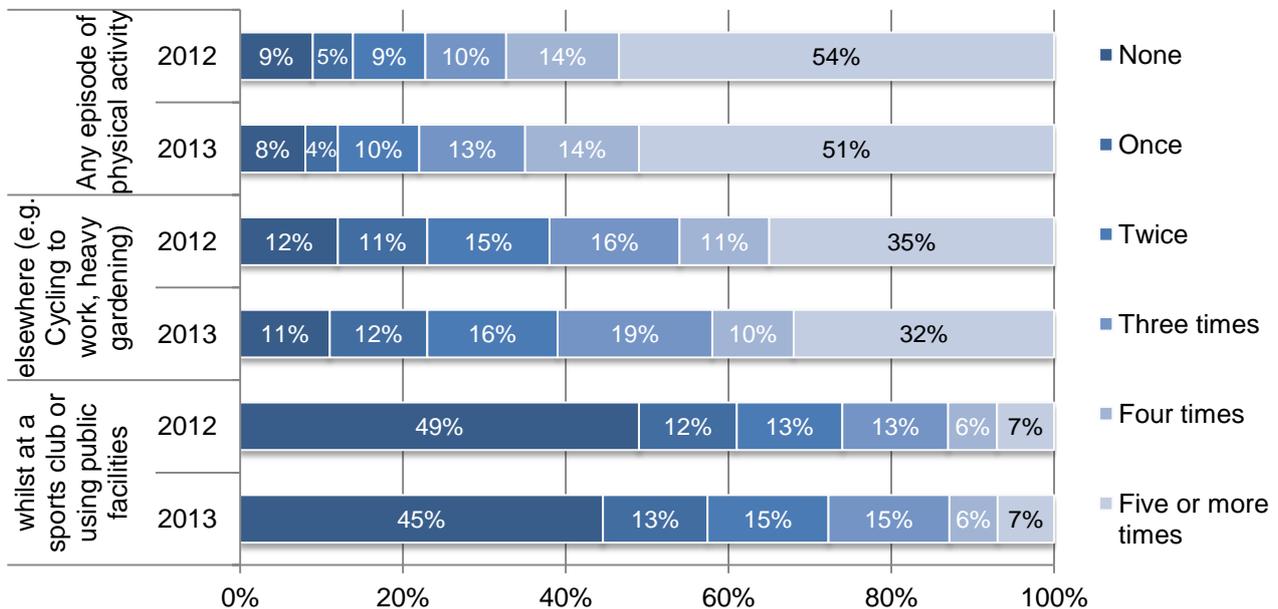
Source: JASS 2012 and JASS 2013

Fewer than one in ten (9% in 2012 and 8% in 2013) of our population aged 16 and over reported undertaking no physical activity at all - 9% of men and 7% of women in Jersey. This compares favourably with the latest reported figures in England where 26% of women and 19% of men who reported being inactive[73].

Sun Safety

As shown in the Burden of Disease chapter, Jersey has high levels of skin cancer, for which sun exposure is the well established risk factor.

Fewer than one in ten (8%) of adults in Jersey reported that they 'never' take precautions to protect their skin from sun damage; whilst over two-fifths (43%) 'always' do so. A higher proportion of men (13%) 'never' took precautions compared to just 4% of women[74].

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[73] HSCIC (2014), *Statistics on Obesity, Physical Activity and Diet, England 2014*, published February 2014 www.hscic.gov.uk
[74] JASS 2012

One in six (16%) men working in routine professions reported 'never' taking precautions against sun damage, this compares to less than one in ten men working in professional or managerial occupations. For women, there was little difference in the proportions taking precautions when occupation was considered[75].

One in three (33%) of adults reported that hearing the UV Index 'always' prompted them to protect their skin, whilst another 52% said that it was 'sometimes' a prompt for them. A sixth (15%) said that hearing the UV Index did not prompt them to take precautions, with men being less likely to be prompted by the UV Index than women (25% of men 'always' taking precautions compared to 42% of women)[76].

Over two-fifths (43%) of adults in Jersey always take precautions to protect their skin from sun damage

Healthy Schools

Both Jersey and Guernsey run a Healthy Schools programme, designed to promote the link between good health, behaviour and achievement. Schools are encouraged to develop health related work using a 'whole school approach' that involves students, staff, parents and the wider school community. The programme focuses on the four key areas of Personal Social and Health Education, Healthy Eating, Physical Activity and Emotional Health and Wellbeing.

Since April 2011, the administrative responsibility for the Healthy Schools programme in the UK was transferred to schools and local authorities, as part of the UK government move to decentralise services. As the award is now administered locally, Education Sport and Culture and Health and Social Services have adapted the programme to best fit local needs and the Jersey curriculum. Schools now participate in the programme on a voluntary basis and 11 primary schools achieved Healthy Schools Status by the end of 2013.

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[75] JASS 2012
[76] JASS 2012

9. WIDER DETERMINANTS OF HEALTH

Our Life Chances

The health of individual people and local communities is affected by a wide range of factors such as where and how people live and what is happening and what has happened to them.

Figure 9.1: The key factors recognised as having a major influence on health and wellbeing
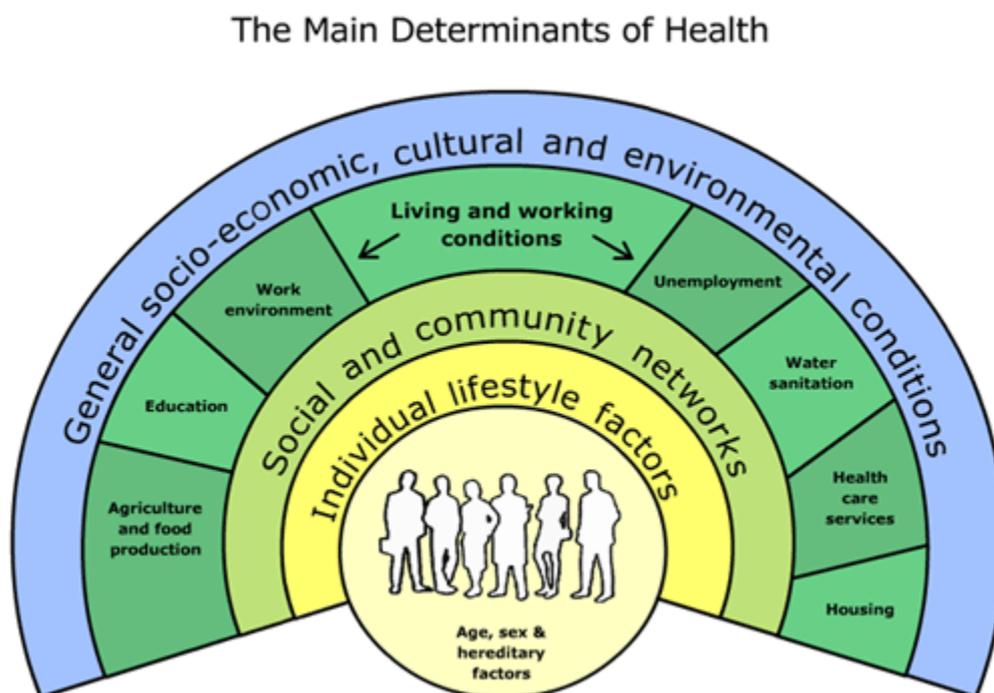
A Social Model of Health **-** Dahlgren & Whitehead (1991)

The factors that can contribute towards our good or bad health include:

- Genetic makeup
- Lifestyles (how we live and what we do)
- Housing and community
- Income
- Education
- Relationships with friends and family
- Economy and society (where we live and what is around us)
- Environment we live in

9. Wider Determinants of Health

Some of these factors can be controlled, some can be influenced, but some can't.

Factors outside of our control include:

Gender - men and women are susceptible to some different diseases, conditions and physical experiences which play a role in our general health.

Genetic makeup - people's longevity, general health, and propensity to certain diseases are partly determined by their genetic makeup.

The factors that are generally outside an individual's personal control (to at least some extent) but which can be improved with support from organisations such as the Government, local Councils, the NHS and Police include:

Socioeconomic status - the higher a person's socioeconomic status, the more likely he/she is to enjoy good health. The link is a clear one. Socioeconomic status affects all members of the family, including newborn babies.

Education - people with lower levels of education generally have a higher risk of experiencing poorer health (this is also linked to socioeconomic status).

Job prospects and employment conditions - statistics show that people in employment are more likely to enjoy better health than people who are unemployed. If you have some control over your working conditions your health will benefit too.

Physical Environment - if water supplies are clean and safe, the air clean, workplaces are safe and healthy, housing and homes are comfortable and safe, then people are more likely to enjoy good health compared to others whose water supply is not clean and safe, who are exposed to air that is contaminated, and whose workplace is unsafe or unhealthy.

Social Environment - where people have support from family as well as from friends and the local community then their chances of enjoying good health, especially good mental wellbeing, are far greater than where people are isolated and lonely.

Access and use of health services - a society that has access to and uses good quality health services is more likely to enjoy better health than one that doesn't. For example, the population of developed countries that have universal health care services like the NHS have longer life expectancies compared to developed countries that don't (UK vs. USA).

Factors that affect our health that are much more within our control (although not necessarily all the time) include;

What we do and how we manage (our lifestyles) - factors such as what people eat, how physically active they are, whether or not they smoke or drink alcohol excessively or take drugs, and how they cope with stress all play an important role in physical and mental wellbeing.

In Jersey information on some of these wider determinants of health can be found from a number of different local sources, all available on the gov.je web site:

Statistics Unit reports and documents (www.gov.je/statistics)
including:
- Jersey in Figures (annual publication)
- Jersey Annual Social Surveys (JASS)
- Jersey Housing Affordability Reports
- Registered unemployment
- House Price Index Reports
- RPI reports
- Jersey Economic trends
- Jersey Household Spending Survey
- Jersey Household Income Distribution Survey

Building a Safer Society Annual Reports
www.gov.je/Government/Departments/HomeAffairs/Departments/BASS/Pages/WhatIsBASS.aspx

Education Sport and Culture
- Exam results
  www.gov.je/Education/Schools/SchoolLife/Pages/ExamResults.aspx
- General Education reports published by Education Sport and Culture
  www.gov.je/Government/Departments/EducationSportCulture/Pages/index.aspx

Environment
www.gov.je/Environment

Air quality monitoring
www.gov.je/Environment/ProtectingEnvironment/Air/Pages/AirQuality.aspx

Sea water quality monitoring
www.gov.je/Environment/ProtectingEnvironment/SeaCoast/Pages/SeawaterMonitoring.aspx

Radon
www.gov.je/Health/Environment/Pages/Radon.aspx

States of Jersey Police
www.jersey.police.uk/be-safe/

10. Glossary and Abbreviations

95% CI LL	95% Confidence Interval Lower Level (see also Statistical Methods)
95% CI UL	95% Confidence Interval Upper Level (see also Statistical Methods)
ASR	Age-standardised rate (see also Statistical Methods)
BMI	Body Mass Index
COPD	Chronic Obstructive Pulmonary Disease
DH	Department of Health
'Flu	Influenza
GUM	Genitourinary Medicine
HSCIC	Health and Social Care Information Centre
HSSD	Health and Social Services Department
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision
MoH	Medical Officer of Health
IHD	Ischaemic Heart Disease (coronary heart disease)
NHS	National Health Service
NMSC	Non-Melanoma Skin Cancer
ONS	Office for National Statistics
PCT	Primary Care Trust (former National Health Service administrative bodies, responsible for commissioning primary, community and secondary health services from providers. PCTs ceased to exist in 2013 since when their work has been taken over by Clinical Commissioning Groups)
PHE	Public Health England
PHOF	Public Health Outcomes Framework (a Public Health England data tool which sets out a vision for public health, desired outcomes and indicators that enable an understanding of how well public health is being improved and protected)
UK	United Kingdom
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
YOLL/YWLL	Years of Life Lost/ Years of Working Life Lost (see also Statistical Methods)

11. Sources of Data

Documents

ASH (2013), *Factsheet on Smoking Statistics – Illness and Death*, published April 2013, www.ash.org.uk

Cataroche, J. and Bridgman, S. (2014), *Health Profile for Guernsey and Alderney 2010-2012*, published April 2014, States of Guernsey, Guernsey

Department of Health (2013), *Abortion Statistics, England and Wales 2012*, published July 2013 www.gov.uk

Department of Health (2013), *Report on Breastfeeding Statistics*, published June 2013, www.gov.uk

Department of Health (2013), *Reducing Harmful Drinking; Policy Document,* published March 2013, www.dh.gov.uk

Department of Health (2013), *Annual HPV Vaccine Coverage Report 2012-2013*, published December 2013, www.gov.uk

Health Intelligence Unit (2014), *Jersey Alcohol Profile*, to be published 2014, www.gov.je

Health Intelligence Unit (2010), *A picture of Health Jersey 2010; reflections on the health-related behaviour of young people aged 10-15 years*, published 2010, www.gov.je

HSCIC (2011), *Smoking, Drinking and Drug Use Among Young People – England 2010*, published July 2011, www.hscic.gov.uk

HSCIC (2013), *Health Survey for England 2012*, published December 2013, www.hscic.gov.uk

HSCIC (2013), *NHS Immunisation Statistics 2012-2013*, published September 2013, www.hscic.gov.uk

HSCIC (2013),*Statistics on obesity, Physical Activity and Diet England 2013*,published February 2013 www.hscic.gov.uk

HSCIC (2014), *Statistics on Obesity, Physical Activity and Diet, England 2014*. published February 2014 www.hscic.gov.uk

HSCIC (2014), *Statistics on Smoking 2013*, published August 2013, www.hscic.gov.uk

Public Health England Knowledge and Intelligence Team (South West) (2013), *Cancer in Jersey Report*, published July 2013, available from www.gov.je

Public Health England Knowledge and Intelligence Team (South West) (2014), *Channel Islands Cancer Report 2013*, published January 2014,available from www.gov.je

Public Health England (2014), *Sexual and Reproductive Health Profiles,* published March 2014, www.phe.org.uk

OECD (2012), *Health at a Glance: Europe 2012*, published November 2012, OECD publishing

OECD (2013), *Health at a Glance 2013*, published November 2013, OECD publishing

11. Sources of Information

ONS (2014), *Alcohol-related Deaths in the United Kingdom,* published February 2012, www.ons.gov.uk

ONS (2013), Avoidable Mortality in England and Wales 2011, published May 2013, www.ons.gov.uk

ONS (2013), *Birth Summary Tables England and Wales 2012*, published July 2013, www.ons.gov.uk

ONS (2014), *Compendium of UK Statistics*, published February 2014, www.ons.gov.uk

ONS (2014), *Conceptions in England and Wales 2012*, published February 2014, www.ons.gov.uk

ONS (2013), *Deaths from selected causes by Place of Death in England and Wales between 1997 and 2012*, published November 2013, www.ons.gov.uk

ONS (2013), *Drinking habits amongst Adults 2012*, published December 2013, www.ons.gov.uk

ONS (2013), *Life Expectancy at Birth and at Age 65 for Local Areas in England and Wales, 2010-2012 Statistical Bulletin,* published October 2013, www.ons.gov.uk

ONS (2013), *Stillbirth rates 1965-2010,* published April 2013, www.ons.gov.uk

States of Jersey Statistics Unit (2013), *Jersey's Better Life Index*, published March 2013, www.gov.je/statistics

States of Jersey Statistics Unit (2012), *Jersey Annual Social Survey 2012 Report*, published December 2012, www.gov.je/statistics

States of Jersey Statistics Unit (2013), *Jersey Annual Social Survey 2013 Report*, published November 2013, www.gov.je/statistics

States of Jersey Statistics Unit (2013), *Population Projections Report 2013*, published September 2013, www.gov.je/statistics

Scottish Government (2013), *Scottish Health Survey 2012: Volume 1*, published September 2013, www.scotland.gov.uk

Welsh Government (2013), *Welsh Health Survey 2012*, published September 2013, www.wales.gov.uk

World Health Organization (2001), *The Optimal Duration of Exclusive Breastfeeding; Report of the Expert Consultation,* www.who.int

World Health Organization (2010), *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*. Volume 1. World Health Organization www.who.int.

World Health Organization (2013). *Tobacco Factsheet No. 339,* published July 2013, www.who.int

World Health Organization (2013). *World Health Statistics 2013*. www.who.int

Websites

British Government: www.gov.uk

83

CIA Factbook: www.cia.gov

Department of Health: www.dh.gov.uk

EuroStat: http://ec.europa.eu/eurostat/help/new-eurostat-website

Health and Social Care Information Centre: https://indicators.ic.nhs.uk/webview/

ISD Scotland: www.isdscotland.org

Jersey Met Office: www.jerseymet.gov.je

Network of Public Health Observatories: www.apho.org.uk

Office for National Statistics: www.statistics.gov.uk

Public Health Agency Northern Ireland: www.hscni.net

Public Health England: www.gov.uk/government/organisations/public-health-england

Public Health England Longer Lives Tool: http://healthierlives.phe.org.uk/topic/mortality

Public Health England National Obesity Observatory: www.noo.org.uk

Public Health Outcomes Framework data tool: http://www.phoutcomes.info/

Public Health Wales: www.wales.nhs.uk

States of Jersey: www.gov.je

States of Jersey Statistics Unit: www.gov.je/statistics

World Bank: data.worldbank.org

World Health Organisation: www.who.int

12.   Statistical Methods

Confidence Intervals	The 95% Confidence Interval is used as a way of quantifying the uncertainty around a point estimate. This uncertainty arises as factors influencing the indicator are subject to chance occurrences that are inherent in the world around us. These occurrences result in random fluctuations in the indicator value between different areas and time periods. Jersey has a comparatively small population so rates or percentage estimates over short periods of time are sensitive to random fluctuations in numbers of events. Confidence intervals quantify the uncertainty in the estimate and, generally speaking, describe how much different the point estimate could have been if the underlying conditions stayed the same, but chance had led to a different set of data. In health profiles, confidence intervals are given with a 95% stated probability level. Where confidence intervals for two estimates are available these can be examined to gauge the statistical significance of the difference in estimates. Non-overlapping confidence intervals signify that estimates are likely to be significantly different. Overlapping confidence intervals, by contrast, suggest that true values of the two estimates may be the same.
Age standardised rates	Age-standardised rates is the rate of events that would occur in a population with a standard age structure is that population were to experience the age-specific rates of the subject population. The 1976 European Standard Population has been used to calculate the standardised rates in this report, (except where comparative data has used the 2013 European Standard Population). The same population is used for males, females and all persons and rates are expressed per 100,000 population.
Crude Rates	A crude rate refers to the number of events per 1,000 or 100,000 population
Life expectancy calculations	Life expectancy at birth is a summary measure of the all cause mortality rates in an area in a given period. It is the average number of years a new-born baby or 65 year old would survive, were he or she to experience the particular age-specific mortality rates for that time period throughout his or her life.
YOLL/YWLL	Years of life lost is a measure of premature mortality which is used to compare the mortality experience of different populations for all causes of death and/or particular causes of death by quantifying the number of years **not** lived by individuals who die under a given cut-off age. The most frequently used cut-off age is 75, this having been set as an age that everyone can be expected to reach. The age of 65 can also be used to calculate years of working life lost (YWLL) which is a useful indicator of the economic impact of premature deaths.

13. Background Notes

1. The profile provides facts about how Jersey compares with other areas. It does not seek to answer why the figures are as they are or what may need to be done about them, though these will be important questions to consider.

2. Comparisons are performed on a like-for-like basis unless otherwise stated. Where a comparable figure uses a mid-year population, the Jersey rates are calculated using the average of the two applicable end-year population estimates as published by the States of Jersey Statistics Unit. This estimate of the mid-year population assumes that half of births, deaths and migration occurs in the first half of the calendar year.

3. Percentages may not add up to 100% due to rounding.

4. This report uses the 1976 European Standard Population in the calculation of age-standardised rates, unless otherwise specified. A new European Standard population is available (2013) which was used for the Longer Lives comparison in the Burden of Disease Chapter as the comparative data for England used this standard population. It is anticipated that future health profiles will use the 2013 European Standard Population as more of the comparative data is revised.

5. Fertility
   (1) Information on births in Jersey comes from the Child Health System which uses data provided by the Maternity Department.
   (2) Stillbirth's data comes from the Maternity Department
   (3) Information on Infant Mortality is collected via the deaths registrations and details from the Hospital
   (4) Low birth weight statistics for Jersey are not directly comparable with Guernsey and the UK as data on the weight of stillbirths is not available
   (5) Breastfeeding information is collected by the Maternity Department at 48 hours and by GP's at the 6 to 8 week checks. Previously, routine recording of this was not completed so reported coverage was low.

6. Deaths
   (1) Death figures are compiled from returns to the Registrars in each parish in Jersey. The Marriage and Civil Status (Jersey) Law 2001 requires all deaths to be registered within 5 days of the date of death.
   (2) The number of deaths may differ from previously published figures due to the inclusion of data from inquests which can take up to 18 months to complete and register. This means that total deaths in a given year should be treated as provisional and used with caution.
   (3) The results are based on analysis of all deaths of Jersey residents registered as having occurred in calendar years 2010 to 2012.
   (4) Cause of death is classified using the tenth revision of the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-10). As is convention, deaths classified under ICD-10 as 'events of undetermined intent' along with 'intentional self-harm' are jointly reported as 'suicide'.
   (5) Coding of Jersey deaths is undertaken by the Office for National Statistics on a quarterly basis.
   (6) Potential Years of Life lost estimates the number of years a person would have lived had they not died prematurely. It is based on the assumption that every individual could be

expected to live until the age of 75 and premature death before that age may be preventable.

(7)   Preventable Deaths are calculated according to ONS methodology, for more information see Avoidable Mortality in England and Wales 2011 Report, ONS 2013

7.   Cancer registry information in Jersey is collated and analysed by Public Health England Knowledge and Intelligence Team (South West) with data supplied by the Public Health Department, for more information see the Channel Islands Cancer Report 2013, published January 2014.

8.   The Jersey Annual Social Survey is a voluntary postal and internet survey run independently by the States of Jersey Statistics Unit. The survey is sent to more than 3,000 randomly selected households each year, and has a high response rate of around 58%. In addition to the very good response rates overall, statistical weighting techniques are used to compensate for different patterns of non-response from different sub-groups of the population. The result is that the survey results can be considered broadly accurate and representative of Jersey's population. As with all sample surveys, there is an element of statistical uncertainty, typically around ±2% for results for the overall population. For further details see www.gov.je/JASS

9.   Passive Smoking Risk data is collected by GP's at the 6 to 8 week check and reported back to the Child Health Team.

10. All enquiries and feedback should be directed to:

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