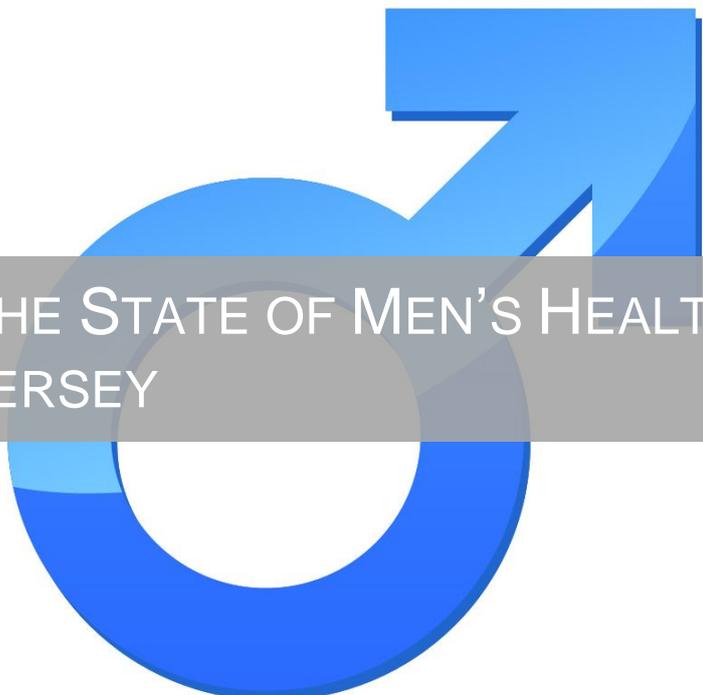


STATES  
OF  
JERSEY



THE STATE OF MEN'S HEALTH IN  
JERSEY

Health Intelligence Unit  
Public Health Directorate  
Health and Social Services Department

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Published: December 2014

## HIU INFORMATION READER

Document purpose	Explore gender specific health issues in Jersey
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<b>Title</b>	The State of Men's Health in Jersey
Author	Health Intelligence Unit
Publication date	1 <sup>st</sup> December 2014
Target audience	Public
Circulation list	HSSD staff, CMEX, Statistics Unit
Description	Analysis of gender specific health issues in Jersey using data available at year end 2013, with like for like comparisons to available European data.
<b>Amendment history</b>	
Officer	Amendment date and detail
M Clarke	Report data compiled in 2014 using data available at the end of 2013. Comparisons to the European Men's Health Report published in 2011 by the European Commission. Data check and formatting of document.
J Birbeck and S Turnbull	Final edit
Contact details	HealthIntelligence@health.gov.je

<b>Embargo/confidentiality</b>	<b>Embargoed until 00:01 1<sup>st</sup> December 2014</b>
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## Foreword from the Jersey Medical Officer of Health

This report provides an overview of the state of men's health in Jersey. It has been inspired by the first European Men's Health Report, 'The State of Men's Health in Europe'<sup>1</sup>, published in 2011, which highlighted the broad range of mortality and morbidity data arising from the many different health conditions and health outcomes which affect men in Europe.

This report provides information on various topics relating to men's health, such as cancer, alcohol and tobacco, based on data and information that was available at the end of 2013.

### Understanding men's health

A better understanding of the health of men is essential for two main reasons. The first relates to the need for our male population to be as fit and able as possible. The second is tied to the fundamental values of equality and equity. Many men suffer illness and early death, which in many instances could have been prevented. This has a huge impact; not only on men themselves, but also on their families and wider society.

This report provides analysis of a broad range of health and social issues that affect the health of men and attempts to give an insight into why, compared with women, men seem so vulnerable to premature death.

### Putting the spotlight on men and 'men's health'

Throughout European history, men have maintained a central and prominent place in society and have traditionally been the major holders of political and religious office and of economic resources. Nevertheless, the categories of 'men' and 'masculinity' have remained largely taken for granted, as the gender spotlight focussed on improving the equality of women.

The European report was considered particularly timely, against a backdrop of unprecedented political, economic and social changes that have occurred across Europe over the past 30 years. There have been significant economic changes with an overall decline of primary industry and, more recently, increased labour market vulnerability associated with economic recession. This is coupled with a changing demographic picture within Europe, as witnessed and projected in Jersey: with a declining younger population and an expanding older population, the workforce implications and pressure on resources are becoming more intense.

Currently, along with the rest of Europe, we are losing a significant proportion of our working age men through premature mortality, with a quarter of all male deaths occurring before 65 years of age, compared to one in six female deaths. This is not just an issue of gender equality, but a more

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<sup>1</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

fundamental equity concern, which relates to the right of all men to be able to live a long and fulfilling life.

### **Social determinants of health**

Men's health status is more than simply a consequence of biological, physiological or genetic factors; it is also affected by much broader economic, social, cultural and environmental elements, as well as avoidable individual lifestyle risk factors (such as smoking, hazardous alcohol drinking and being overweight and obese).

### **Men's health as an investment**

Many of the solutions of addressing the social determinants of men's health rely on the ability of professionals to recognise that men have significant potential to be a health resource rather than just a consumer of health services. This is a departure from the traditional focus on the 'deficiencies' of men with respect to their health. Public debate on men's health in Europe has tended to be dominated by negative portrayals of men and masculinity, whereby men are blamed for being less likely than women to seek appropriate health care, for being violent and for taking more health-harming lifestyle risks.

Improving the health of men can also have both direct and indirect benefits for women and children. In the case of single-income, lower socio-economic group families, absenteeism from work due to a father's ill-health - or indeed premature death - is likely to have significant material repercussions for the family as a whole. In the case of sexual or mental health, interventions that are effective for men are also likely to have positive consequences for men's families.

### **Main message**

A main message from this report is that there is a high level of preventable premature morbidity and mortality in men, which will need to be addressed by raising awareness, along with targeted activity. As in Europe, we have identified a significant inequality in the health risks, and in turn health outcomes, of Jersey men compared with Jersey women. Improving men's health will also have both direct and indirect benefits for women and children.

### **Acknowledgements**

I am most grateful to my Health Intelligence Team for providing the relevant data and comparisons, and in particular to Marguerite Clarke, for her work in drafting and producing the main body of this report.

**Dr Susan Turnbull**

**Medical Officer of Health, Public Health Jersey**

***'Protecting and improving the health and well-being of Islanders'***

**December 2014**

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## Executive Summary

We see patterns emerging from the Jersey data that show differences between the health of men and women, consistent with patterns elsewhere in Europe. The data in 'The State of Men's Health in Europe' report of 2011 highlighted the disparities in health outcomes between men and women in different countries and within male populations in individual European countries. This demonstrates that men's health disadvantage is not biologically inevitable.

The changing demographic picture in Jersey, as across the EU, highlights the increasing longevity of much of the male population. Based on current projections, there will be nearly 10% fewer working age men (aged 16-64 years) and a significant increase in the number of men over 65 by 2060.

Overall life expectancy for men in Jersey is higher than the European average and is increasing but life expectancy is lower for men than for women. Around 90 men of working age (16-64) die each year in Jersey, compared with around 60 women at this age.

On average, around 120 male deaths each year are considered avoidable, (either preventable through public health interventions or amenable to health care). This compares to around 70 female deaths.

Two of the main causes of premature death in men are cardiovascular disease and cancer. Men are 58% more likely than women to die from the main cancers and are also at higher risk of developing cancer. Tobacco remains the largest single preventable cause of cardiovascular and cancer deaths, with one in five male deaths smoking-related.

There is also a consistent pattern of higher mortality rates from accident and violence-related injuries among men in Jersey compared to women.

Lifestyle behaviours and preventable risk factors account for a high proportion of premature death and morbidity in men. In Jersey, smoking levels and alcohol consumption are highest amongst men. A third of men are overweight, whilst one in six is obese in the Island. This is of concern as the male form of overweight, with central fat deposition, is associated with increased risk of many health problems – notably diabetes, heart disease and cancer. Fat-related cancers (such as colorectal, pancreas, gall-bladder, kidney and oesophagus<sup>2</sup>) are more linked to the male form of overweight or obesity.

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<sup>2</sup> Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. *British Journal of Cancer*. 2011;105: S77-S81

Although men and women in Jersey report similar levels of longstanding illness and poor health, men under 65 report being less likely than women to visit their GP. In contrast, admissions to hospital are higher for men than for women for all of the principal diseases and health problems.

While Jersey men and women report similar levels of extreme anxiety and depression and have similar mental health scores, men have a much higher suicide rate than women. This is especially true in the 24-35 age group. This is of concern as men's depression and other mental health problems have been shown to be underdetected and undertreated in all European countries.

## **Conclusion**

This report, along with 'The State of Men's Health in Europe' 2011 Report, provides the foundation for information around the emerging field of 'men's health' and sheds light on the challenges men face in the second decade of the 21st century. Analysis of our local data demonstrates that a substantial health inequality exists between the health prospects of men compared to that of women here in Jersey just as much as it does elsewhere in Europe.

## Introduction

This report is the first time we have examined the state of men’s health in Jersey, both in comparison to women in the Island and to other men across Europe. It examines the broad range of aspects of health that affect men at all ages of their lives and looks at the many causes of premature deaths of men in the Island.

The scope of this report is limited by the amount of comparable data available for 2011/2012. The Jersey data analysed comes from a range of sources, including the States of Jersey Statistics Unit, previously published Health Intelligence Unit reports such as the 2014 Health Profile and Jersey General Hospital data. Information has also been kindly supplied by the States of Jersey Police, Social Security and Education Departments.

### Country Codes

Country	Code		Country	Code		Country	Code
Austria	AT		Germany	DE		Norway	NO
Belgium	BE		Greece	EL		Poland	PL
Bulgaria	BG		Hungary	HU		Portugal	PT
Croatia	HR		Iceland	IS		Romania	RO
Cyprus	CY		Ireland	IE		Slovakia	SK
Czech Republic	CZ		Italy	IT		Slovenia	SI
Denmark	DK		Latvia	LV		Spain	ES
Estonia	EE		Liechtenstein	LI		Sweden	SE
Finland	FI		Lithuania	LT		Switzerland	CH
Former Yugoslav Republic of Macedonia	MK		Luxembourg	LU		Turkey	TR
			Malta	MT		United Kingdom	UK
France	FR		Netherlands	NL		<b>Jersey</b>	<b>JE</b>

## Key findings by chapter

### The Male Population (48,800 in 2012)

- The highest number of men in our population are currently in their 40s;
- There are likely to be fewer men of working age and an increase in the proportion of men over 65 by 2065;
- Men are more likely to be working full-time and working longer hours than women;
- Proportionately more men than women are employed in manual jobs and working with machinery. As men tend towards more manual jobs, their risk of workplace injury increases;
- A greater number of men are registered as Actively Seeking Work with the Social Security Department.

### Lifestyle and Preventable risk factors

- Around half of local men said they met recommendations to exercise 5 times a week for half an hour or more;
- Men in Jersey reported eating around 3.5 portions of fruit and vegetables a day, below the recommended 5-a-day; Just over a quarter of men achieve this recommendation;
- Over half of 16-34 year old men were classified as having a normal BMI. At 35-44 years old, this drops to just under half of men with a normal BMI (45%).
- After 45 years of age, only 1 in 3 men have a normal BMI, 45%-48% are overweight and another 1 in 5 are obese. The male form of overweight, around the middle, increases male risk of health problems;
- A fifth of men aged 35-64 are likely to be drinking at levels that are harmful or hazardous to their health;
- Similar proportions of males and females smoke daily in Jersey, although men smoke more each day than women.

### Access to health services

- Almost a fifth (18%) of men had not visited the GP in the last 12 months, whilst some 3% were not registered with a GP in Jersey;
- Male hospital episodes for circulatory diseases, cancers, digestive system diseases and diseases of the genitourinary system were higher than episodes for females in Jersey in 2013;
- In 2012 and 2013, more women approached the Help2Quit smoking cessation service, but a higher proportion of men successfully quit than women;
- Men under 45 in Jersey were less likely to use primary health services in the Island than women.

## Health Status

- Men and women report a similar overall health status with some four-fifths describing their health as good or better;
- Similar proportions of both men and women reported having a longstanding illness, disability or infirmity (26% of men, 25% of women);
- Baby boys born in Jersey in 2012 can expect to live to 79 years of age. However, life expectancy for women is some 5 years longer;
- Around a quarter (24%) of male deaths occur in the working age group (15-64), compared with around 1 in 6 of all female deaths in the working age group;
- On average around 120 male deaths a year would be considered avoidable, compared to 70 female deaths;
- Over 2,000 male years of potential life (below 75 years of age) are lost on average each year;
- 1 in 5 (21%) of all male deaths were smoking-related. This compares to 1 in 7 (13%) of all female deaths.

## Cardiovascular disease (CVD), stroke and Ischaemic Heart Disease (IHD)

- There have been marked reductions in mortality from cardiovascular diseases. Nevertheless, Cardiovascular Disease (CVD) is still one of the biggest risks to men's health and in the older population it is the principal cause of death;
- CVD accounts for over 100 male deaths a year in Jersey (27% of all male deaths);
- Ischaemic Heart Disease (IHD) is responsible for around half of these CVD deaths (50 male deaths a year), about 13% of all male deaths in the population;
- Cerebrovascular disease (stroke) constitutes around 7% of annual male death, around 30 deaths per year.

## Cancer

- Mortality rates from cancer are 58% higher in men than women in Jersey;
- Cancers are currently the main cause of death for men causing around 130 male deaths a year (35% of all male deaths);
- Malignant cancer incidence in men is 29% higher than in women;
- 1 in 10 (11%) of cancers diagnosed in men each year are lung cancers. Lung cancer is the main cause of cancer deaths in men locally;
- Overall relative survival from malignant cancers is similar in both males and females, although some specific cancers show differences between the genders;

- Prostate cancers account for more than a quarter (28%) of all malignant cancers diagnosed in men each year; but only accounts for 13% of all cancer deaths. This high incidence is linked to the availability of PSA testing in Jersey.

## Accidents

- Injuries and accidents are an important public health issue as they cause premature death, absenteeism from the workplace and strain on the health system;
- Around 4% of all deaths each year are due to external causes of injury, such as accidents or intentional self-harm - 5% for men compared to 3% for women;
- External injuries account for around 500 potential male years of life lost each year, compared with around 240 female years of life lost;
- Accidents account for around half (52%) of all male deaths from external injuries;
- Around 600 males were injured on Jersey roads during 2010-2012;
- In 2013, around 200 men reported a workplace accident to the Social Security Health and Safety Inspectorate.

## Mental Health

- Reported rates of depression and anxiety in Jersey are similar for both men and women, with around 2% reporting extreme anxiety or depression;
- Suicide rates for men have fallen recently in Jersey, but still remain three times higher than the rate for females;
- Self-harm hospital admissions peak in the 20-44 age group for men; younger (under 18 years) and older women (55 years and over) make up the highest proportions of admissions locally.

## Communicable diseases

- Local deaths from communicable diseases are low.
- Over a quarter (28%) of male deaths from influenza and pneumonia occur before 80 years of age, compared to 1 in 6 (17%) female deaths from both infections;
- TB affects a small number of individuals in Jersey, with less than 5 deaths occurring over the past 6 years;
- Men in Jersey are more likely to be diagnosed with gonorrhoea and syphilis than women;
- Uptake of HIV tests in the Jersey GUM clinic is consistently higher than the UK;
- Four-fifths (80%) of those who started treatment for Hepatitis C in 2013 were male.

## Dental & oral health

- Around two-thirds of men reported visiting the dentist at least once in the previous twelve months;
- Around a fifth (22%) of men were not registered with a dentist in 2013, compared to 1 in 7 (14%) of women;
- Half of men not registered with a dentist gave the reason that they couldn't afford to go to the dentist;
- Men in Jersey are more likely to be diagnosed with and die of oral cancer than women.

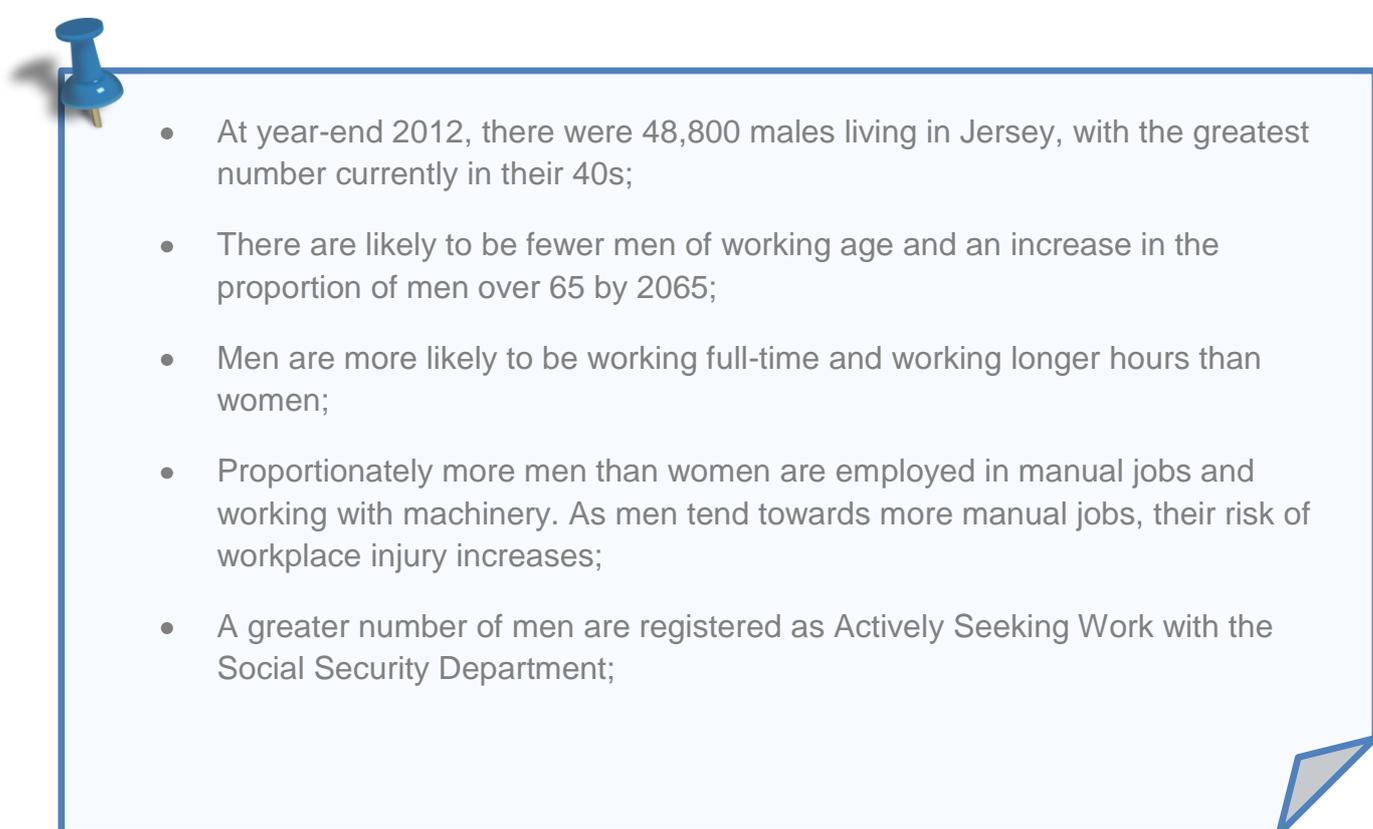
## Other conditions

- Chronic Lower Respiratory Diseases account for 6% of local male deaths each year and are a top five cause of death for men;
- Diabetes Mellitus accounts for 2% of male deaths annually in Jersey, and is a contributory condition in 1 in 10 (9%) of male deaths from cardiovascular diseases;
- The local diabetic clinic has more men than women with Type II diabetes.
- There were 240 annual male admissions to the Jersey General Hospital where a fall had been documented; there are less than 5 male deaths from falls each year.

CHAPTER  
1

THE MALE POPULATION



- 
- At year-end 2012, there were 48,800 males living in Jersey, with the greatest number currently in their 40s;
  - There are likely to be fewer men of working age and an increase in the proportion of men over 65 by 2065;
  - Men are more likely to be working full-time and working longer hours than women;
  - Proportionately more men than women are employed in manual jobs and working with machinery. As men tend towards more manual jobs, their risk of workplace injury increases;
  - A greater number of men are registered as Actively Seeking Work with the Social Security Department;

## Summary

The changing demographic picture in Jersey, as across the EU, highlights the increasing longevity of much of the population. Projections based on maintaining the current registered population suggest that the proportion of working age men (aged 15-64 years) will decrease by 10% (from 70% of the male population in 2012 to 60% in 2065) and there will be an increase in the proportion of men over 65 to one in four (26%). One in three of all 25 year old males still live at home compared with one in five females. Fewer men have achieved higher educational qualifications than women. This may be because more men are employed in skilled trades and other more manual industries than in professional employment. Men work on average more hours than women which could impact on their ability to access primary health care.

## Total Male Population

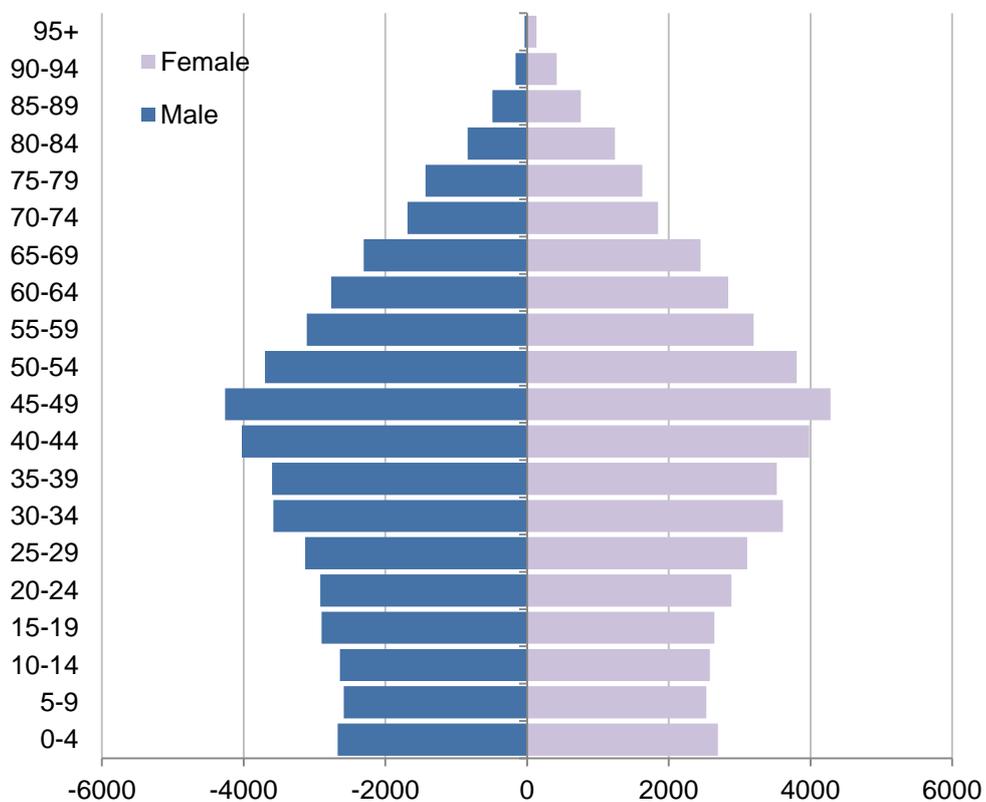
At the end of 2012, there were 48,800 males living in Jersey; 16% were under 15 years of age and 14% over 65 years. There were slightly more females living in the Island - 50,200 in total -17% of which were aged 65 and over.

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
<b>Total</b>	<b>48,800</b>	<b>50,200</b>	<b>99,000</b>

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

Figure 1.1: The population structure of Jersey 2012



Source: States of Jersey Statistics Unit for year-end 2012

The greatest numbers of men living in the Island are currently in their 40s. The health status of this group as they age has important implications for the future.

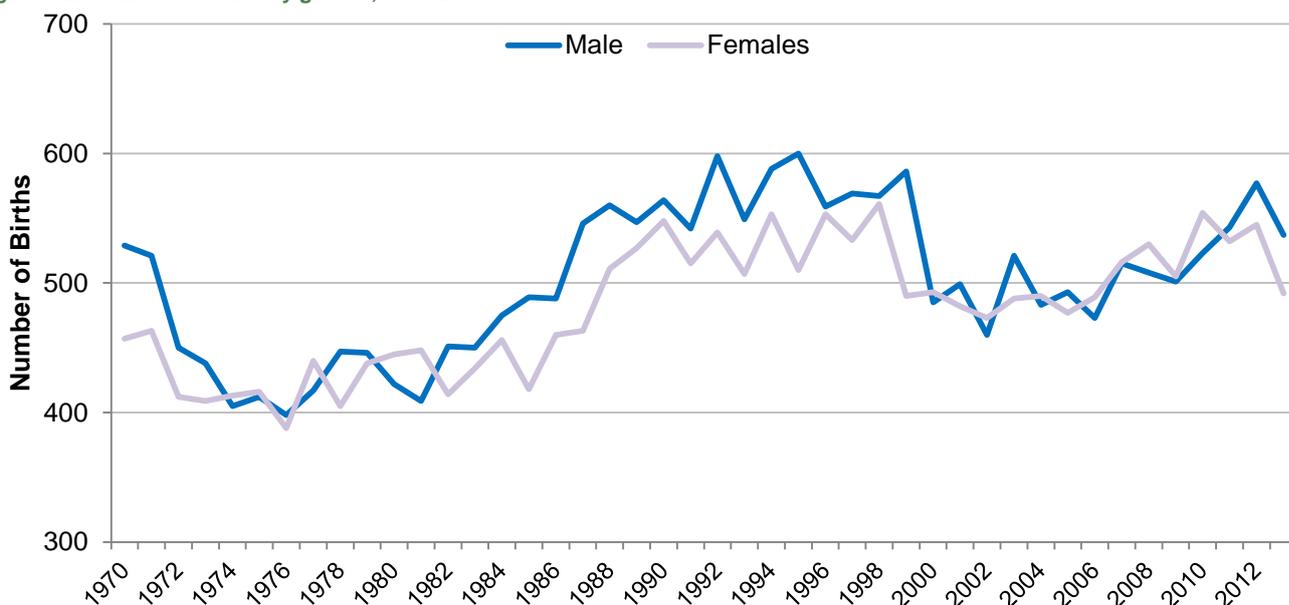
Like many western societies, Jersey is experiencing an ageing of its population. If the current registered population is maintained, the current dependency ratio<sup>3</sup> of 48% (as of year-end 2012) will increase to 66% by 2035.<sup>4</sup>

Under this scenario of migration<sup>5</sup>, the working population will decrease from 69% of the population to 58%, whilst the over 65 age group will increase to around a quarter of the population by 2065. The relative proportion of the population aged 16 and under will decrease by around 2% over this time.

Assuming this scenario is maintained, 2065 would see a 33% increase in the total male population from 2012. Jersey has already seen an 18% increase in the number of males between 1991 and 2011, compared to a 15% increase of women over the same time period.

## Birth Rate

Figure 1.2: Number of births by gender, 1970-2013



Source: Jersey Health Intelligence Unit

<sup>3</sup> The dependency ratio is calculated as the number of children aged under 16, plus the number of adults aged 65 and over (i.e. 'dependent persons'), divided by the number of persons aged 16-64.

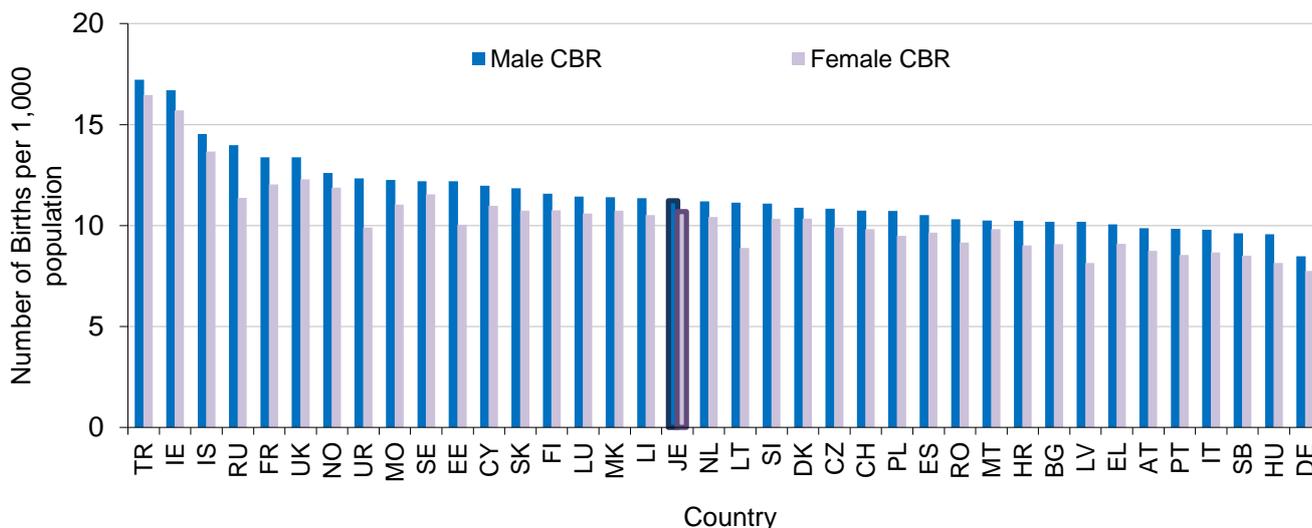
<sup>4</sup> 2013 Jersey Population Projections, States of Jersey Statistics Unit, published September 2013

<sup>5</sup> Where the current registered population is maintained

Since 1970, there have been an extra 948 more boys born than girls, although for a period more recently (2006-2010), there were a greater number of girls born.

The higher crude birth rate of boys in Jersey reflects this. The crude birth rate for males in Jersey is similar to Europe at 11.2 per 1,000 population (EU27 average 10 per 1,000), while the female crude birth rate was 10.7 per 1,000 population (Figure 1.3).

Figure 1.3: Crude Birth Rate, 2011



Source Eurostat: demo\_gind and Jersey Health Intelligence Unit

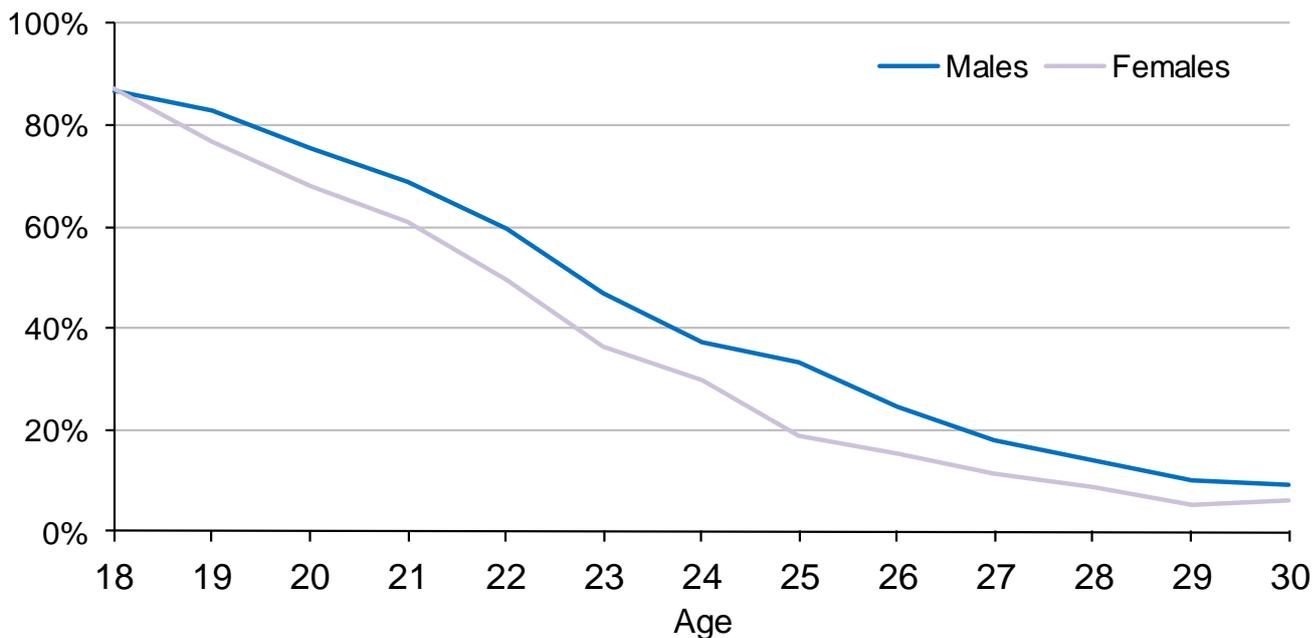
## Living Arrangements

Males are more likely to still be living at home than females. Around a third (33%) of 25 year old males were still living at home in 2011, compared with a fifth (19%) of females aged 25.

The percentage of males aged 25-30 still living at home who have attained a degree or higher was 31%, compared to 22% of the 25-30 population not living at home. The same pattern is seen with females living at home (46%) compared to those not living at home (31%).<sup>6</sup>

<sup>6</sup> Jersey Census 2011

Figure 1.4: Percentage of Males and Female still living at home 2011

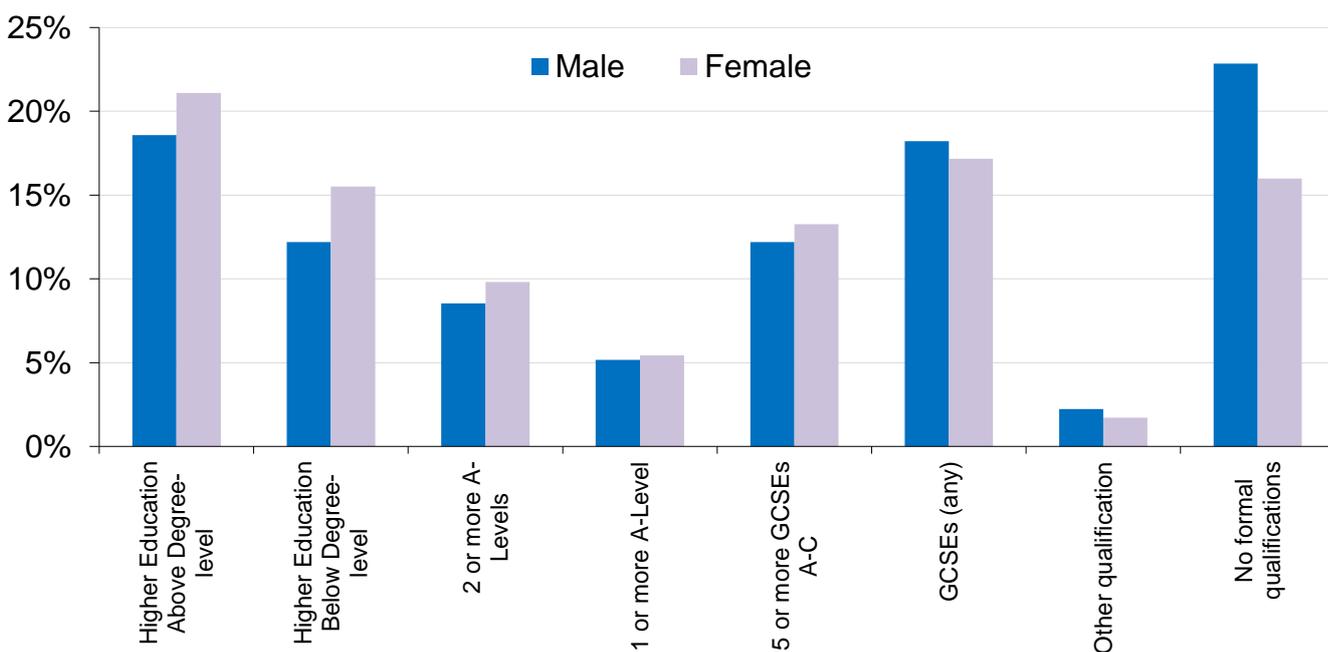


Source: Census 2011 data  
 Note: only where relationship to main householder was 'child' or 'grandchild'

## Education

A larger proportion of the female population have achieved higher educational qualifications than their male counterparts. The proportion of males with no formal qualifications (23%) is significantly greater than the proportion of females (16%).

Figure 1.5: Highest Educational Qualification, 2011



Source: 2011 Census

A greater number of males in the working population have no formal qualifications, across all ages.

## Employment

In Jersey, more men worked full-time, while a larger proportion of women worked part-time in 2011. There were also more self-employed males than females.

Of those who were not working, more men were unable to work due to sickness compared to women and there were a higher number of female homemakers.

Comparing the major occupations of working age adults (16-59/64 years) shows that a larger number of men were employed in 'Process, Plant and Machine operations', 'skilled trades' and as 'Managers, directors and senior officials'.<sup>7</sup> Women held more 'Administrative and Secretarial' and 'Caring, Leisure and Other service' roles. As men tend towards the more manual industries, there is a greater risk of workplace injury.

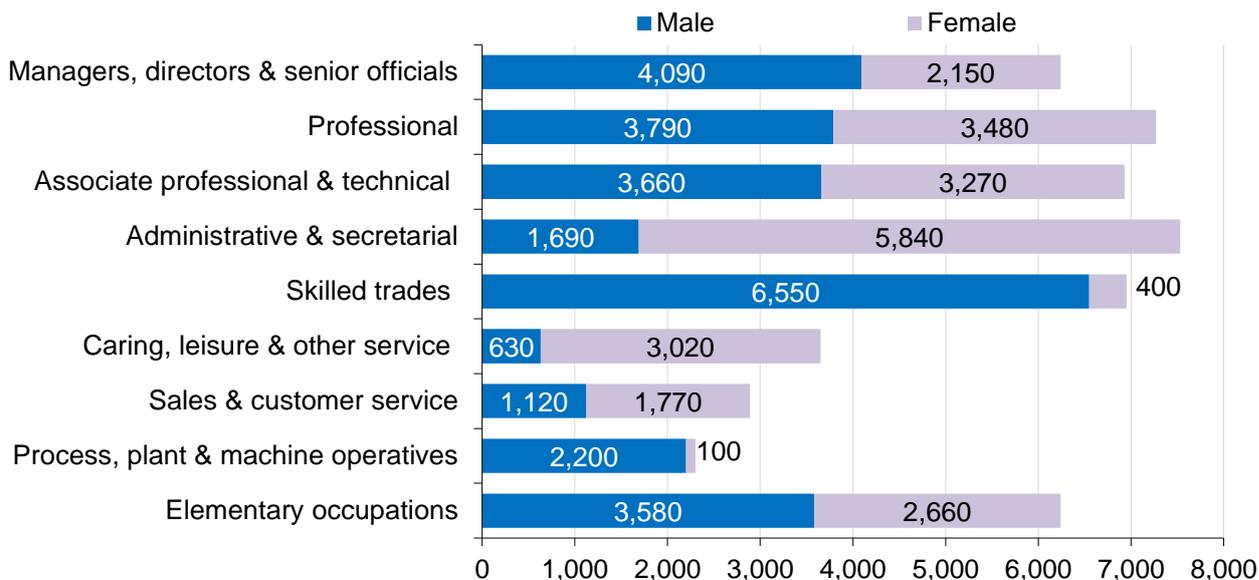
Table 1.2: Proportions of active and inactive adults aged 16 and over, 2011

		Male	Female	Total
Active	Working Full Time	75%	65%	70%
	Working Part Time	4%	25%	14%
	Self - Employing Others	7%	2%	5%
	Self - Not Others	8%	3%	6%
	Unemployed Looking	5%	4%	5%
		<b>100%</b>	<b>100%</b>	<b>100%</b>
Inactive	Retired	61%	49%	54%
	Homemaker	2%	27%	17%
	Full Time Education	20%	14%	16%
	Unable Sick	13%	7%	10%
	Unemployed Not Looking	4%	3%	3%
		<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: 2011 Census

<sup>7</sup> Jersey Census 2011

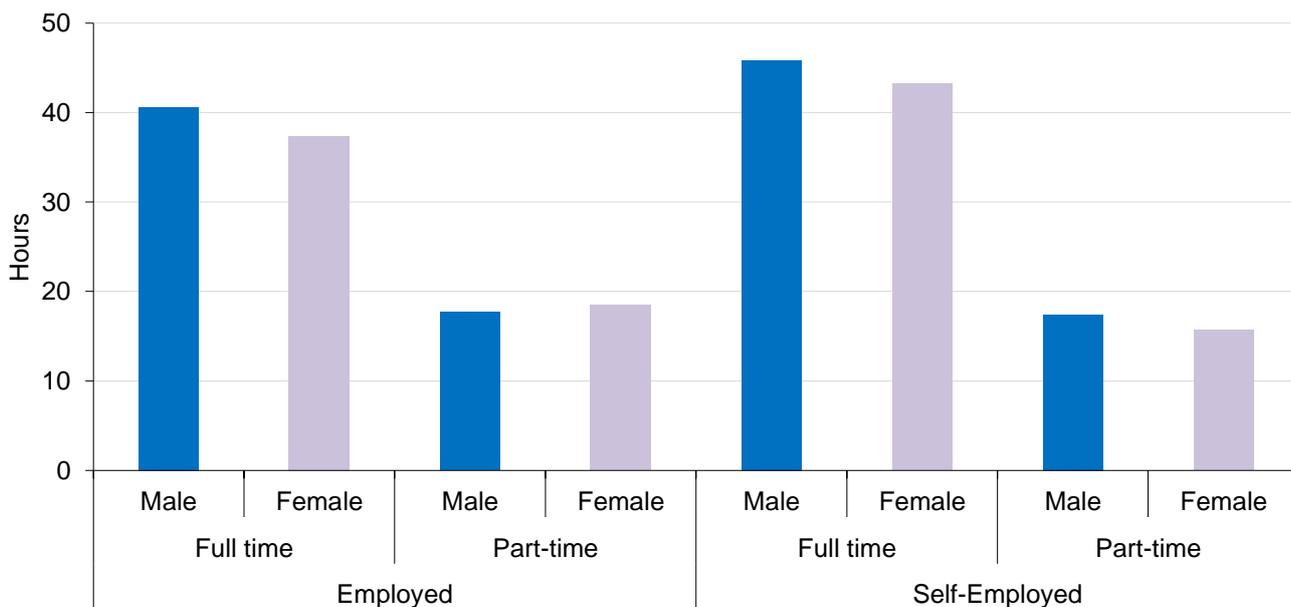
Figure 1.6 Major occupation of working adults (of working age) by gender, 2011



Source: 2011 Census, numbers rounded to nearest 10.

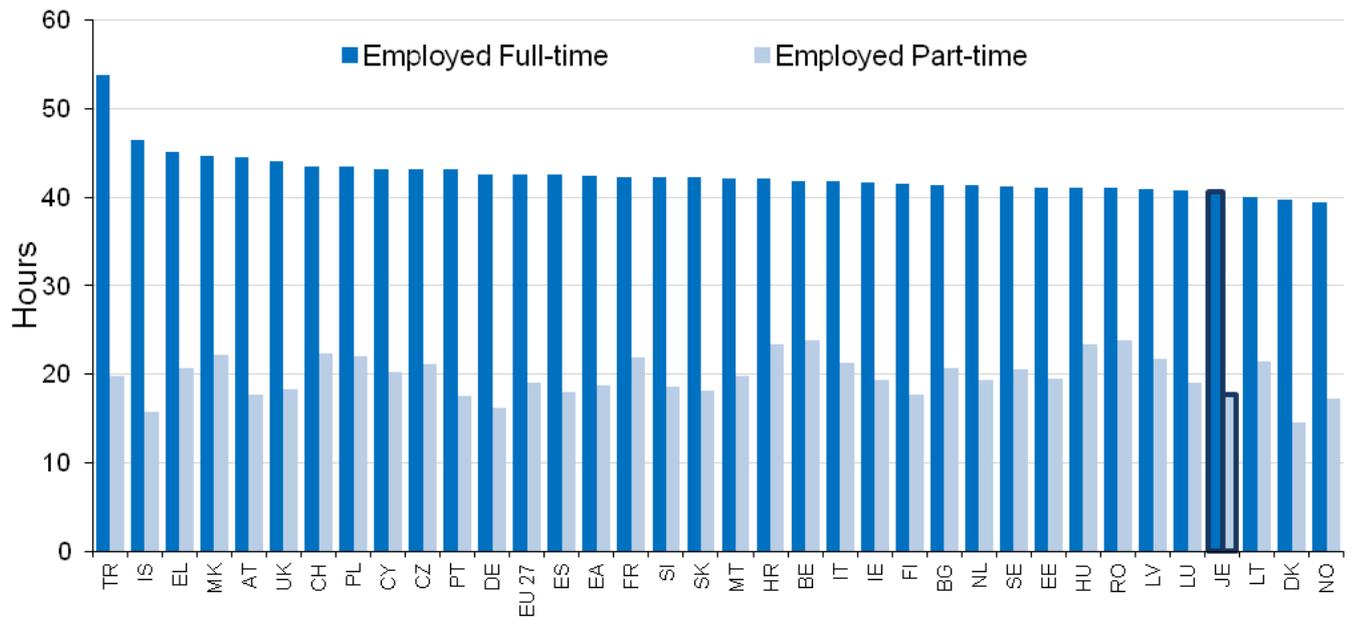
On average, men work more hours than women in Jersey. Self-employed men work the greatest number of hours. These increased hours of work can affect access to primary healthcare which traditionally run during working hours.

Figure 1.7: Average number of hours worked per week for employees and the self-employed by gender, 2011



Source: 2011 Census

Figure 1.8: Average number of hours worked per week by men working for an employer, 2011



Source: Eurostat lfsq\_eggias and Jersey Census 2011

Figure 1.9: Average number of hours worked per week by self-employed men, 2011



Source: Eurostat lfsq\_eggias and Jersey Census 2011

The International Labour Organisation’s (ILO) unemployment rate is a globally comparable figure which measures the proportion of unemployed people in the workforce. In March 2011, the ILO unemployment rate was 4.7%<sup>8</sup>; in June 2013 it was 5.7%.<sup>9</sup> This corresponds

<sup>8</sup> Jersey Census 2011

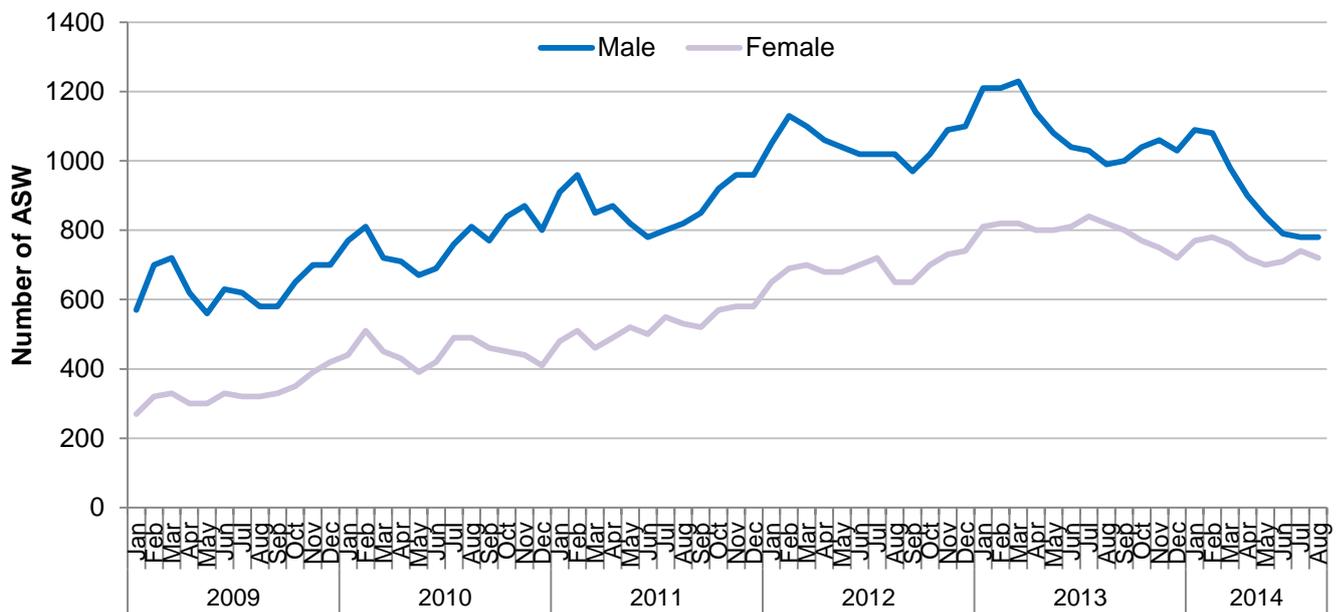
<sup>9</sup> 2013 Jersey Annual Social Survey

to 3,200 people in Jersey being unemployed and looking for work; a subset of which are actively seeking work through the Social Security Department.

The number of men actively seeking work in Jersey has consistently been greater than the number of women since 2009 (Figure 1.10).

The proportion of workers classed as ‘underemployed’ - those employees willing to supply more hours of work than their employers are prepared to offer - was reported in JASS 2013. Overall, one in six (17%) of workers would prefer to work longer hours at their current rate of pay if given the opportunity. This ranges from one in four of those in routine or manual occupations to around one in ten of those in professional (11%) or managerial (14% in middle manager, 7% in senior manager) roles. A number of men, therefore, may wish to work more hours than are currently available, possibly impacting on their mental health.<sup>10</sup>

Figure 1.10: Number of individuals registered as ASW, January 2009 – August 2014



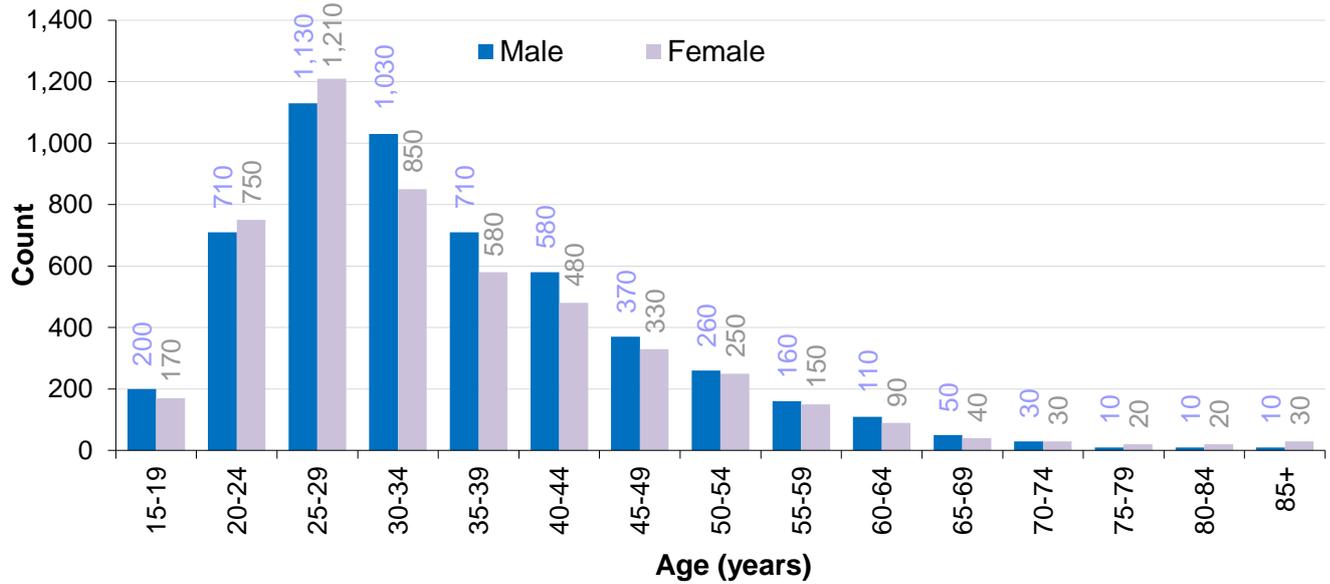
Source: States of Jersey Statistics Unit, Actively Seeking Work

<sup>10</sup> Freidland D.S. & Price R.H. (2003), Underemployment: Consequences for the health and well-being of workers. American Journal of Community Psychology 32.1 (2) 33-45

## Recent Arrivals

The majority of men moving to Jersey are aged between 25 and 34 years. Proportionally more men than women aged 30 and over arrived in the Island in the five years prior to census day 2011; whereas a greater number of women aged 20-29 arrived compared to the proportion of men the same age.

Figure 1.11: Age and gender profile of recent arrivals (those whose period of continuous residence in Jersey began after 2005 and who are aged 16 or over), 2011



Source: 2011 Census



CHAPTER  
2

LIFESTYLE & PREVENTABLE RISK  
FACTORS



- Around half of local men said they met recommendations to exercise 5 times a week for half an hour or more;
- Men in Jersey reported eating around 3.5 portions of fruit and vegetables a day, below the recommended 5-a-day; just over a quarter of men achieve this recommendation;
- Over half of 16-34 year old men were classified as having a normal BMI. At 35-44 years old, this drops to just under half of men with a normal BMI (45%);
- After 45 years of age, only 1 in 3 men have a normal BMI, 45%-48% are overweight and another 1 in 5 are obese. The male form of overweight, around the middle, increases male risk of health problems;
- A fifth of men aged 35-64 are likely to be drinking at levels that are harmful or hazardous to their health;
- Similar proportions of males and females smoke daily in Jersey, although men smoke more each day than women.

## Summary

Men's health is heavily influenced by lifestyle and health behaviours. Poor lifestyles and preventable risk factors account for a high proportion of premature death and morbidity in men.<sup>11</sup>

In Jersey, although smoking proportions for men and women are similar, men are likely to be smoking more per day than women. Alcohol consumption is higher in men than in women and men are more likely to binge drink and to be exposed to alcohol-related harm. Though males have slightly higher levels of physical activity than females in Jersey, the majority of older men do not meet recommended levels. Men also tend to have less balanced diets than women; eating on average 3.5 portions of fruit and vegetables a day. Obesity is increasing across Europe and the male form of overweight, with central fat deposition, increases the risk of many health problems e.g. diabetes and heart disease. In Jersey, a greater proportion of men were found to be overweight or obese compared to women.

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<sup>11</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

Understanding men's lifestyles is a significant factor in the development of health strategy aimed at supporting men to lead lives less damaging to their health.

The European report<sup>12</sup> found that the way men live their lives has a major effect on their overall health and wellbeing. From childhood onwards, the lifestyles that many men develop are building up problems for their future. Whether it is smoking, excess alcohol intake, illicit drug use, poor diet or limited physical activity, the effect is seen in their high rates of premature death and chronic morbidity. The risks men face are not only the consequence of the life choices they take, but there are anatomical and physiological, social and environmental, and service provision factors that can compound the problems.

## 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. For men, the importance of physical activity, especially when long working hours are taken into consideration, should be highlighted.

*In accordance with WHO guidelines, the EU recommends a minimum of 60 minutes of daily moderate-intensity physical activity for children and young people and a minimum of 30 minutes of daily moderate-intensity physical activity for adults (EU Working Group 'Sport & Health', 2008<sup>13</sup>).*

When asked to rate their level of physical activity, a greater proportion of men described themselves as 'very active' compared to women (28% compared to 20%) whilst similar proportions described themselves as 'fairly active'<sup>14</sup> (Figure 2.1).

Around half of respondents undertook at least five sessions of moderate physical activity per week, as recommended. Proportions were similar between the genders but slightly smaller proportions of older persons (over 65 years) reported meeting or exceeding this recommendation (Figure 2.2).

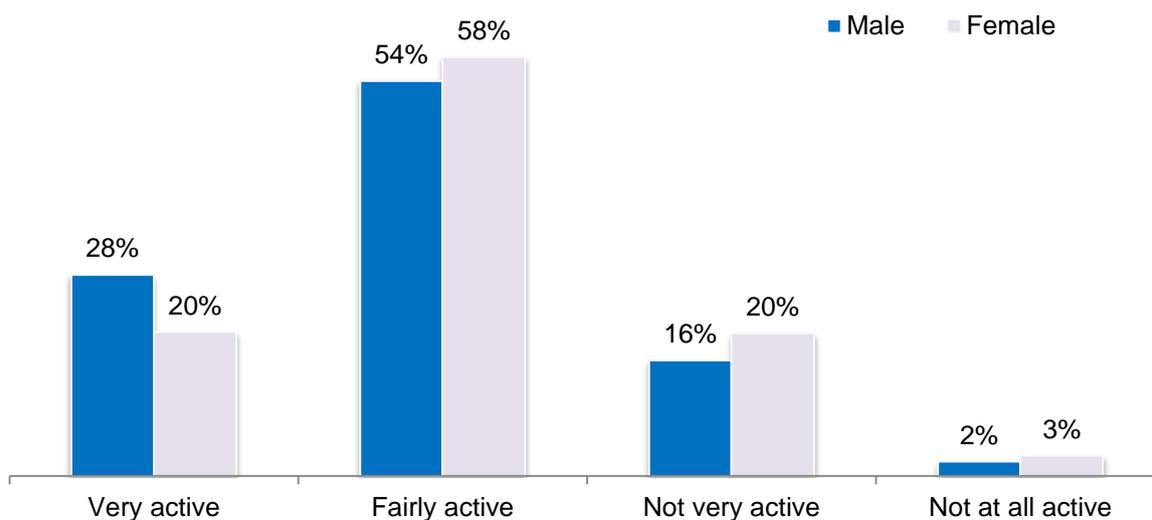
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<sup>12</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

<sup>13</sup> European Union Physical Activity Guidelines, Published by the European Commission 2008 – available from [www.europa.eu](http://www.europa.eu)

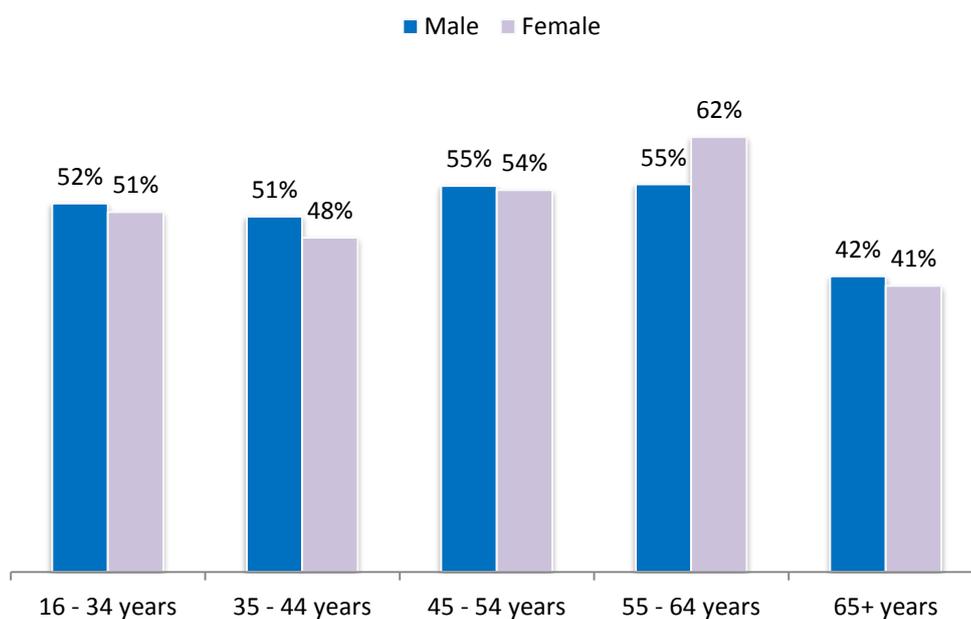
<sup>14</sup> 2013 Jersey Annual Social Survey

Figure 2.1: Self-reported level of physical activity, by gender



Source: JASS 2013

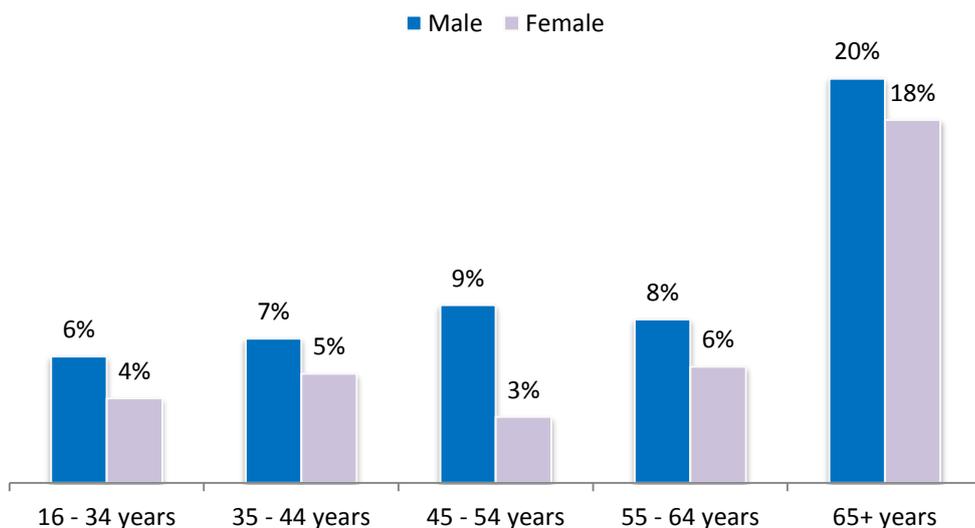
Figure 2.2: How many times in a typical week do you normally undertake moderate intensity sport of physical activity for 30 minutes or longer, proportion doing five or more episodes a week



Source: JASS 2013

Less than one in ten of those aged under 65 reported doing no physical activity; however one in five men aged 65 and over were found to do no episodes a week (Figure 2.3).

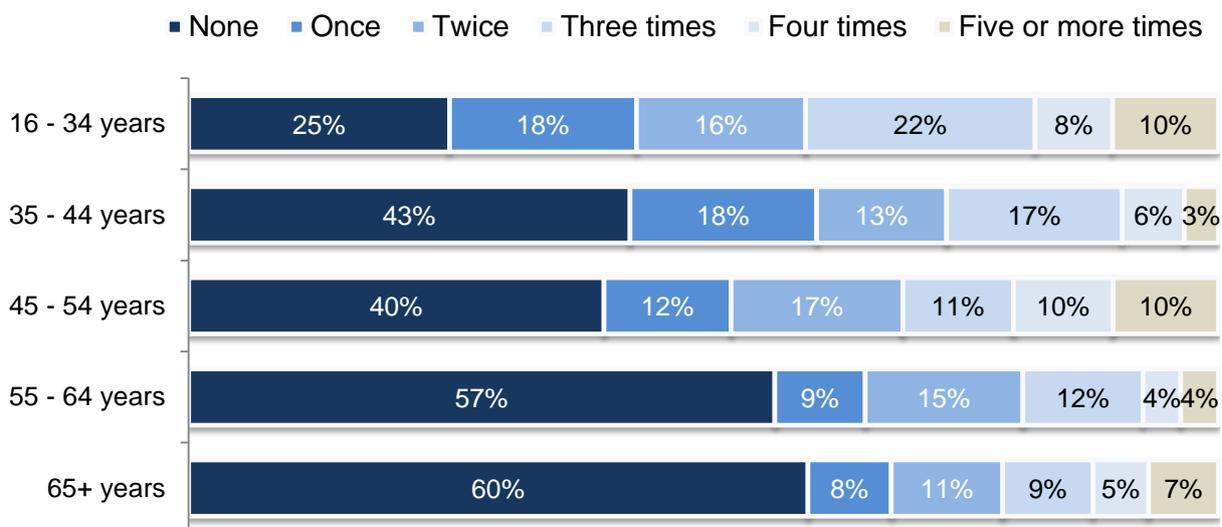
Figure 2.3: Proportion of the population undertaking no moderate intensity activity, by age and gender



Source: JASS 2013

Three-quarters of men aged 16-34 undertake moderate intensity exercise at a sports club or using sports facilities at least once a week (Figure 2.4). Less than half (40%) of older men reported undertaking such exercise. More than two-thirds (70%) of women aged 65 and over reported doing no physical activity at a sports club or using public facilities in a typical week compared with 60% of men in the same age group.

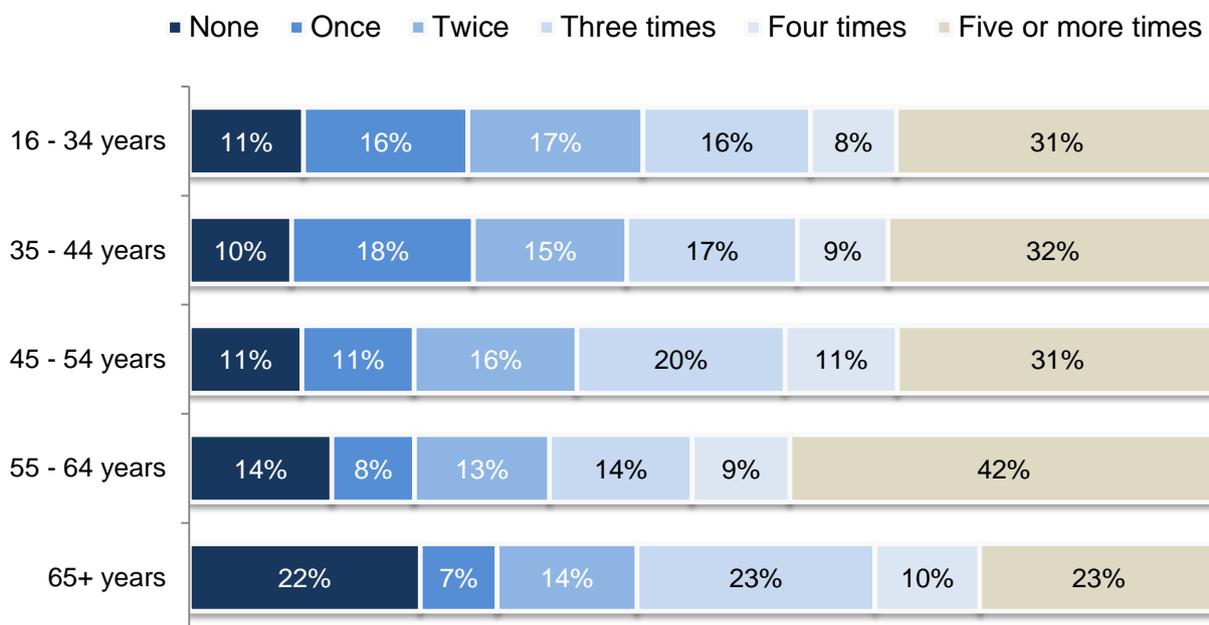
Figure 2.4: How many times in a typical week do you normally undertake moderate intensity sport or physical activity for 30 minutes or longer whilst at a sports club or using public facilities, men by age



Source: JASS 2013

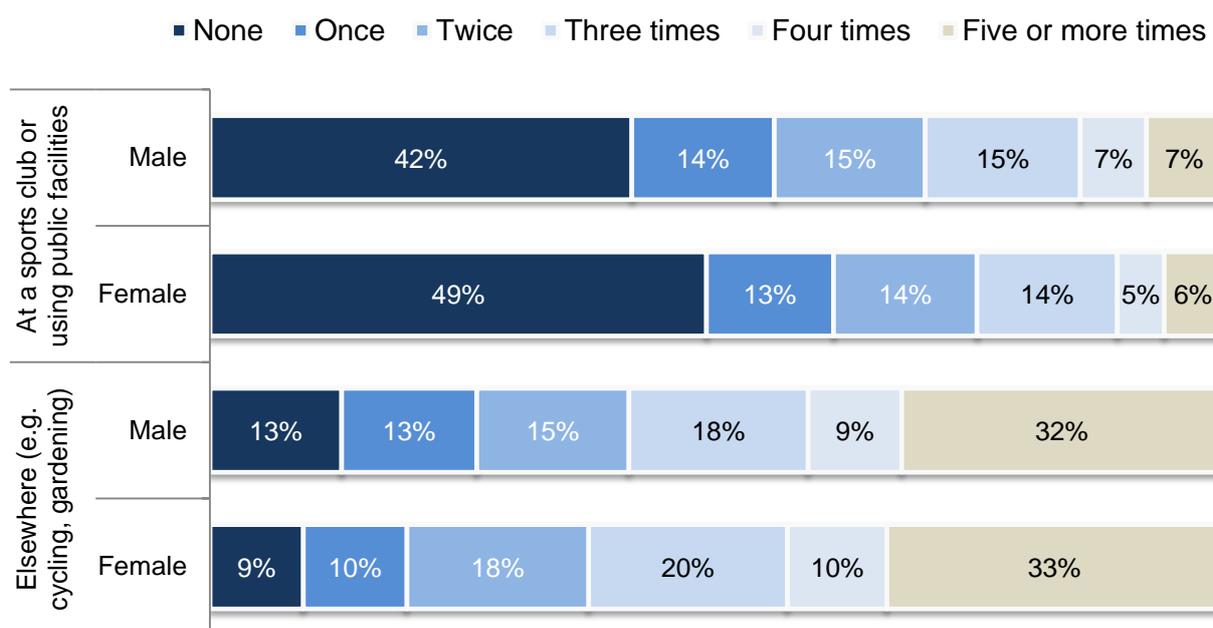
A much greater proportion of men of all ages undertake physical activity outside of organised sport, for instance by cycling to work or heavy gardening. This pattern was similar for females of all ages (Figure 2.6).

Figure 2.5: How many times in a typical week do you normally undertake moderate intensity sport of physical activity for 30 minutes or longer elsewhere (e.g. cycling to work, heavy gardening), men by age



Source: JASS 2013

Figure 2.6: How many times in a typical week do you normally undertake moderate intensity sport of physical activity for 30 minutes or longer, by gender



Source: JASS 2013

## Sports Participation

Information from the Department for Education Sport and Cultures' Sport Development programme shows that for every age group more males than females participate in organised sport.

Table 2.1: Number of participants in affiliated sports in 2012

	Male	Female	Total
Aged 5-11	1,391	347	1,738
Aged 12-18	2,131	350	2,481
Adult	2,740	736	3,476

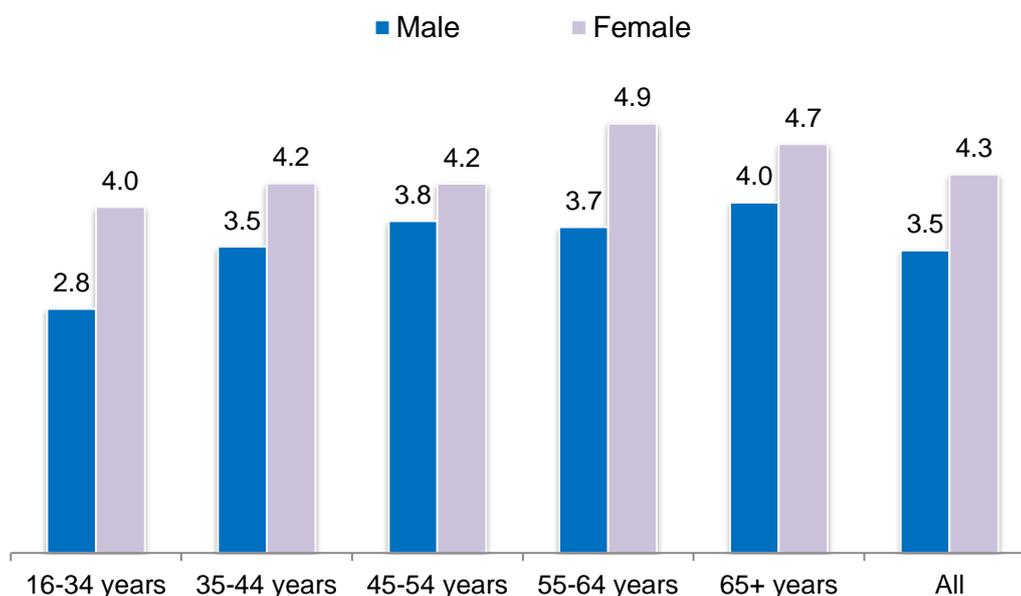
Source: Jersey in Figures 2012

Note: Figures exclude tennis and golf participation

## Diet

Information on the diets of Islanders is limited. However, JASS 2013 found that men were more likely not to eat the recommended five portions of fruit or vegetables daily ([www.nhs.uk/livewell/5aday](http://www.nhs.uk/livewell/5aday)). On average, women in all age groups ate almost a whole portion of fruit a day more than men (Figure 2.7).

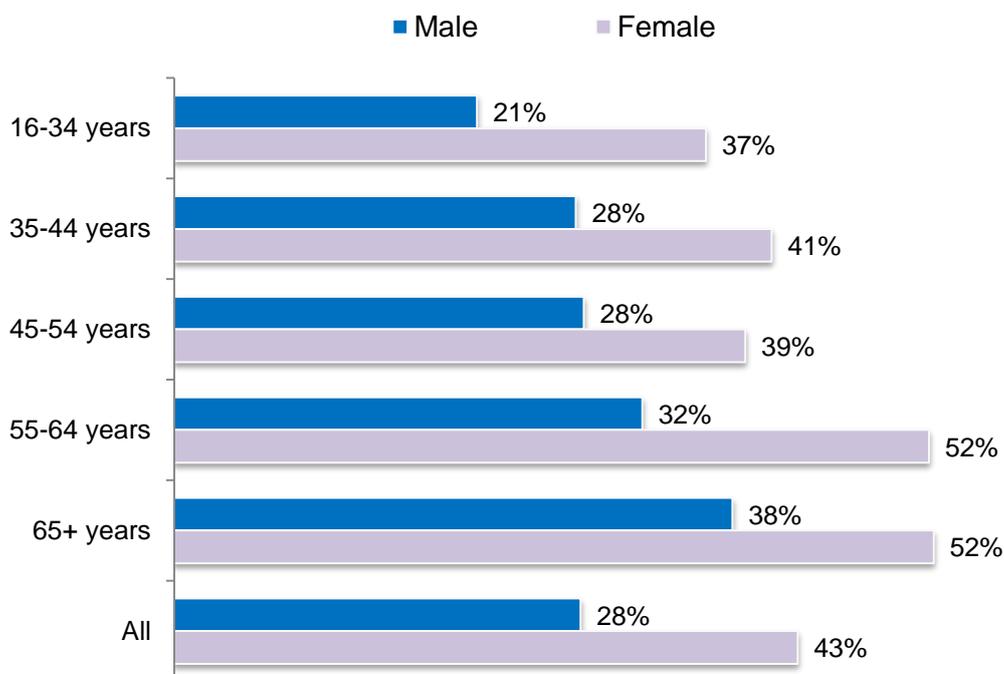
Figure 2.7: Average (mean) number of portions of fruit and vegetables eaten in the previous 24 hours



Source: JASS 2013

Greater proportions of women ate five or more portions in the previous 24 hours than men (Figure 2.8). Only one in five (21%) of men aged 16-34 ate the recommended amount. Eating the recommended portions of fruit and vegetables each day has been linked to lower risks of all-cause mortality, cardiovascular disease, cancer and diabetes.<sup>15,16</sup>

Figure 2.8: Proportion achieving 5 or more portions of fruit and vegetables eaten in the previous 24 hours



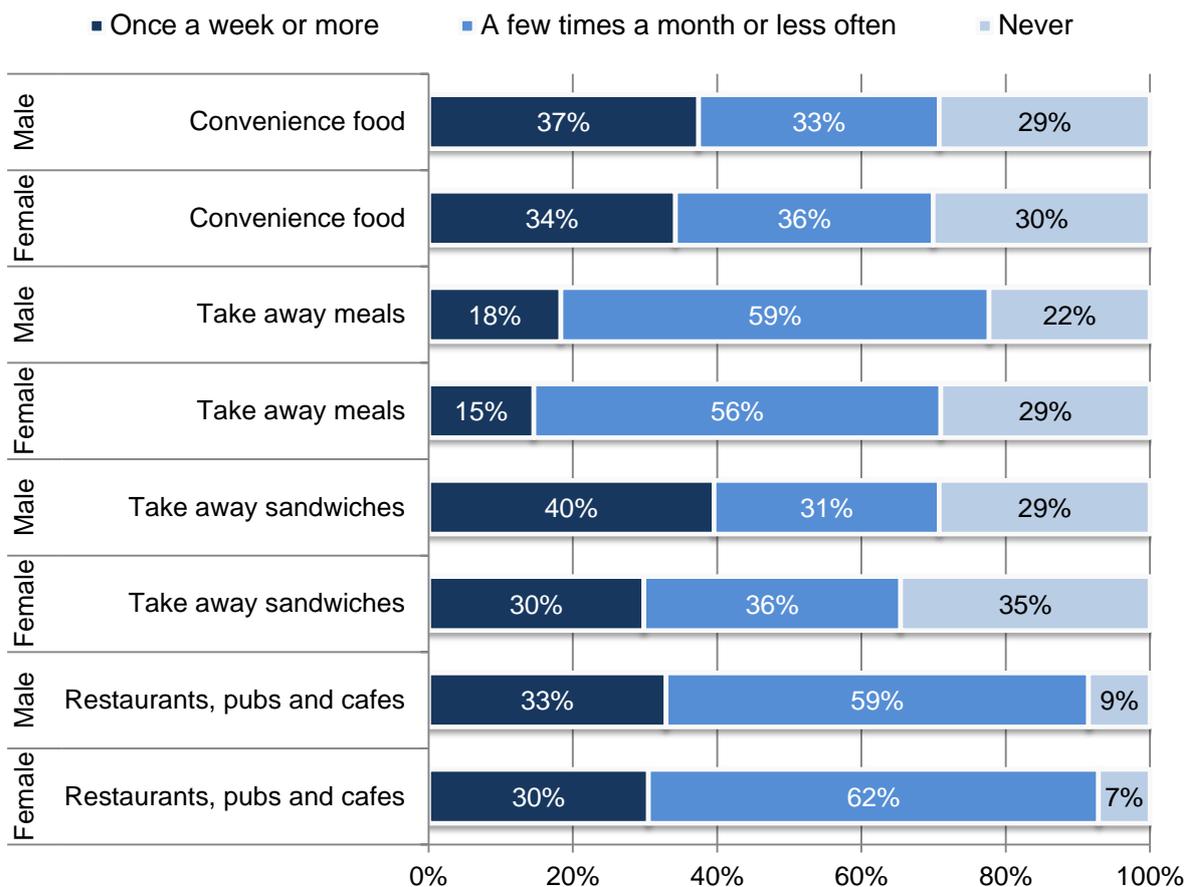
Source: JASS 2013

Men who ate convenience food more frequently were found to eat less portions of fruit and vegetables in the previous 24 hours than those who ate such food a few times rarely or never. A similar pattern was seen for women (Figure 2.9).

<sup>15</sup> Wang X et al (2014). *Fruit and vegetable consumption and mortality from all causes, cardiovascular disease, and cancer: systematic review and dose-response meta-analysis of prospective cohort studies*. *BMJ*. ;349:g4490

<sup>16</sup> World Health Organisation (2014). *Promoting food and vegetable consumption around the world*. Available from <http://www.who.int/dietphysicalactivity/fruit/en/index2.html>

Figure 2.9: How often do you eat the following types of meals?



Source: JASS 2013

## Obesity

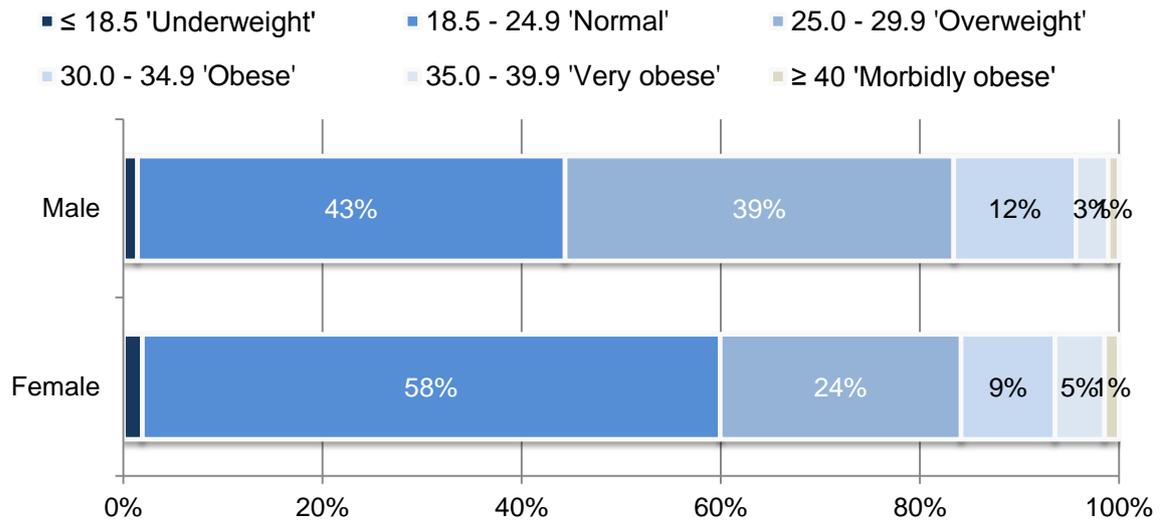
Obesity in men is a key risk factor for a number of health problems, such as type II diabetes, Coronary Heart Disease (CHD), some cancers, stroke and, overall, to a reduced life expectancy. One reason for this is because fat in men tends to be deposited intra-abdominally, leading to a higher risk of the metabolic syndrome.

An increased sedentary lifestyle, longer working hours, less exercise and less manual work have all contributed to an increased number of overweight or obese men in Europe. This is likely to also be the case in Jersey.

In Jersey, around two-fifths (43%) of men have a normal Body Mass Index (BMI)<sup>17</sup>, whilst a similar proportion (39%) are overweight. One in six men in Jersey are obese, very obese or morbidly obese (Figure 2.10).

<sup>17</sup> BMI = weight (in kilos) / square of height (in metres)

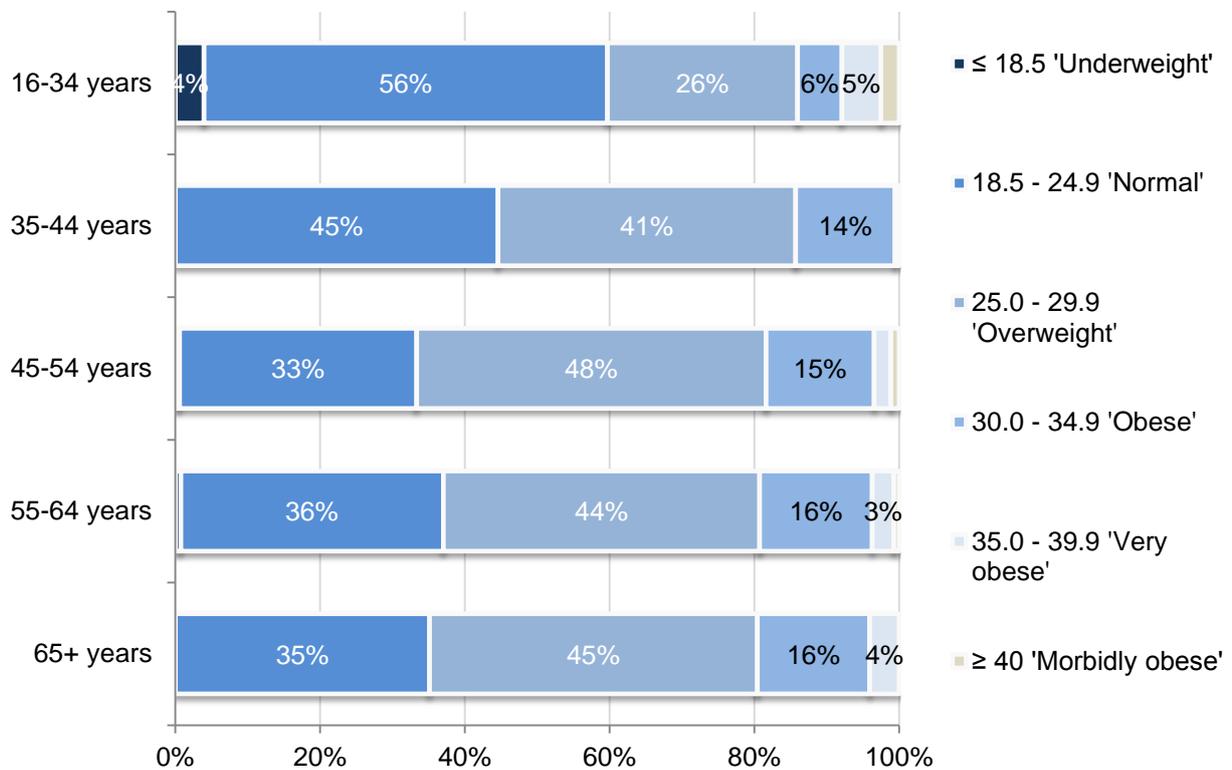
Figure 2.10: Body Mass Index by gender



Source: JASS 2013

Below the age of 45 years, more men have a normal BMI than are overweight; after 45 years of age, only a third of men have a normal BMI (Figure 2.11) whilst more than half are overweight or obese.

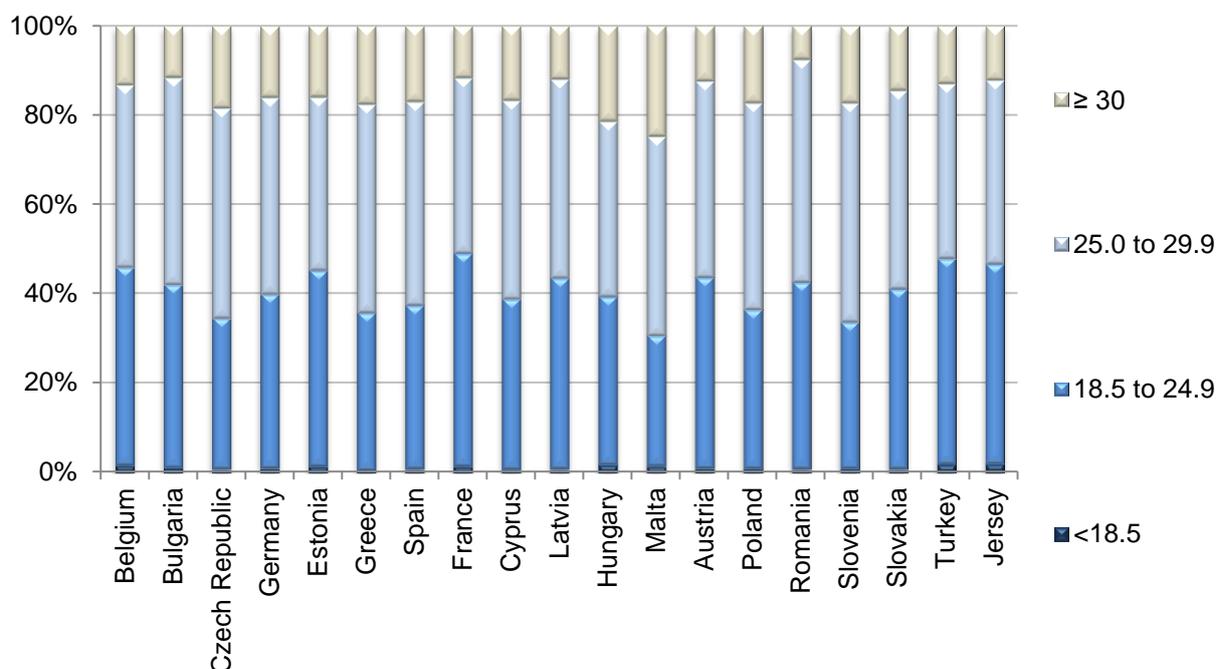
Figure 2.11: Male Body Mass Index by age



Source: JASS 2013

There is academic evidence to suggest that using self-reported height and weight to look at the distribution of BMI amongst populations can lead to an underestimation of actual rates of obesity. Self-reported BMI has been found to be lower than measured BMI more frequently for overweight and obese people, and this under-estimation tended also to be more common in women than men, particularly overweight or obese women.<sup>18</sup>

Figure 2.12: Body Mass Index for males, by country, 2008



Source: JASS 2008 and Eurostat hlth\_ehis\_de1 2008

BMI can classify individuals with a large muscle mass as overweight or obese<sup>19</sup> and so using waist measurements along with BMI can identify the proportion of the population at risk of visceral fat (fat stored intra-abdominally) that can lead to the metabolic syndrome.

Table 2.2 and 2.3 show the distribution for the population of Jersey in 2013. Of those men previously classified as overweight, the majority have a waist circumference less than 94cm, indicating that they are not at risk of cardiovascular disease and diabetes, whilst 5% of men are classified as very high risk.

<sup>18</sup> Akhtar-Danesh et al (2008), *Validity of self-reported height and weight for measuring prevalence of obesity*, Open Medicine; Vol 2 (3): E14-19

<sup>19</sup> UK Faculty of Public Health (2008), *Healthy weight, healthy lives: a toolkit for developing local strategies: Tool E3 Measurement and Assessment of overweight and obesity – Adults*. Available from [www.fph.org.uk](http://www.fph.org.uk)



Table 2.2: Cardiovascular disease risk by waist measurement and BMI, males

BMI		<94 cm	94-102 cm	102+ cm
Underweight	<18.5	2%	0%	0%
Health Weight	18.5-24.9	40%	2%	1%
Overweight (or pre-obese)	25-29.9	29%	7%	3%
Obesity	30+	5%	6%	5%

Source: JASS 2013

Waist measurements for women are slightly different and reflect the difference in storage of fat (Table 2.3). Almost one in ten (9%) of women were at very high risk, while 13% were at high risk.

Table 2.3: Cardiovascular disease risk by waist measurement and BMI, females

BMI		<80	80-88 cm	88+ cm
Underweight	<18.5	2%	0%	0%
Health Weight	18.5-24.9	47%	9%	4%
Overweight (or pre-obese)	25-29.9	6%	10%	11%
Obesity	30+	1%	2%	9%

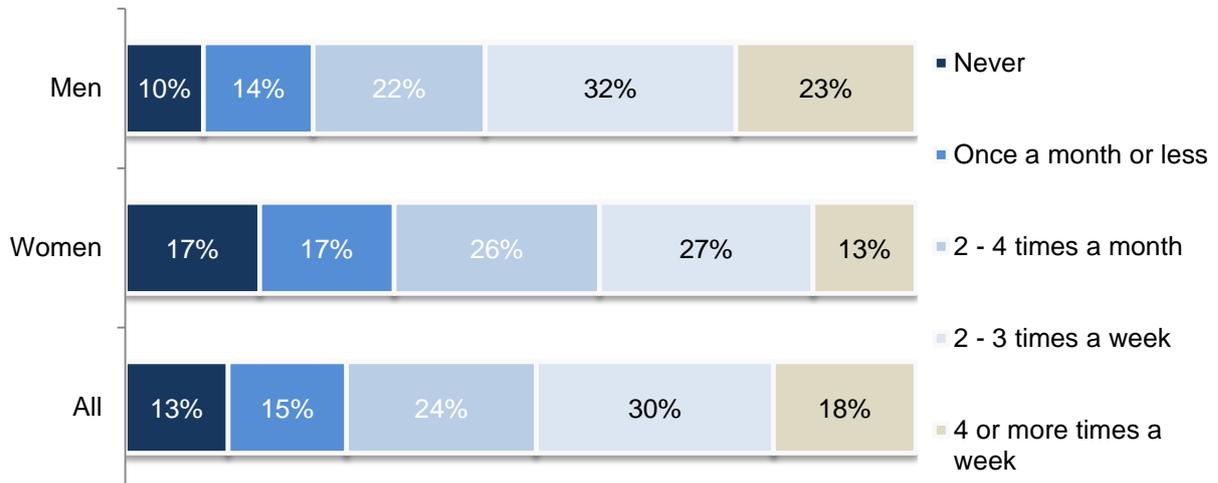
Source: JASS 2013

## Alcohol consumption

Hazardous alcohol consumption and alcohol-related harm are a major public health concern in Jersey. Alcohol has been identified as a causal factor in more than 60 medical conditions.

Nearly a quarter (23%) of men reported drinking on four or more occasions a week in 2012. This compares to around one in seven women (13%).<sup>20</sup> One in ten (10%) men reported never drinking alcohol, while a larger proportion of women (17%) never drink alcohol (Figure 2.13).

Figure 2.13: How often do you have a drink containing alcohol?



Source: JASS 2012

Over half of men aged 16-64 in Jersey are likely to be exceeding recommended daily limits.<sup>21</sup> In all age groups, the proportion of men drinking more than the recommended daily upper limit on at least one day of the week is higher than for women.

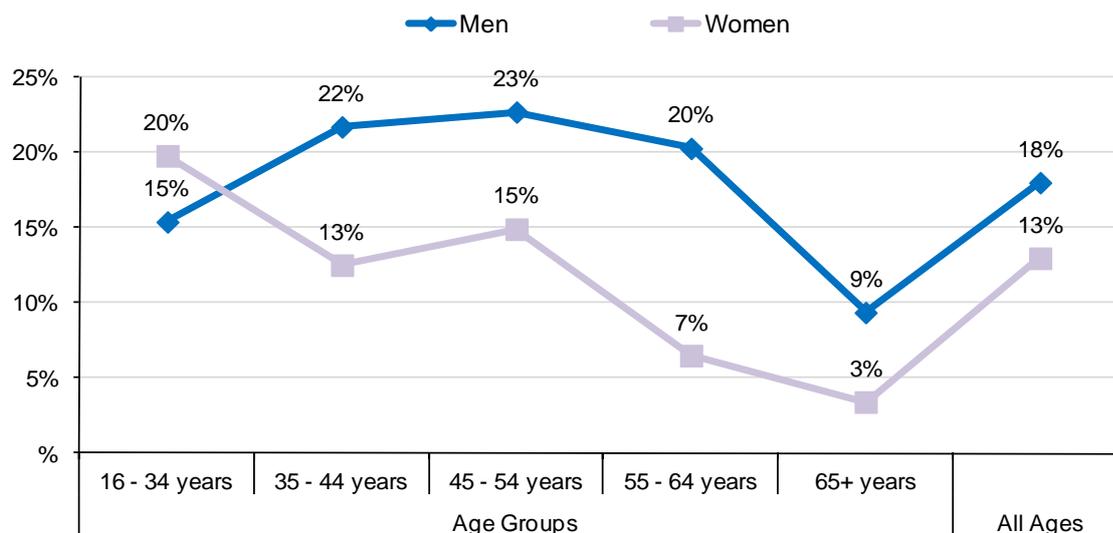
Locally a fifth of men (18%) and one in ten women (10%) are drinking more than double the recommended daily limit in one session at least once per week – binge drinking. This type of drinking increases the risk of being involved in an accident, incident or anti-social related behaviour.

A fifth of men (20%) between 35 and 64 are likely to be drinking at levels harmful or hazardous to themselves. The proportion of women in this age group drinking at such levels is lower. However, more 16-34 year old women (20%) reported negative effects associated with their current drinking behaviour compared to men at this age (15%) (see Figure 2.14).

<sup>20</sup> 2012 Jersey Annual Social Survey

<sup>21</sup> 2010 Jersey Annual Social Survey

Figure 2.14: FAST<sup>22</sup> scores of 3 or more, by age and gender



Source: JASS 2010

## Tobacco Smoking

Action to reduce the smoking of tobacco in the Island has been highlighted as a major priority for reducing preventable deaths in the local population. The proportion of daily smokers in the Island has remained at a fairly constant level since 2008, with just under half of Islanders never smoking.

Table 2.4: Do you smoke? By year, percent

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

Source: JASS 2013

When looking at the differences between males and females in the Island, a larger proportion of women have never smoked (47% compared to 41% of males).

<sup>22</sup> The FAST screening tool is a set of questions used to establish if an individual is drinking harmfully or hazardously (score of 3 or above) and thus likely to have future health issues associated with their drinking.

Figure 2.14: Do you smoke? By gender, percent



Source: JASS 2013

Of those men who do smoke on a daily basis, they tend to smoke more cigarettes per day than women who smoke daily (Table 2.5).

The amount smoked by men and women in Jersey is very similar to that in Europe where the average for male smokers was 15.4 cigarettes per day and the average for female smokers was 12.8 (Eurobarometer Tobacco Report 2012<sup>23</sup>).

Table 2.5: How many cigarettes do you smoke per day? (Average, daily smokers only)

	2012	2010	2008
<b>Men</b>	15	17	16
<b>Women</b>	13	14	13
<b>All daily smokers</b>	14	16	14

Source: JASS 2012

<sup>23</sup> Eurobarometer Tobacco Report 2012, *Attitudes of Europeans towards Tobacco*, Special Eurobarometer 385, European Commission

## Drug Use and Drug-Related Harm

Data on recreational drug use in Jersey is limited. However, data from the States of Jersey Police on the number of convictions reveals that around 90% (2011-2013 average) of all drug-related convictions are of males, some 180 a year, compared with around 20 convictions of females each year.

A report by Imperial College London<sup>24</sup> in 2011 found that around a quarter (27%) of all deaths due to drugs were the result of taking illegal drugs or a mixture of illegal and legal drugs. Between 2004 and 2010, there were around 50 drug-related deaths, of which two-thirds (67%) were male. A larger proportion of the male deaths were due to the consumption of illegal drugs (one in three) compared to female deaths.

In more recent years (2007-2013), drug-related deaths have decreased slightly with 34 deaths that had drugs as an underlying cause<sup>25</sup> of death, but as before the majority (three-fifths) were male.

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<sup>24</sup> Baldwin D, Sinclair J. *Suicide in Jersey 2009*. Faculty of Medicine, University of Southampton, July 2011.

<sup>25</sup> ICD-10 codes X40-X44, X60-X64 and Y10-Y14

CHAPTER  
3

ACCESSING HEALTH SERVICES





- Almost a fifth (18%) of men had not visited the GP in the last 12 months, whilst some 3% were not registered with a GP in Jersey;
- Male hospital episodes for circulatory diseases, cancers, digestive system diseases and diseases of the genitourinary system were higher than episodes for females in Jersey in 2013;
- In 2012 and 2013, more women approached the Help2Quit smoking cessation service, but a higher proportion of men successfully quit than women;
- Men under 45 in Jersey were less likely to use primary health services in the Island than women.

## Summary

The EU Men's Health report<sup>26</sup> concluded that we can learn much about health systems from how men use them, and how they impact on the health of men. It suggested that men's infrequent use of, and late presentation to, health services leads to higher levels of potentially preventable health problems and men having reduced effective treatment options.

Although men and women in Jersey report similar levels of longstanding illness and poor health, men under 45 are less likely than women to visit their GP. In contrast, admissions to hospital are higher for men than for women for all of the principal diseases and health problems. This suggests the need for a targeted approach to encourage men to seek medical advice sooner when they have worrying symptoms.

## Men, Primary Care and Involvement in Health Issues

In Jersey, due to the lack of available data, the actual number of men not registered with a GP is hard to obtain. In future, the GP central server project along with a names and address register will enable this to be ascertained. However, a question was asked in JASS 2013 to estimate the proportion not registered and their reasons for this. Similar proportions

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<sup>26</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

of both men and women reported not being registered with a GP (3% men and 2% women). Of those men not registered, three-fifths (60%) gave their main reason as having no need to because they are generally in good health. Almost a quarter of this group of men (23%) hadn't had time to register, whilst around one in three (30%) couldn't afford to go to the doctor or don't like going (20%).

Almost a fifth (18%) of men reported not having visited the GP in the last 12 months, compared to one in ten (10%) of women answering JASS 2013.

## Are Men 'Healthier' than Women?

Similar proportions of both men and women reported having a longstanding illness, disability or infirmity<sup>27,28</sup> (26% of men, 25% of women), this proportion being similar to that found in the EU (26% of men, 31% of women).<sup>29</sup> Around half (53%) of men aged over 65 years reported a longstanding condition and similar proportions of men and women were being treated for such conditions. Of those with a longstanding illness, disability or infirmity, around 73% of men and 77% of women reported they were receiving long-term medical treatment for the condition. Information on what conditions men were likely to be receiving medical treatment for is not available.

When asked to rate their health on a scale of one to ten<sup>30</sup>, on average men rated their health slightly lower than women (7.3 for men; 7.6 for women) but this difference is not statistically significant (Figure 3.1).

The results from the latest annual social survey would seem to suggest that men in the population report being ill at a similar rate to women, differing from the pattern seen in the EU where men report less ill-health than women.<sup>31</sup> However, caution should be taken when comparing JASS to the Eurobarometer report which uses a face-to-face interview to collect information rather than a voluntary postal questionnaire.

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<sup>27</sup> 2013 Jersey Annual Social Survey

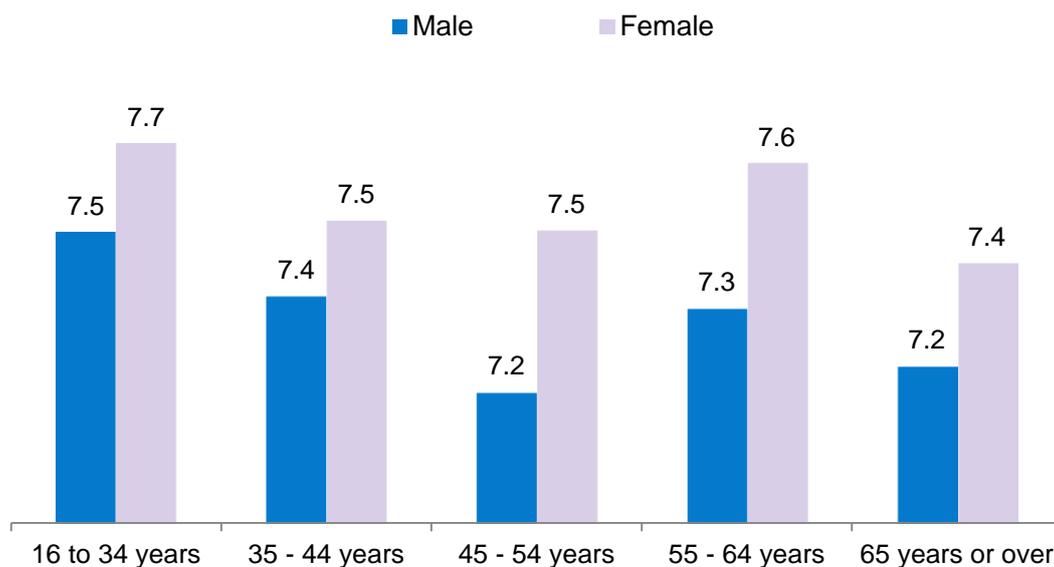
<sup>28</sup> It should be noted that JASS is a voluntary postal questionnaire and as such may prove difficult to complete by individuals who have a longstanding illness, disability or infirmity,

<sup>29</sup> Eurobarometer (2007) Health in the European Union. Special Eurobarometer 272e/Wave 66.2 – TNS Opinion and Social. Available at: [http://ec.europa.eu/health/ph\\_publication/eb\\_health\\_en.pdf](http://ec.europa.eu/health/ph_publication/eb_health_en.pdf)

<sup>30</sup> Where ten is the best imaginable health and one is the worst

<sup>31</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

Figure 3.1: On a scale of one to ten, where ten is the best imaginable health and one is the worst, how good or bad is your own health today? Average rating by age and gender



Source: JASS 2013

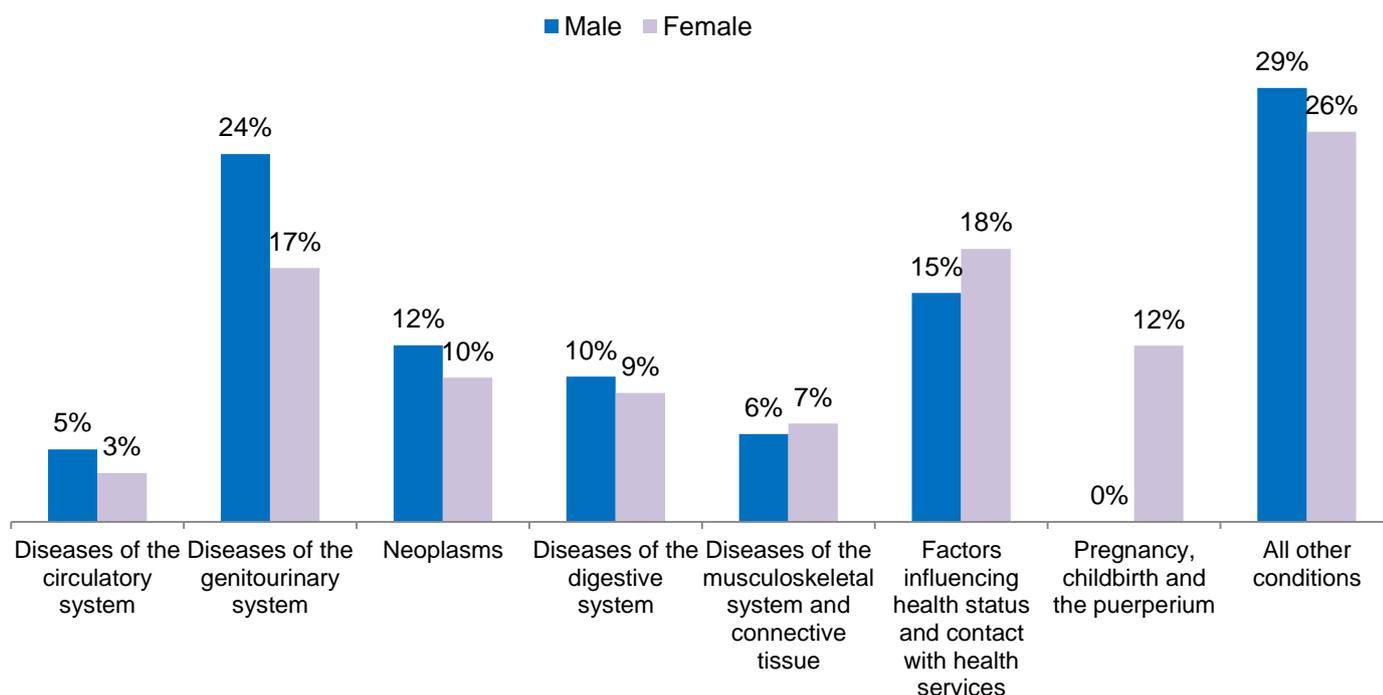
## Hospitals

In total, there were around 15,700 male patient episodes in the Jersey General Hospital in 2013, whilst there were 17,300 female patient episodes.

Male hospital episodes for circulatory diseases, neoplasms (cancers), digestive system diseases and diseases of the genitourinary system were higher than episodes for females (Figure 3.2).

In Europe, the greatest proportion of male admissions are for diseases of the circulatory system, injuries, poisoning & external causes (e.g. accidents and suicide), diseases of the digestive system and diseases of the respiratory system. In Jersey, cancer, along with diseases of the digestive system account for most male admissions.

Figure 3.2: Diseases as a percentage of all episodes, primary reported diagnosis code by gender, 2013



Source: Hospital Episode Data (excluding day surgery and renal unit), Health Intelligence Unit

## Preventative Health

Information on preventative health steps taken by men in the Island is limited. With the introduction of a new GP computer system in 2014, information about the number of men who have had a heart check-up, blood pressure test or cholesterol test in the community will become accessible.

Women were more likely to have visited an optician in the last 12 months (58% vs. 46%) or visited a chiropodist (15% vs. 6%).<sup>32</sup> Women were also found to be more likely to have consulted a pharmacist for advice on health-related issues, including how to manage medicines over the previous 12 months (41% vs. 28%).<sup>33</sup>

Similar proportions of men and women reported using general internet searches for health information and information about specific symptoms but a greater proportion (55%) of men hadn't used any source for information about specific symptoms<sup>34</sup> as shown in Table 3.1.

<sup>32</sup> 2009 Jersey Annual Social Survey

<sup>33</sup> 2009 Jersey Annual Social Survey

<sup>34</sup> 2013 Jersey Annual Social Survey

**Table 3.1: Have you used any of the following internet or telephone services to find out...**  
(Respondents were able to tick more than one method)

	...general health information		...information about specific symptoms	
	Male	Female	Male	Female
General internet search	35%	40%	36%	42%
UK Government website (e.g. NHS)	14%	17%	12%	16%
Another website you trust for health queries	12%	15%	11%	15%
States of Jersey website (www.gov.je)	8%	8%	4%	2%
Health advice phone line	1%	2%	0%	2%
Online medical diagnosis service (where you post a message to a doctor)	N/A	N/A	2%	2%
None	52%	49%	55%	46%

Source: JASS2013

The Jersey smoking cessation service, Help2Quit, offers information, support and nicotine replacement therapy free of charge to Islanders. In 2012 and 2013, a greater number of women approached the service and set a quit date than men. Of those men that had connected with the service and set a quit date, around two-fifths (44% in 2012 and 35% in 2013) successfully quit compared to around a third of women using the service (38% in 2012 and 31% in 2013).

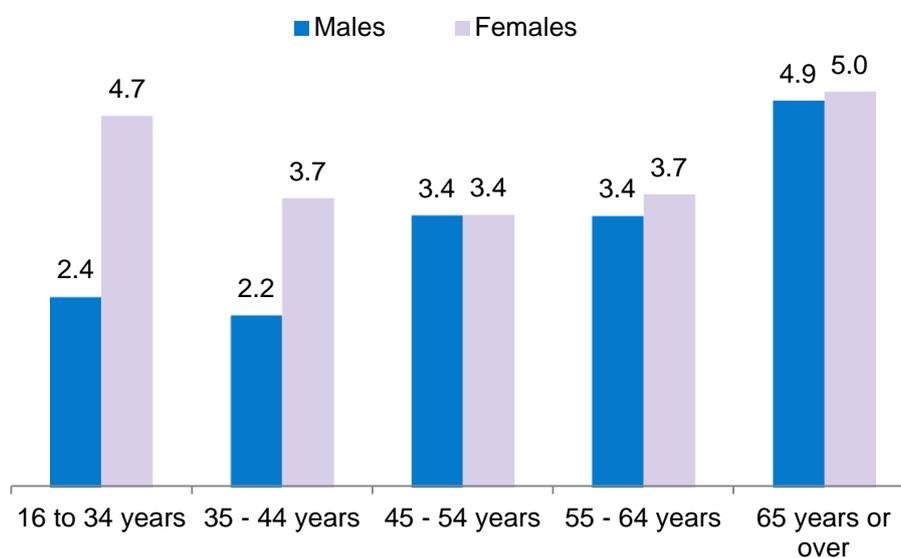
A free heart screening event held in the General Hospital in 2013 attracted almost 1,000 people, only a third of which were male. 23 people attending this event were found to have a previously unknown abnormality, comprising similar proportions of men and women.<sup>35</sup>

<sup>35</sup> Mitchell AR, Le Page P, MacLachlan H, Anderson L, Penn P, Moss A. The efficacy of a smartphone electrocardiogram application for cardiac screening in 1% of an unselected island population. *Europace* 2014 16 (suppl 2): ii39

## Men's Usage of Primary Health Services

Men under 45 in Jersey were less likely to use primary health services in the Island than women.<sup>36</sup> Over 45 years of age, the proportions visiting a GP are similar for men and women (Figure 3.3). When looking at differences between groups of men, employed men visited the GP fewer times (2.6 visits) than those unemployed and looking for work (3.9 visits) and non-economically active men (4.4 visits). Men who reported having no educational qualifications or other qualifications attended the GP on average more than those educated to secondary level (3.8 compared to 3.1 visits) and more than those with higher qualifications (2.6 visits). Similar patterns were seen for females.

Figure 3.3: Average number of visits to the GP in the last 12 months, 2013



Source: JASS 2013

<sup>36</sup> 2013 Jersey Annual Social Survey

CHAPTER  
4

HEALTH STATUS





- Men and women report a similar overall health status; with some four-fifths describing their health as good or better;
- Similar proportions of both men and women reported having a longstanding illness, disability or infirmity (26% of men, 25% of women);
- Baby boys born in Jersey in 2012 can expect to live to 79 years of age. However, life expectancy for women is some five years longer;
- Around a quarter (24%) of male deaths occur in the working age group (15-64), compared with around 1 in 6 of all female deaths in the working age group;
- On average around 120 male deaths a year would be considered avoidable, compared to 70 female deaths;
- Over 2,000 male years of potential life (below 75 years of age) are lost on average each year;
- 1 in 5 (21%) of all male deaths were smoking-related, this compares to 1 in 7 (13%) of all female deaths.

## Summary

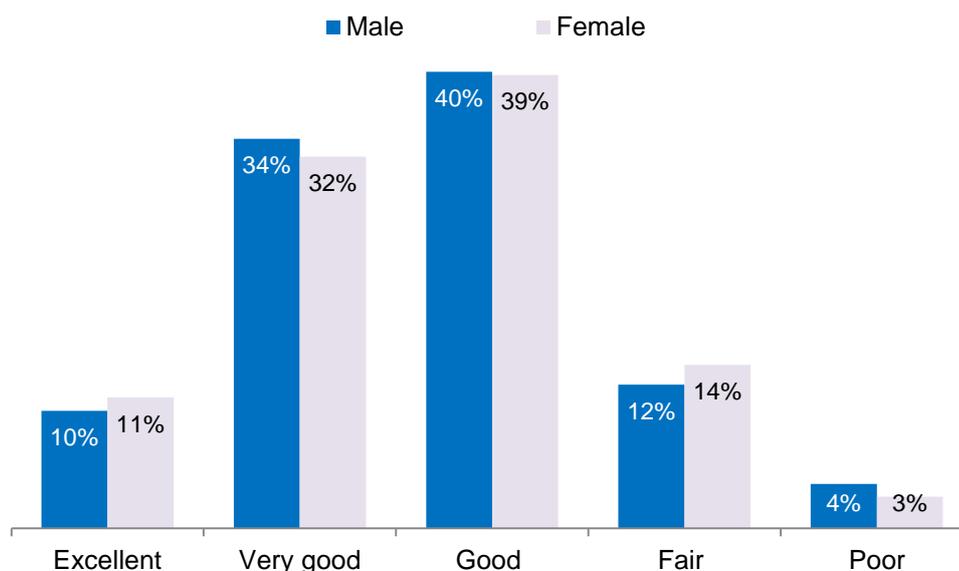
Although overall life expectancy for men in Jersey is higher than the European average and is increasing, life expectancy has always been lower for men than for women. Women are likely to live five years longer than men. One in four of all male deaths in Jersey occur in the 15-64 age range, compared with one in six of all female deaths. Around 90 male deaths occur annually in working age men (under 65). A greater number of male deaths are smoking-related, whilst males accounted for almost three-quarters of all alcohol-related deaths in the Island.

The biggest challenge facing men with regard to the mortality figures is in relation to their higher levels of premature death.

## Self-Perceived Health Status

There is little difference between male and female self-reported health status (within the confidence intervals of JASS), despite the higher levels of premature deaths in men. Four-fifths of both men and women describe their health as good or better (Figure 4.1).

Figure 4.1: In general, how would you rate your health?



Source: JASS 2013

## Self-Reported Chronic Morbidity

Men and women in Jersey report similar levels of chronic morbidity. Around a quarter (26% of men and 25% of women) reported having a longstanding illness, disability or infirmity in 2013.<sup>37,38</sup> A slightly greater proportion of men over 65 years of age reported a long-standing condition (53%) compared to women of this age (47%) (Figure 4.2).

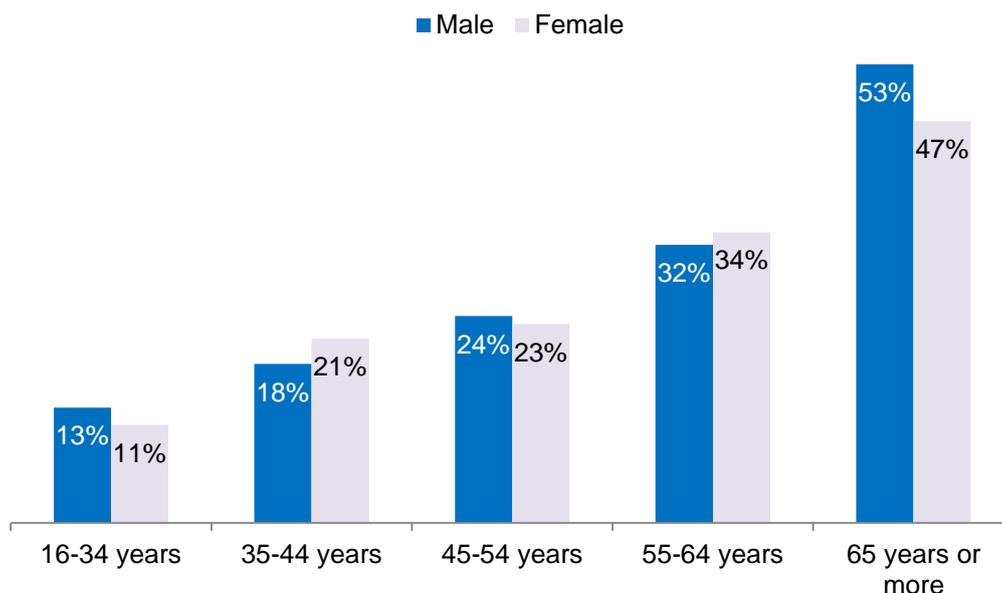
A fifth (20%) of both men and women reported that their long-standing condition limited their day to day activities 'a lot', whilst half (48% of men and 52% of women) said it affected their day to day activities 'a little'.

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

<sup>37</sup> 2013 Jersey Annual Social Survey

<sup>38</sup> It should again be noted that a voluntary postal questionnaire such as JASS will have a lower response rate from persons who are unable, due to ill health, to answer the survey and as such will provide an underestimate of the prevalence of ill health in the population.

Figure 4.2: Percentage who have a self-reported longstanding illness, disability or infirmity? By age and gender



Source: JASS 2013

## Life Expectancy

In Jersey, life expectancy<sup>39</sup> for men was 79 and 84 for women in 2012. This is a difference of some five years (Table 4.1). Across Europe, men are expected to live to 77.5, with women living an extra 5.6 years above this (female life expectancy is 83.1 in Europe). Male life expectancy in Jersey is 1.7 years greater than the average for their counterparts in the EU.

Table 4.1: Life expectancy 2012

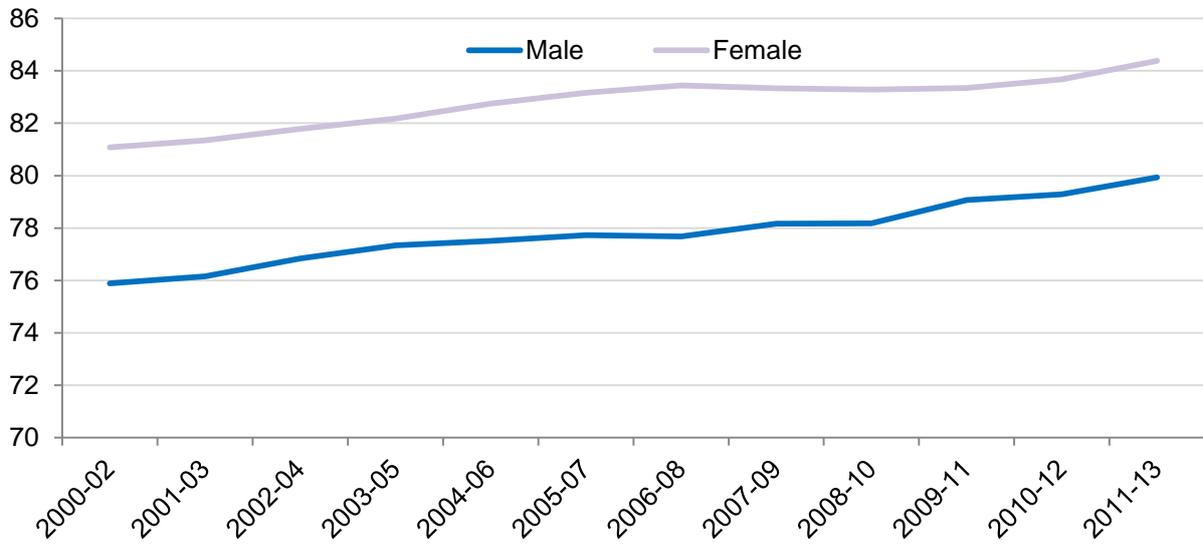
		Males	Females
At Birth	Jersey	79.2	84.0
	Europe (28 countries)	77.5	83.1
At 65	Jersey	19.2	21.5
	Europe (28 countries)	17.7	21.1

Source: HIU and EuroStat tsdph220, tsdph100

<sup>39</sup> 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.

Since 2000, there has been a small incremental increase in life expectancy for both men and women over time in Jersey.

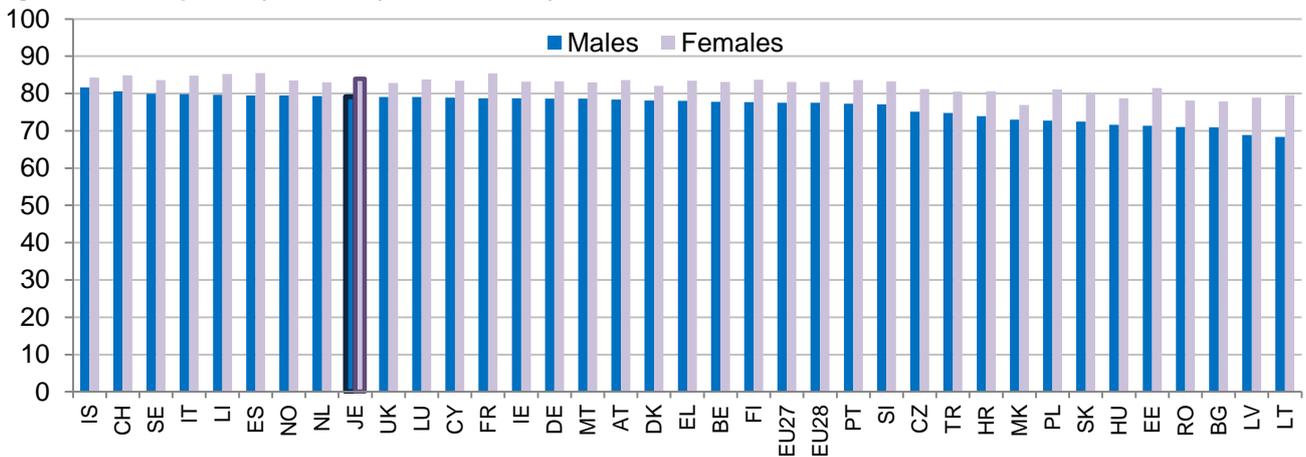
Figure 4.3: Change in Life Expectancy over time



Source: HIU

Compared to Europe (Figure 4.4 and 4.5) Jersey is among the countries with the highest life expectancy for both men and women at birth and at 65 years of age.

Figure 4.4: Life expectancy at birth, by sex and country, 2012

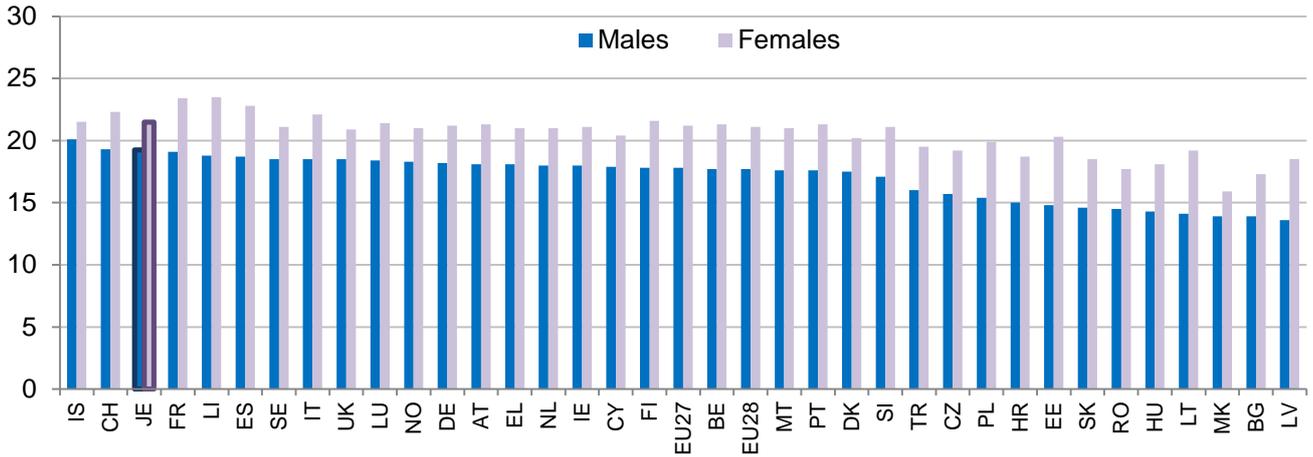


Source: HIU and EuroStat tsdph100

Life expectancy changes for those at older ages, as each year of survival improves the expectancy of a longer life.

In Jersey, men reaching 65 years of age can expect to live a further 19.2 years and women a further 21.5 years.

Figure 4.5: Life expectancy at age 65, by sex and country, 2012

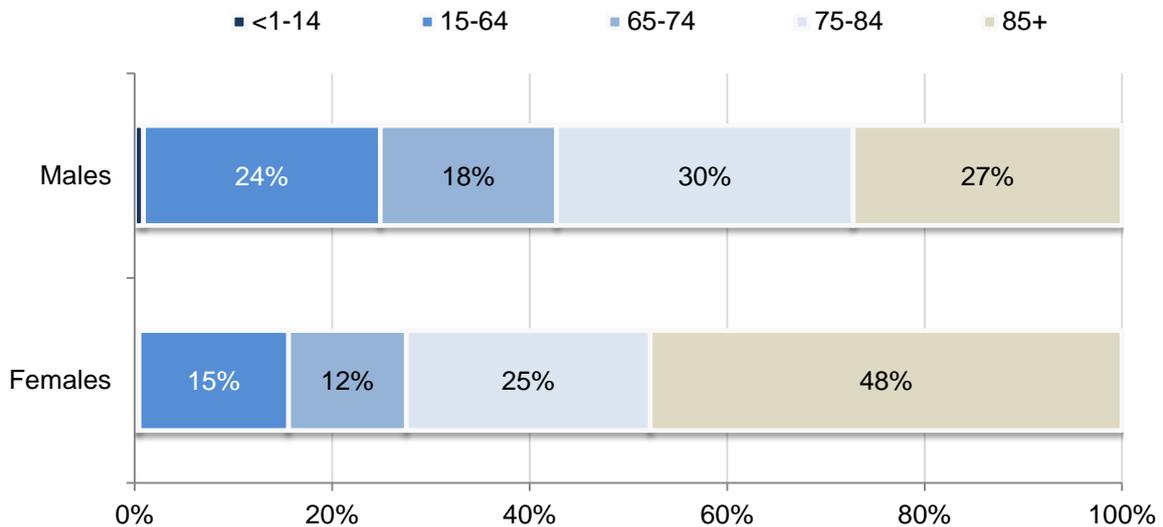


Source: HIU and EuroStat tsdph220

## Male Mortality across the Lifespan

In Jersey, around 90 men die each year below the age of 65, compared to around 60 women. The majority of these deaths occur in the working age population.

Figure 4.6: Proportion of deaths across age groups, 2011-2013

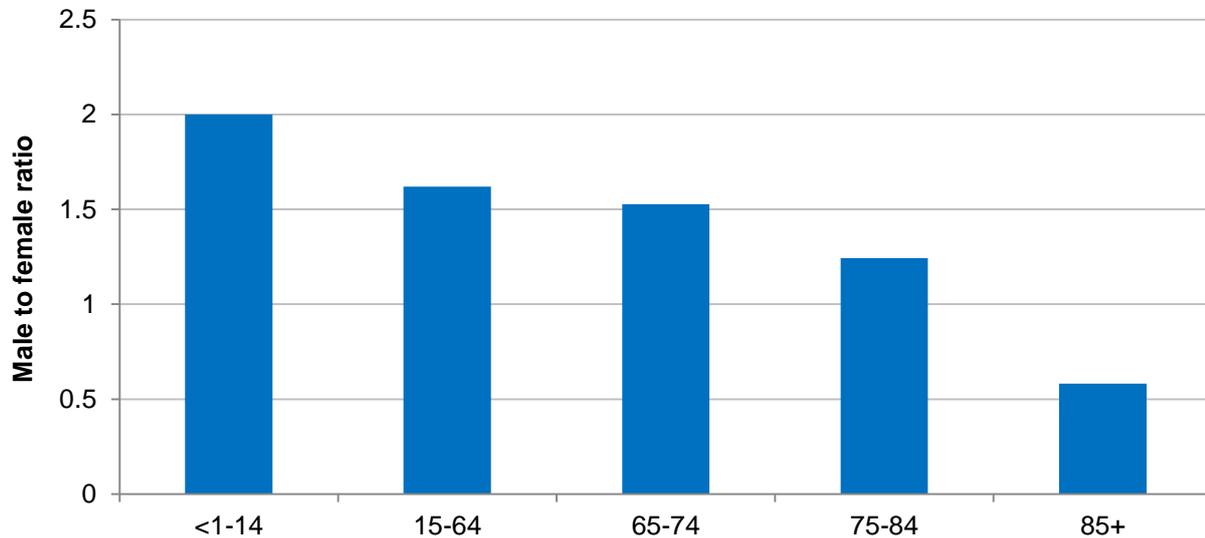


Source: Health Intelligence Unit

When the number of deaths in the working age population is compared to the total number of deaths, one in four of all male deaths occur in the 15-64 age range, compared to one in six of all female deaths (24% and 15%, respectively).

At older ages, male deaths on average outnumber female deaths between ages 65 to 84 years each year. A higher proportion of all female deaths occur after 85 years of age (48%) compared with 27% of male deaths.

Figure 4.7: Sex ratio of the total number of deaths, by age, 2011-2013

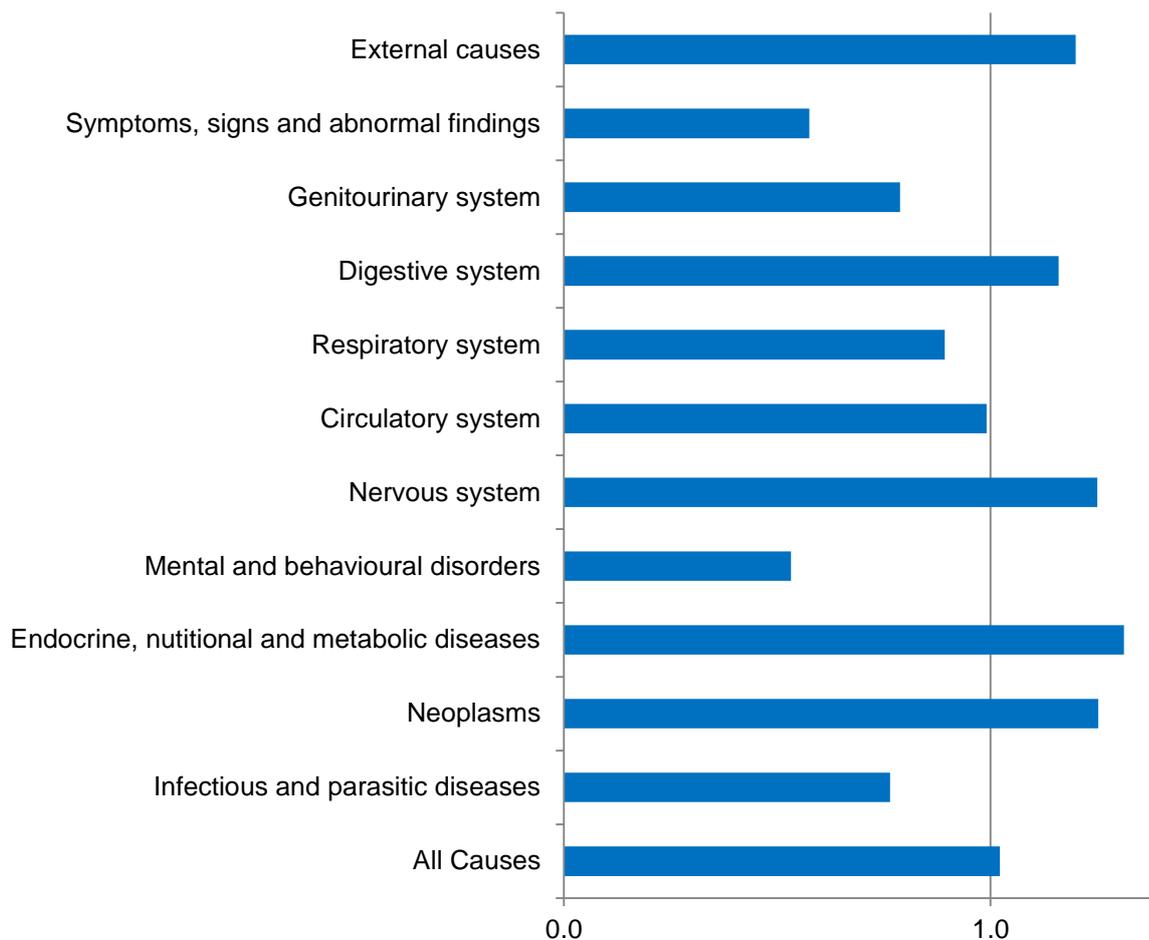


Source: Health Intelligence Unit

## Overall Burden of Disease

There is a difference in the diseases that cause the most deaths in men and women. Figure 4.8 shows that there is a higher burden of male deaths from external causes, digestive and nervous system, cancers, and 'endocrine, nutritional and metabolic diseases'. Conversely there were more female deaths from mental and behavioural disorders (e.g. dementia), respiratory system, genitourinary system and 'infectious and parasitic diseases'. Roughly similar numbers of male and female deaths were due to circulatory system diseases, although more men die from coronary heart disease whereas more women die from cerebrovascular disease (stroke).

Figure 4.8: Sex rate ratio of deaths, main classification groups, 2011-2013

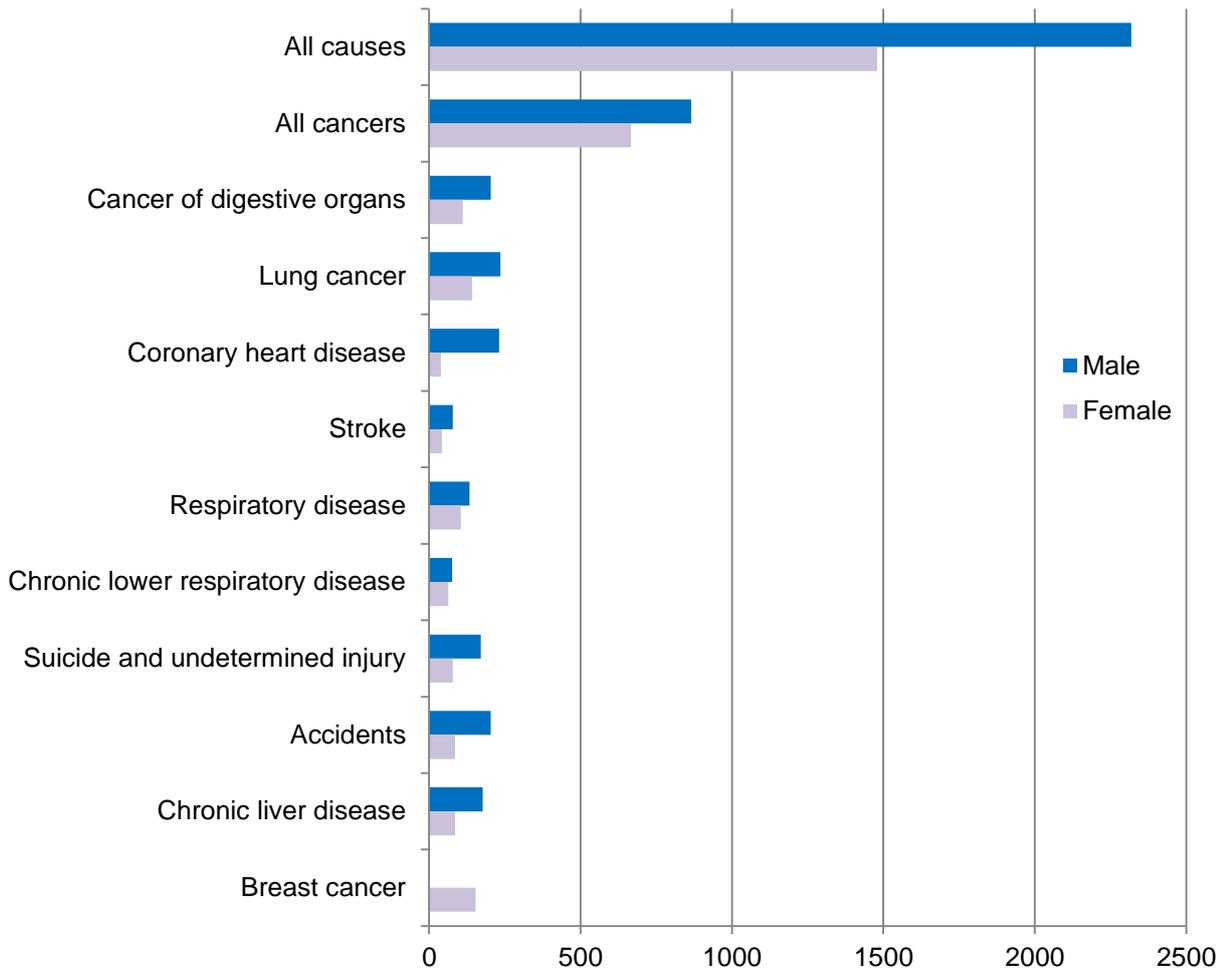


Source: Health Intelligence Unit, where there were more than 10 deaths over 3 years

Differences in mortality between men and women are evident when the burden of disease in those below 75 is examined. The potential years of life lost indicator<sup>40</sup> shows that men account for the greatest number of years lost across the main disease groups (Figure 4.9).

<sup>40</sup> Potential years of life lost (YOLL) 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.

Figure 4.9: Actual potential years of life lost, certain classifications, annual average 2011-2013



Source: Health Intelligence Unit

## Avoidable Mortality

On average around 120 male deaths in Jersey each year would be considered avoidable<sup>41</sup> (either preventable, through public health interventions or amenable to health care). This compares to around 70 female deaths. Those deaths considered preventable in the light of understanding of the determinants of health at the time of death (through public health interventions in the broadest sense) account for around 100 and 60 male and female deaths, respectively (annual average 2010-2012).

<sup>41</sup> The ONS definition of Avoidable deaths: are all those defined preventable, amenable, or both, where each death is counted only once. Where a cause of death falls within both preventable and amenable definition, all deaths from that cause are counted in both categories when they are presented separately.

## Smoking and Drinking-Attributable Deaths

Estimates of the number of deaths each year due to smoking and drinking are useful indicators of the harm these lifestyle choices are having. Table 4.2 presents the number of male and female deaths (annual average 2010-2012) and the proportion of this burden male deaths contribute.

**Table 4.2: Smoking and drinking-attributable deaths, annual average 2010-2012**

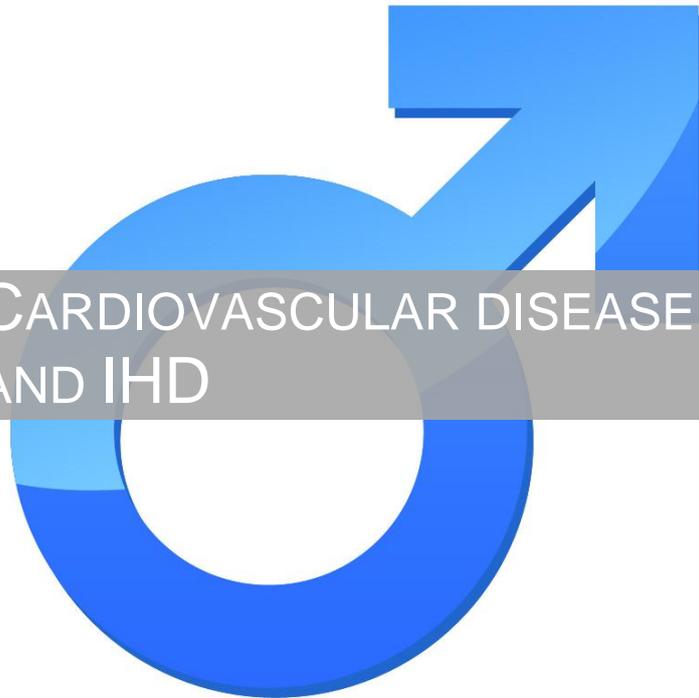
	Male Deaths	Female Deaths	Proportion that are male
Smoking	80	50	63%
Drinking	10	<5	72%

Data round to nearest 10  
Source: Health Intelligence Unit

One in five (21%) of all male deaths were smoking-related. This compares to one in seven (13%) of all female deaths.

CHAPTER  
5

CARDIOVASCULAR DISEASE, STROKE  
AND IHD





- There have been marked reductions in mortality from cardiovascular diseases. Nevertheless, Cardiovascular Disease (CVD) is still one of the biggest risks to men's health and in the older population it is the principal cause of death;
- CVD accounts for over 100 male deaths a year in Jersey (27% of all male deaths);
- Ischaemic Heart Disease (IHD) is responsible for around half of these (50 male deaths a year), about 13% of all male deaths in the population;
- Cerebrovascular disease (stroke) constitutes around 7% of annual male death, around 30 deaths per year.

## Summary

Cardiovascular Disease (CVD), also known as circulatory disease, is one of the biggest risks to men's health. The European Men's Health Report<sup>42</sup> found a decline in CVD in both sexes and all age groups in most countries of Western Europe since the beginning of the 1970s and in Eastern Europe since the 1990s. The reduction in smoking prevalence in the male population in some EU countries since the 1960s is an important factor for the decrease in male cardiovascular mortality.

Although there have been great improvements in cardiovascular health, marked differences exist between different parts of the EU, ranging from 61% of total male deaths in Bulgaria to 25% in France. The European Men's Health Report<sup>43</sup> also highlights inequalities within countries, with a significant degree of social stratification for CVD seen.

Jersey compares favourably with many European countries, whilst exhibiting similar patterns to much of Western Europe. For instance, like many Western European countries, CVD is increasingly the principal cause of death for the older population. In Jersey, CVD accounts for one in five male deaths below 75 years of age and around one in three deaths in those over 75.

The single most important, as well as avoidable, cause of poor cardiovascular health in Europe is smoking.

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<sup>42</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

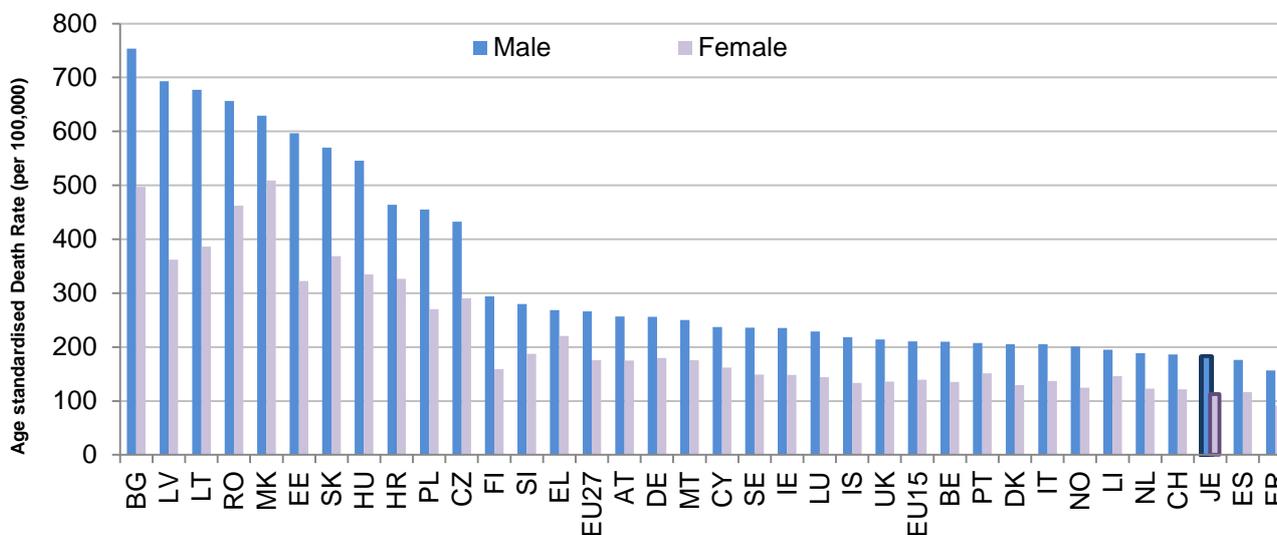
<sup>43</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

## Cardiovascular Disease (CVD)<sup>44</sup>

In Jersey, cardiovascular disease is the second biggest killer of men, after cancer, resulting in just over 100 male deaths each year. Ischaemic Heart Disease (IHD) accounts for around 50 of these deaths (13% of all male deaths) and cerebrovascular disease (mainly stroke) accounts for a further 30 male deaths a year (7% of all male deaths). CVD kills similar numbers of women to cancer, around 100 deaths annually. However, within CVD there are a greater proportion of female deaths from stroke (around 40 deaths a year) compared to deaths from IHD (around 30 deaths), a different pattern to that seen in men.

In Europe, there is a correlation between educational attainment and cardiovascular health, with the risk of mortality from cardiovascular disease up to six times higher in those without a university degree.<sup>45</sup> Smoking is the single most preventable cause of poor cardiovascular health, although obesity has also been linked to poor heart health through the metabolic syndrome which is characterised by increased cholesterol, hypertension and diabetes mellitus (type II).

Figure 5.1: Age-standardised Death Rate (average 2008-2010) for CVD, by sex and country, all ages



Source: Eurostat hlth\_cd\_asdr 2008-2010 and Health Intelligence Unit

Premature deaths (those deaths under 75 years of age) from cardiovascular diseases in Jersey rank amongst the highest of the English regions when compared to Public Health

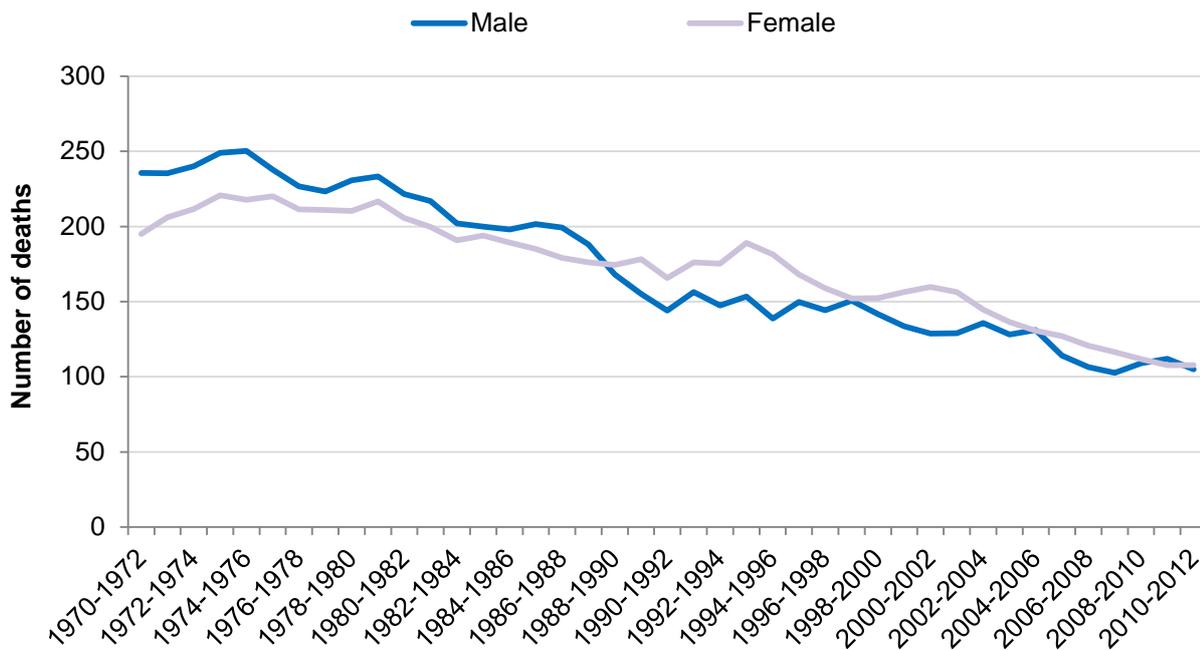
<sup>44</sup> Cardiovascular disease (CVD) includes all the diseases of the heart and circulation including coronary heart disease (angina and heart attack), and stroke. Also referred to as diseases of the circulatory system or circulatory diseases. ICD-10 Codes I00-I99.

<sup>45</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

England's Longer Lives tool.<sup>46</sup> However, the death rate for males in the Island is double that for females dying prematurely from cardiovascular diseases.

Decreasing mortality due to CVD has been seen since the 1960s in Europe. Data for Jersey from 1970 onwards suggests a similar pattern is being observed in the Island, with the number of CVD deaths decreasing in both men and women by around half since the 1970s.

Figure 5.2: Number of CVD deaths annually (3 year averages), all ages



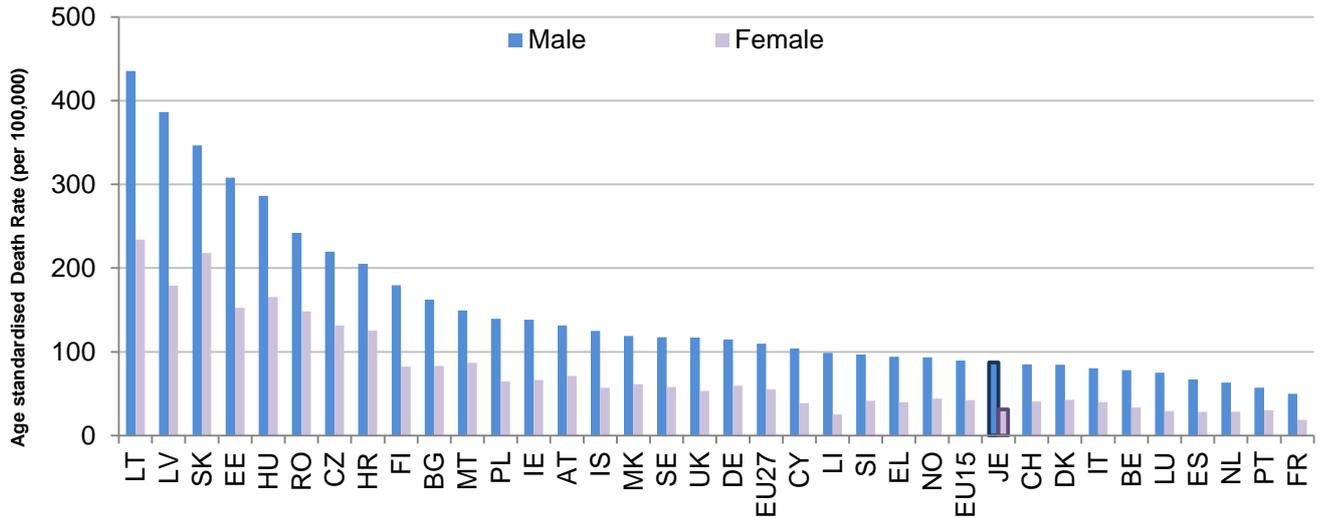
Source: Health Intelligence Unit

## Ischaemic Heart Disease

Around 50 men die annually from Ischaemic Heart Disease (IHD), compared to around 30 women, constituting around 13% of all deaths in men and 9% in women (2010-2012). In Europe, IHD accounts for a similar proportion of all male deaths (15%). In Jersey, this disease resulted in a total of 220 years of life lost in men annually, compared to around 40 for women over the same period (2010-2012). This makes IHD the third-most predominant cause of premature death in men after cancer of the respiratory and intrathoracic organs (predominantly lung cancer) and cancer of the digestive organs (mainly colorectal, pancreatic and oesophageal). The age-standardised rate for men was 80 per 100,000 male population (average 2010-2012) compared to 34 per 100,000 female population for the same period. This shows IHD affects a larger proportion of men in the Island.

<sup>46</sup> For further information, see Premature Deaths of Jersey Residents 2010-2012, Health Intelligence Unit, April 2014, available from [www.gov.je](http://www.gov.je)

Figure 5.3: Age-standardised Death Rate (average 2008-2010) for IHD, by sex and country, all ages

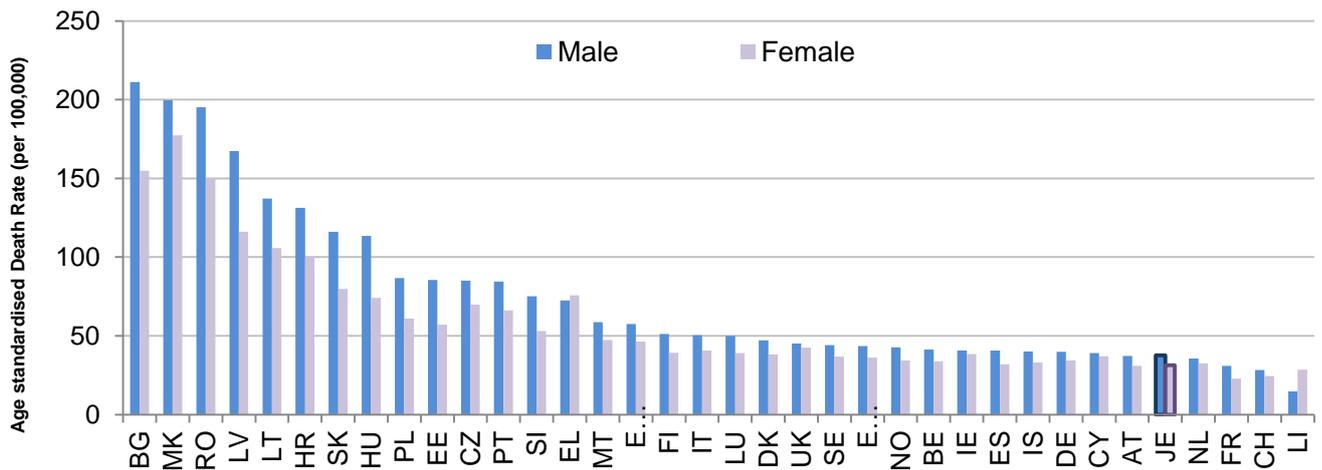


Source: Eurostat hlth\_cd\_asdr 2008-2010 and Health Intelligence Unit

## Cerebrovascular Disease (Stroke)

Cerebrovascular disease (stroke) causes slightly more deaths in women than men each year. Around 30 men and 40 women die from this disease annually (average 2010-2012), 7% and 9% of all deaths within each gender, respectively. The age-standardised rate for deaths for men was 45 per 100,000 and 32 per 100,000 for women (average 2010-2012).

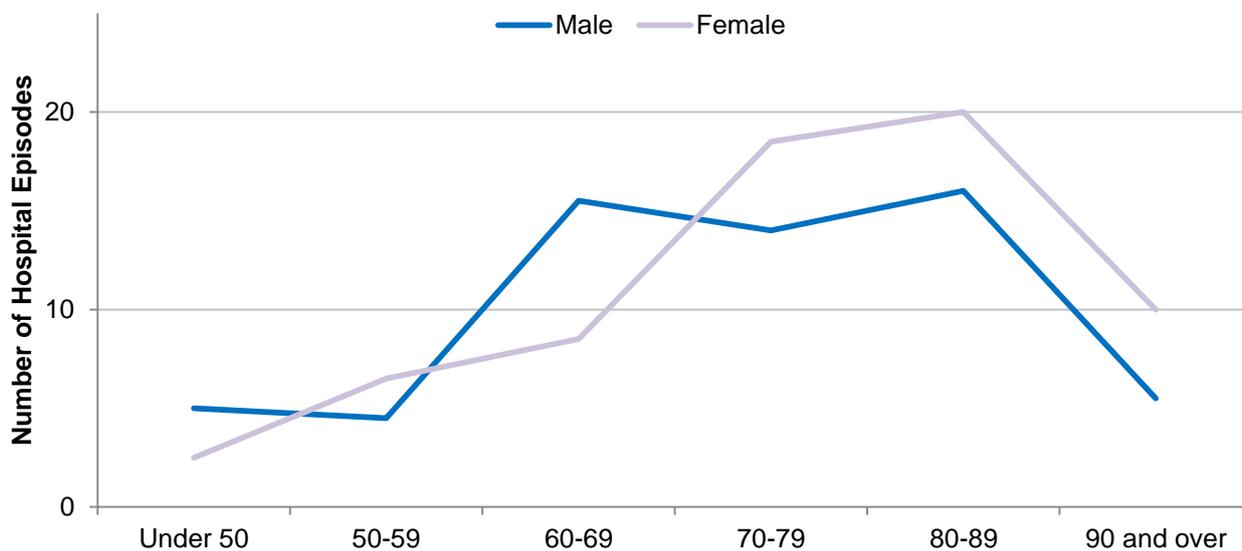
Figure 5.4: Age-standardised Death Rate (average 2008-2010) for Cerebrovascular Disease, by sex and country, all ages



Source: Eurostat hlth\_cd\_asdr 2008-2010 and Health Intelligence Unit

The numbers of hospital admissions for stroke are very similar for both men and women. There were around 60 male and 55 female hospital episodes for a stroke in 2012 and around 60 male and 75 female hospital episodes for the same reason in 2013.

Figure 5.5: Average annual number of hospital episodes by age, 2012-2013



Source: Health Intelligence Unit

## Other Heart Disease

Other types of heart disease, such as hypertensive diseases, aortic aneurysms and pulmonary heart disease, account for around 25 male deaths annually (7% of male deaths). These same heart diseases cause around 40 female deaths per year (10% of female deaths).

CHAPTER  
6

CANCER





- Mortality rates from cancer are 58% higher in men than women in Jersey;
- Cancers are currently the main cause of death for men causing around 130 male deaths a year (35% of all male deaths);
- Malignant cancer incidence in men is 29% higher than in women;
- 1 in 10 (11%) of cancers diagnosed in men each year are lung cancers. Lung cancer is the main cause of cancer deaths in men locally;
- Overall relative survival from malignant cancers is similar in both males and females, although some specific cancers show differences between the genders;
- Prostate cancers account for more than a quarter (28%) of all malignant cancers diagnosed in men each year; but only accounts for 13% of all deaths. This high incidence is linked to the availability of PSA testing in Jersey.

## Summary

The incidence of cancer in Jersey is higher in men than women (643 per 100,000 compared to 497 per 100,000) and each year more men die from cancer (293 per 100,000 compared to 194 per 100,000).<sup>47</sup>

One in three (35%) male deaths in Jersey is caused by cancer. Cancer is the main cause of working age male deaths in the Island<sup>48</sup> (40% in 2012). Men in Jersey are more likely to die earlier from cancer than women, losing more years of life from lung, colorectal, cancers of the digestive system and head and neck cancer than women. This is similar to the pattern of male cancers seen in Europe.

In Europe, male cancer patterns are changing. The incidence of lung cancer is declining and prostate cancer has become the most diagnosed cancer in men. For non-gender specific cancers, mortality rates in men are significantly higher than those seen for women.

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<sup>47</sup> Age-standardised Rate 2009-2011 for all cancers (C00-C97 excluding C44) in adults 20 years and older, Public Health England Knowledge and Intelligence Team (formerly the South West Cancer Intelligence Network) Channel Islands Cancer Report 2013 – available [www.gov.je](http://www.gov.je)

<sup>48</sup> Male working age calculated as 16-64 years.

Of the many causes of cancer, lifestyle factors related to the behaviour of men have been implicated as highly preventable causes.<sup>49</sup> Such factors include smoking, poor diet, a lack of physical activity, level of alcohol consumption and late presentation of symptoms. Fat-related cancers (such as colorectal, pancreas, gall-bladder, kidney and oesophagus<sup>50</sup>) are also more linked to the male form of overweight or obesity.

The European report highlights that while there are many reasons for men's higher risk of developing and dying of cancer, tobacco is the largest source of exposure to carcinogenic substances for men and remains the largest single preventive cause of cancer death among men across Europe.<sup>51</sup>

*Note: Death rates reported here are for all ages and will therefore differ from those reported in the Public Health England Channel Islands Cancer Report which reports rates only for those 20 years old and over. The European comparisons are for all ages and for the latest comparative data (2008-2010) although where possible later data has been used for local comparisons between men and women (2010-2012).*

## Cancer

Cancer kills around 130 men and around 110 women each year in Jersey. Cancer accounted for around a third (35%) of all male deaths and around a quarter (28%) of female deaths over the period 2010-2012.

In comparison, cancer deaths in Europe account for 29% of all male deaths and 22% of all female deaths.<sup>52</sup>

Age-standardised mortality rates are higher for men than women in Jersey (all-ages 2010-2012); 220 per 100,000 male population, compared with a rate for women of 140 per 100,000 female population.

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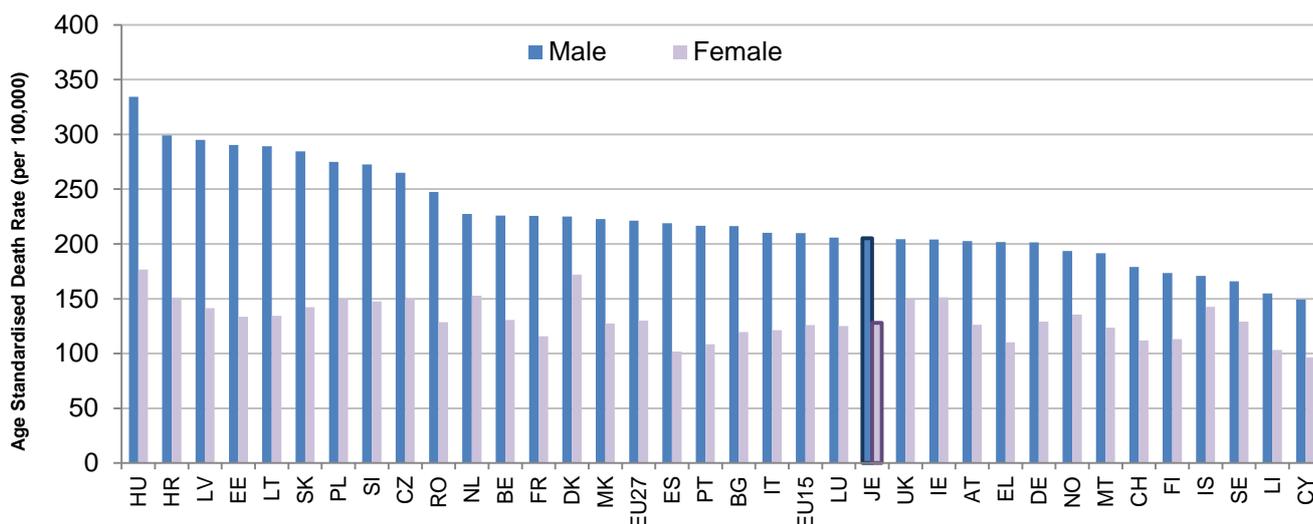
<sup>49</sup> Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. *British Journal of Cancer*. 2011;105: S77-S81

<sup>50</sup> Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. *British Journal of Cancer*. 2011;105: S77-S81

<sup>51</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

<sup>52</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

Figure 6.1: Age-standardised Death Rate for all cancers C00-C99, all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

The main cancer killers in men were lung cancer (24% of all male cancer deaths), upper gastrointestinal cancer (15%, mainly oesophagus and pancreas), prostate cancer (11%), colorectal cancer (9%), head and neck cancers (6%) and liver cancer (5%).

Local data shows that men are more likely to die prematurely (below the age of 75) than women, with cancer accounting for the majority of life lost due to male deaths in those under 75.

Comparing premature deaths from all cancers, for both men and women in Jersey, to that of the English regions, Jersey would rank 91<sup>st</sup> out of 151 regions - worse than the England average. Sixty percent of these premature cancer deaths were male.<sup>53</sup>

Cancers of the digestive system (mainly colorectal, pancreatic and stomach cancers) were the predominant cause of premature death in males, accounting for around 300 years of life lost annually. This compares with around 100 years of life lost to women who die prematurely with cancers of the digestive system.

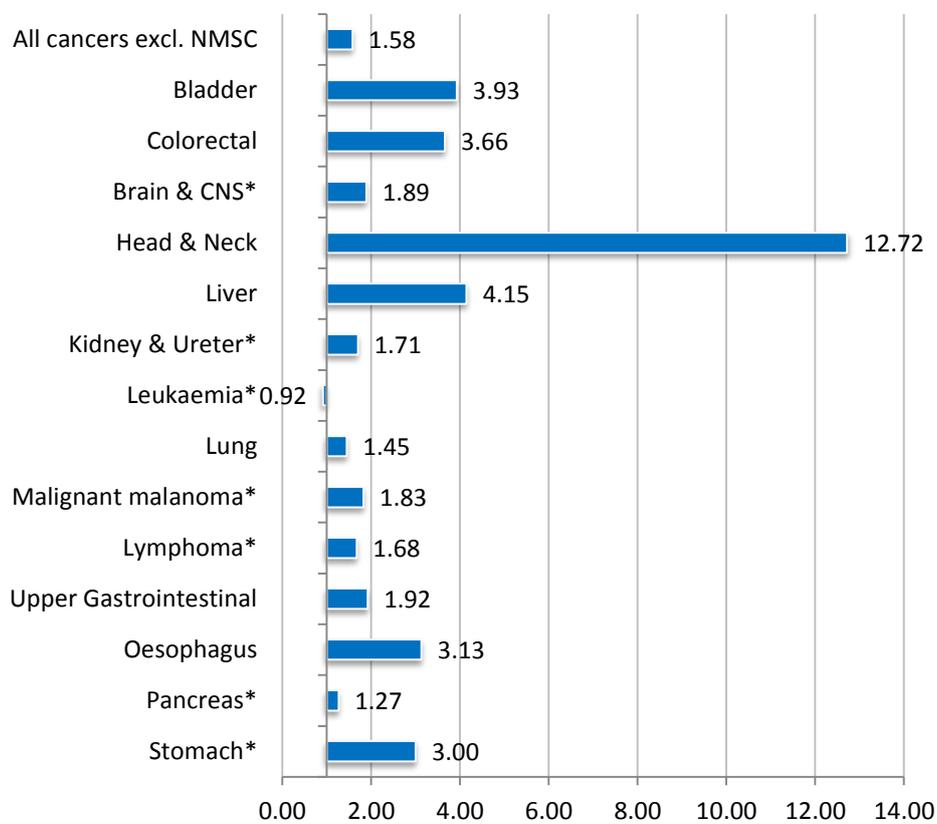
Cancers of respiratory and intra-thoracic organs (predominately lung cancer) accounted for over 200 years of male life lost in 2010-2012, whilst females lost around 150 years due to premature death from these cancers.

<sup>53</sup> For further information, see Premature Deaths of Jersey Residents 2010-2012, Health Intelligence Unit, April 2014, available from [www.gov.je](http://www.gov.je)

Men are 58% more likely to die from cancer than women. Figure 6.2 shows the rate ratios of the mortality (MRR) European age-standardised rates for males and females for all ages. The MRR for all cancers shows the higher rate of cancer deaths in men (1.58).

The disparity in mortality rates between the sexes is particularly noticeable for head and neck, liver, bladder, colorectal, oesophageal and stomach cancers. The mortality rates of each of these cancers is more than three times higher in men than they are in women and in the case of head & neck cancers (oral cavity, larynx & thyroid) almost 13 times higher.

Figure 6.2: Male-to-female Mortality Rate Ratio, all ages, 2010-2012



Source: Health Intelligence Unit  
 All of the above mortality rate ratios were statistically significant except those marked \*

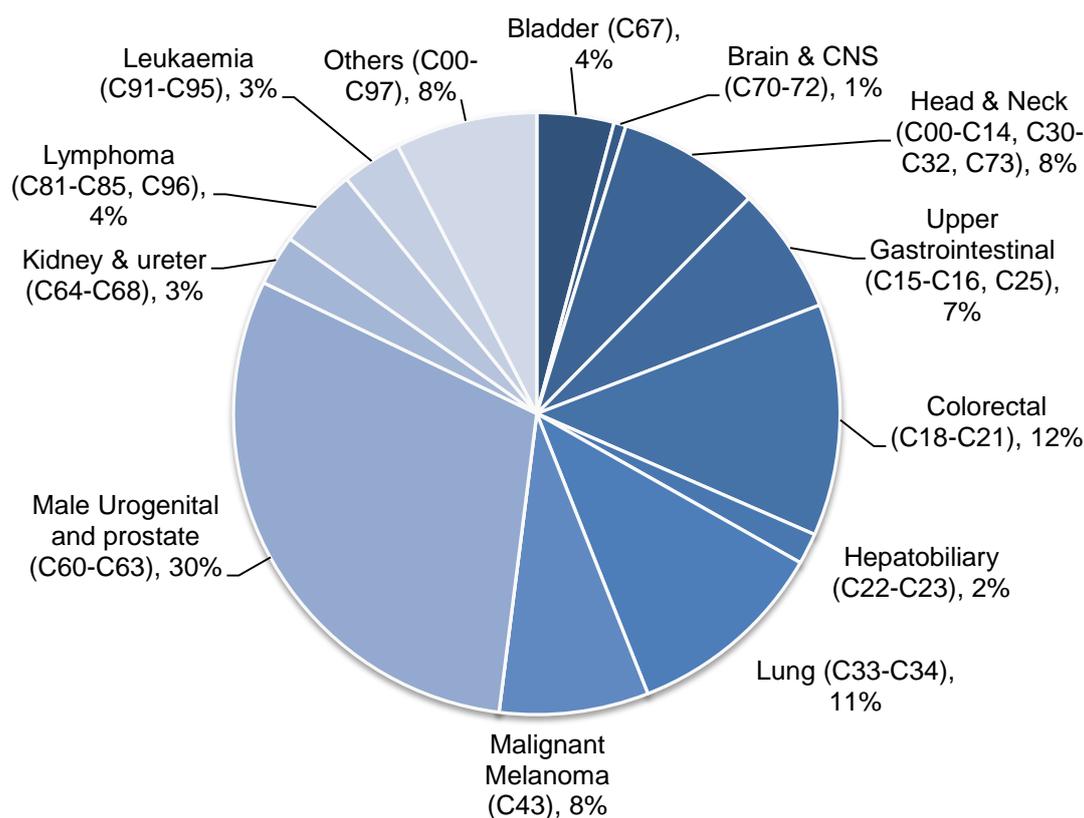
## Cancer Incidence

In Jersey, some 260 new cancer registrations (all cancers excluding non-melanoma skin cancer) are registered in males each year (2009-2011) compared to around 220 in women.<sup>54</sup>

Around a third (30%) of cancers registered each year in males were urogenital and prostate. Non-melanoma skin cancers (NMSC) account for another 170 male registrations annually. This compares to around 150 registrations for women each year.

The distribution of cancer diagnosis each year (excluding NMSC) for males (Figure 6.3) and females (Figure 6.4) are shown.

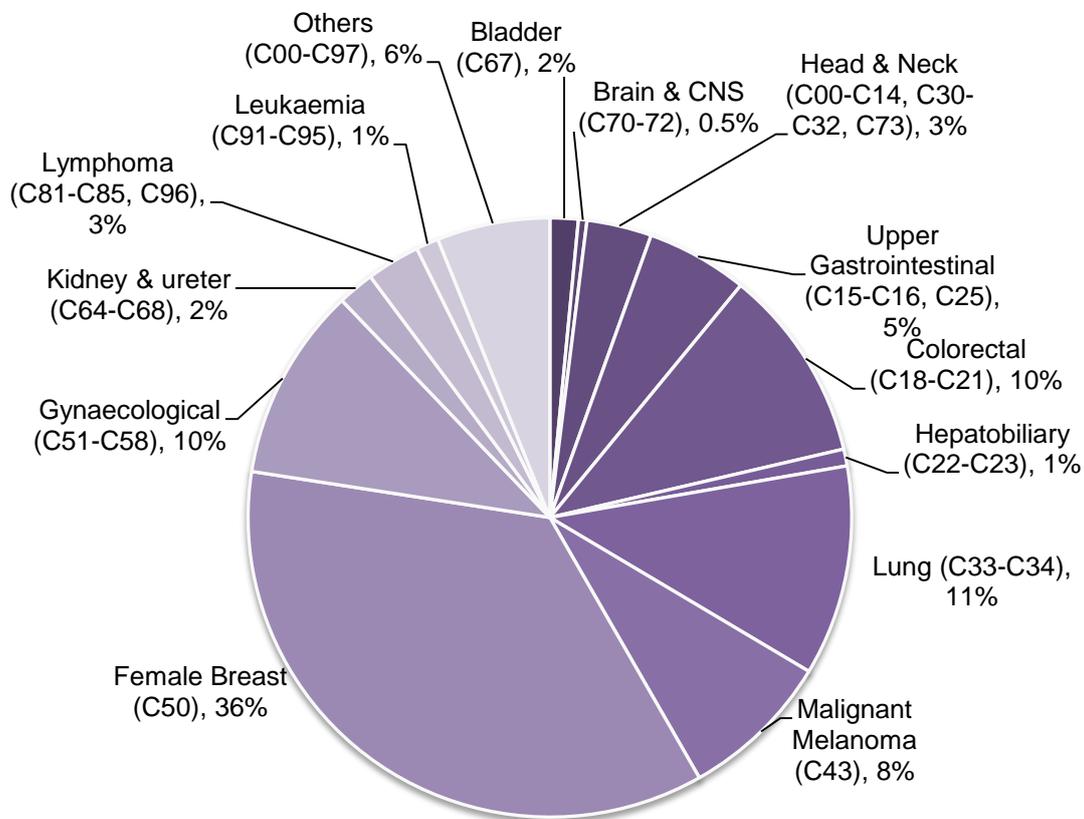
Figure 6.3: Proportion of new cases of all malignant neoplasms in males (C00-C97) by site, 2009-2011



Source: Public Health England Knowledge and Intelligence Team (South West) Channel Islands Cancer Report 2013

<sup>54</sup> Public Health England Knowledge and Intelligence Team (formerly the South West Cancer Intelligence Network) Channel Islands Cancer Report 2013 – available [www.gov.je](http://www.gov.je)

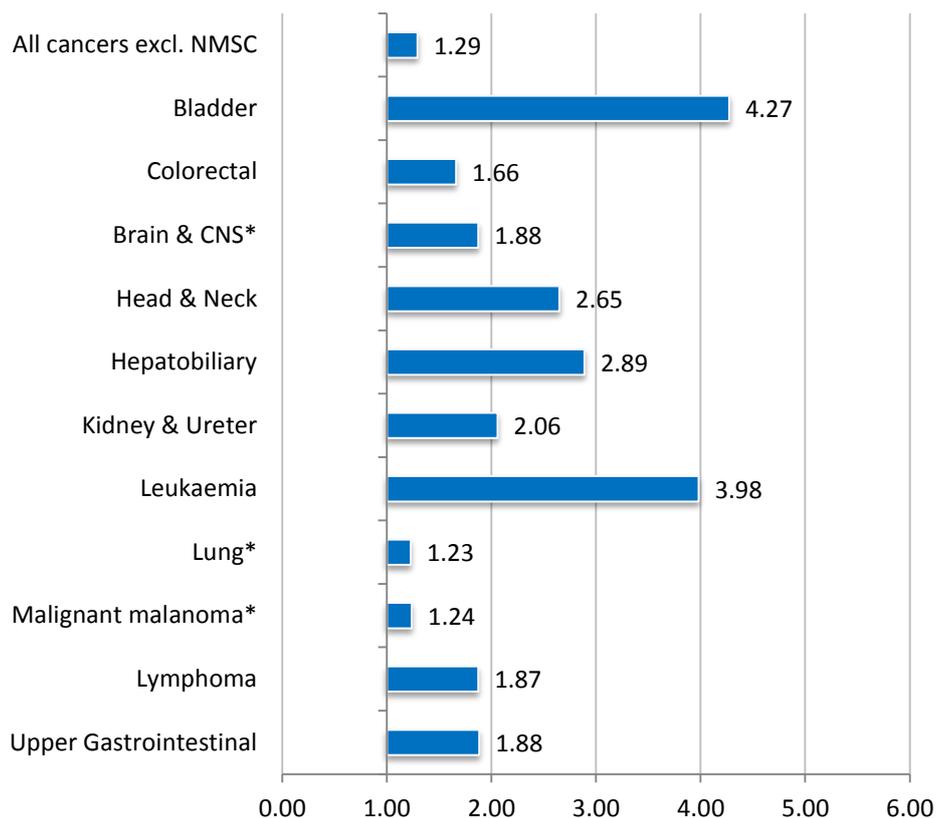
Figure 6.4: Proportion of new cases of all malignant neoplasms in females (C00-C97) by site, 2009-2011



Source: Public Health England Knowledge and Intelligence Team (South West) Channel Islands Cancer Report 2013

When comparing the gender disparity in incidence rates (Figure 6.5), it is evident that males have a higher risk of developing cancer than females (incidence rate ratio (IRR) of 1.29). Males have a higher risk than women for most individual cancers (as shown in Figure 6.5) particularly for bladder, leukaemia, head and neck, and hepatobiliary cancers.

Figure 6.5: Male – to – female Incidence Rate Ratios (IRRs) for incidence, 20 years old and over, 2009-2011

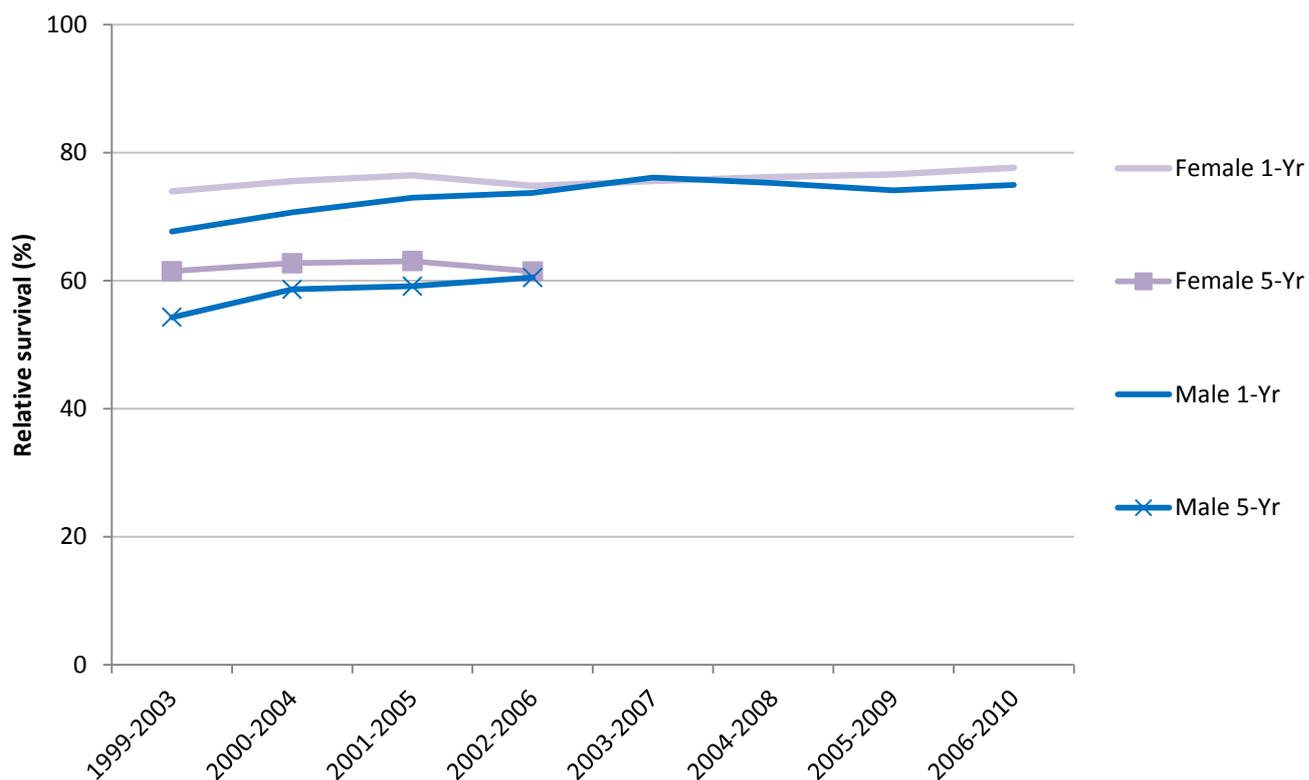


Source: Public Health England Knowledge and Intelligence Team (South West) Channel Islands Cancer Report 2013  
 All of the above incidence rate ratios were statistically significant except those marked \*

Overall relative survival rates for men and women are similar, with around three-quarters surviving until one year after diagnosis and three-fifths to five-year post-diagnosis (see Figure 6.6). For some cancers, survival is different between the genders. One-year survival is marginally worse for men with head and neck cancers and lymphoma than it is for women.

Five-year survival is worse for men with kidney and ureter cancer, whilst five year survival from bladder cancer and lymphoma is worse for women in Jersey. For women, one-year survival is worse for bladder, brain and CNS and leukaemia than men. For more information see the Channel Islands Cancer Report 2013.

Figure 6.6: Relative survival rates for cancer, persons aged 20 and over (1999-2010)



Source: Public Health England Knowledge and Intelligence Team (South West) Channel Islands Cancer Report 2013

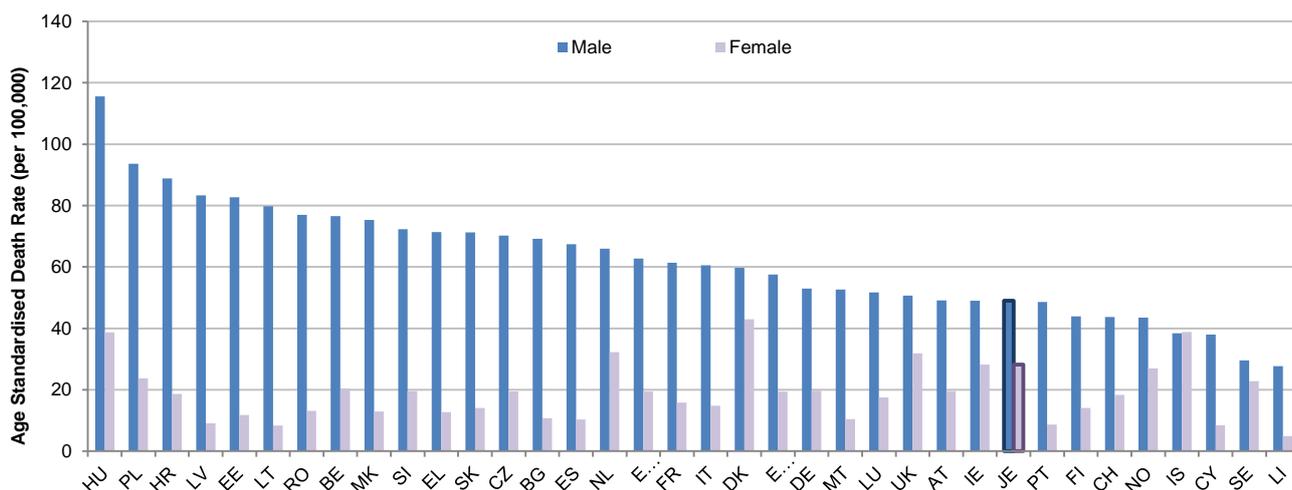
## Lung Cancer

### Deaths

Lung cancer is the top cause of all cancer deaths in Jersey and caused around 50 of both male and female deaths in Jersey in 2010-2012 (around 8% of male deaths and 6% of female deaths). It is the top cause of all malignant cancer deaths, accounting for around a quarter (23%) of all cancer deaths in both men and women locally in 2010-2012. In contrast, lung cancer accounts for a higher number of premature deaths in males than females.

Lung cancer is one of the main contributing factors to premature death from cancer in men under 75 years of age, accounting for around 220 actual potential years of male years of life lost (YOLL) each year (2010 to 2012). This compares to 140 YOLL in women over the same period. Lung cancer claims more male YOLL each year than ischaemic heart diseases.

Figure 6.7: Age-standardised Death Rate for lung and trachea cancers (C32-34), all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

### Incidence

Lung cancer accounts for one in ten (11%) of all new cancer diagnosis each year for both men and women, making it the second most commonly diagnosed non sex-specific cancer in men (after colorectal cancer) and the top non sex-specific cancer in females. It is anticipated that lung cancer incidence in men will fall whilst incidence in women will continue to increase due to the later onset of female smoking habits.<sup>55</sup> Smoking is responsible for around 85% of lung cancers.<sup>56</sup>

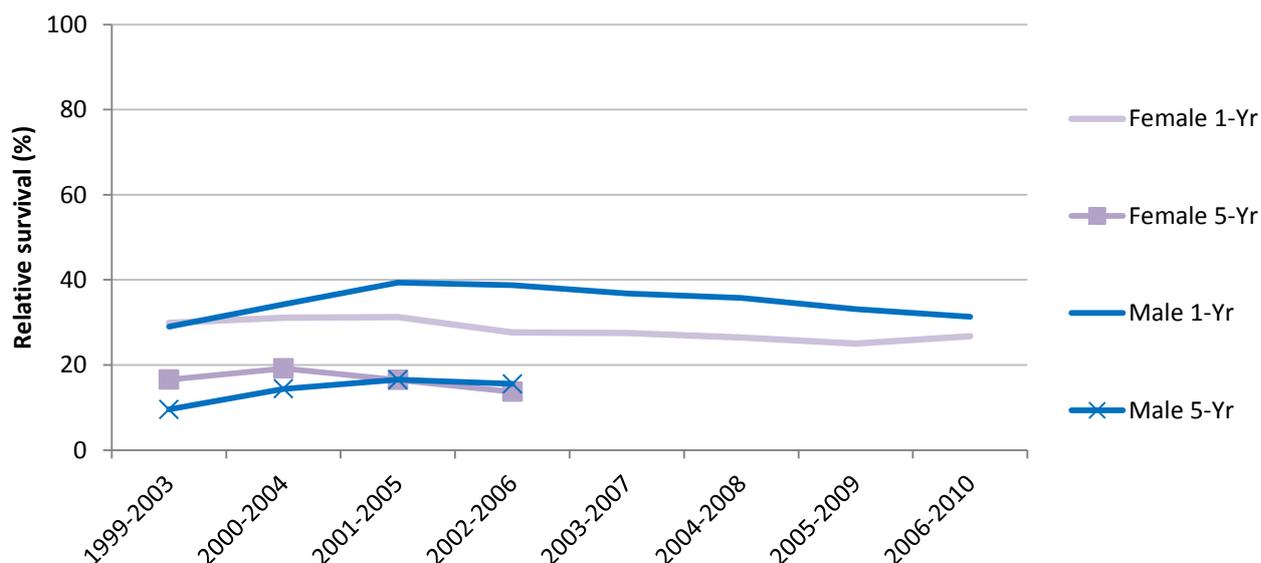
The incidence rate for lung cancer is marginally higher in men than women (68.7 and 56.0 per 100,000 respectively for 2009-2011).

One-year relative survival from lung cancer in men has remained at around 31% (2006-2010 cohort) but five-year survival was found to be increasing (from 10% for the 1999-2003 cohort to 16% for the 2002-2006 cohort) and unchanged for women (14%). See Figure 6.8.

<sup>55</sup> Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. *British Journal of Cancer*. 2011;105: S77-S81

<sup>56</sup> Public Health England Knowledge and Intelligence Team (formerly the South West Cancer Intelligence Network) Channel Islands Cancer Report 2013 – available [www.gov.je](http://www.gov.je)

Figure 6.8: Relative survival rates for lung cancer, persons aged 20 and over (1999-2010)



Source: Public Health England Knowledge and Intelligence Team (South West) Channel Islands Cancer Report 2013

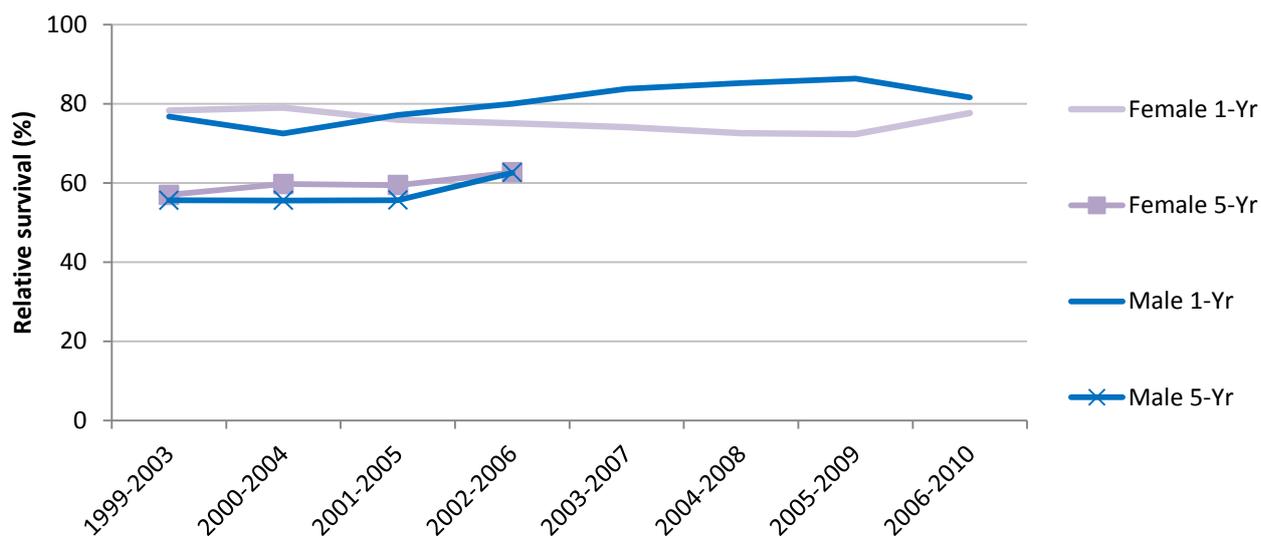
## Colorectal Cancer

Colorectal cancer encompasses cancers of the colon and rectum and causes one in ten (10%) of all male malignant cancer deaths each year, compared to 4% of female cancer deaths. Around 13 men die each year from colorectal cancer, compared with 5 women a year (average 2010-2012).

The incidence of colorectal cancer is significantly higher in men than women (2009-2011) and is the top non-sex specific cancer diagnosed annually in men accounting for around 30 new cases in men each year.

One-year relative survival from colorectal cancer for men has been increasing locally, as elsewhere, as has five-year survival from 72% a decade ago to 82%. For women, one-year survival was found to be unchanged in the latest Channel Islands Cancer Report at 78%.

Figure 6.9: Relative survival rates for colorectal cancer, persons aged 20 and over (1999-2010)



Source: Public Health England Knowledge and Intelligence Team (South West) Channel Islands Cancer Report 2013

## Head and Neck Cancers

The incidence of head and neck cancer in men in Jersey is significantly higher than in women and also higher than rates in England and Europe (Figure 6.10).

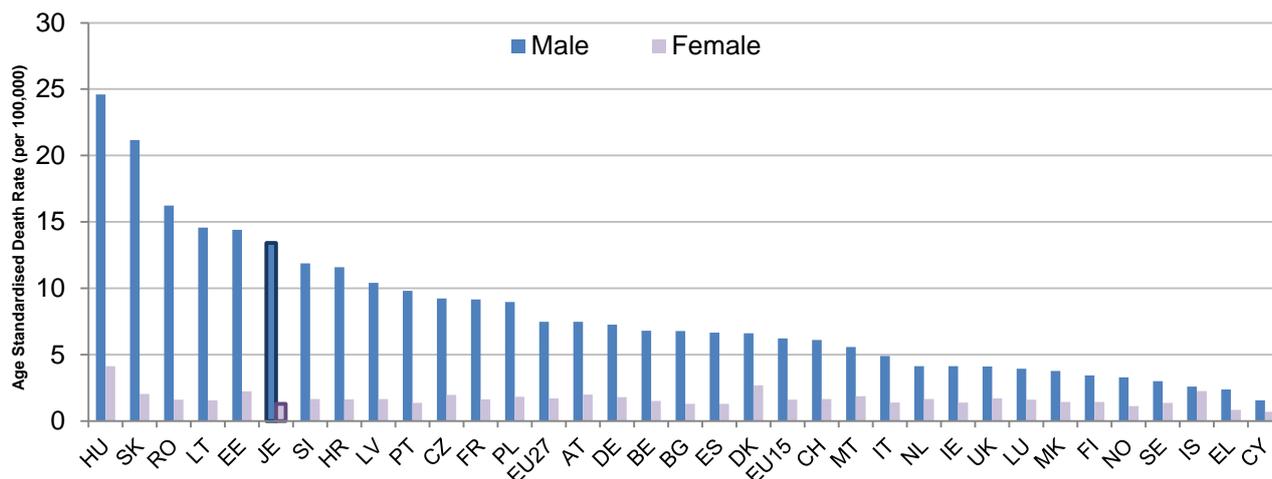
Death rates from head and neck cancers are also significantly higher in men than women (15.2 compared to 1.2 per 100,000 respectively, 2010-2012), causing around six male deaths a year.

The main risk factors are smoking and excessive alcohol use, especially when in combination.<sup>57</sup>

One-year relative survival is around 80% for men and 97% for women. Five-year is also better for women at around three-quarters (72%) compared to 65% for men (2002-2006 cohort).

<sup>57</sup> Public Health England Knowledge and Intelligence Team (formerly the South West Cancer Intelligence Network) Channel Islands Cancer Report 2013 – available [www.gov.je](http://www.gov.je)

Figure 6.10: Age-standardised Death Rate for head and neck cancers (C00-14), all ages, average 2008-2010

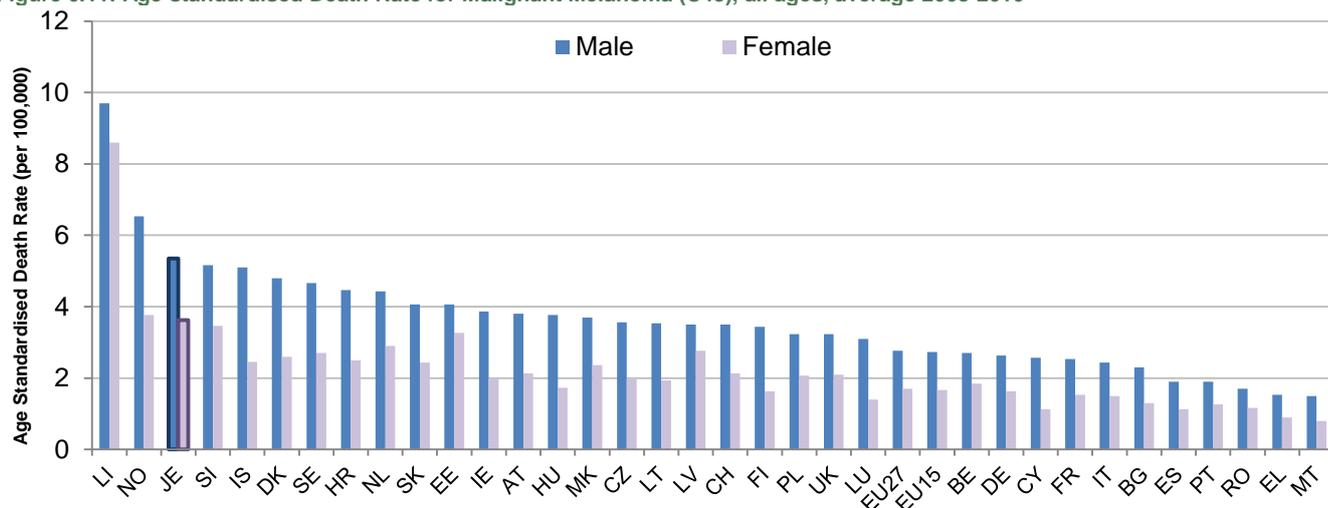


Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

## Skin Cancer

Malignant melanoma is one of the most common cancers in those aged under 40. These account for 8% of both male and female cancer incidence annually with around 20 men and 20 women diagnosed each year. Total death rates from malignant melanoma are very small, less than five a year.

Figure 6.11: Age-standardised Death Rate for Malignant Melanoma (C43), all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

On the other hand, non-melanoma skin cancer is slightly more likely to be diagnosed in men than women (170 men a year compared to 150 women).

The major risk factor for both malignant and non-malignant skin cancers is UV exposure through sunlight or sunbeds. The increased incidence in men could be linked to higher numbers working outdoors in manual and construction industries. A recent Jersey Annual Social Survey<sup>58</sup> asked respondents about the precautions they take in the sun. A higher proportion of men (13%) reported 'never' taking precautions compared to 4% of women. One in six (16%) of men working in routine professions reported 'never' taking precautions against sun damage. This compared 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.<sup>59</sup>

## Upper Gastrointestinal Tract Cancers

Cancer of the digestive organs includes cancers of the upper gastrointestinal tract, hepatobiliary cancers and colorectal cancers. Cancers of the upper gastrointestinal tract (Upper GI) includes cancers of the oesophagus, stomach and pancreas.

There are more male diagnoses of upper GI cancers annually, compared with females but less than 20 a year. Mean age at diagnosis for both males and females combined is around 70 years old. Upper GI cancers account for 7% of all male malignant cancer diagnosis each year and 5% of all female cancer incidence.

Relative survival for these three cancers is generally similar for both men and women with around a third surviving one-year post diagnosis (34% for females and 39% for males) whilst around a fifth survive to five years (17% for females and 19% for males, 2002-2006 cohort).

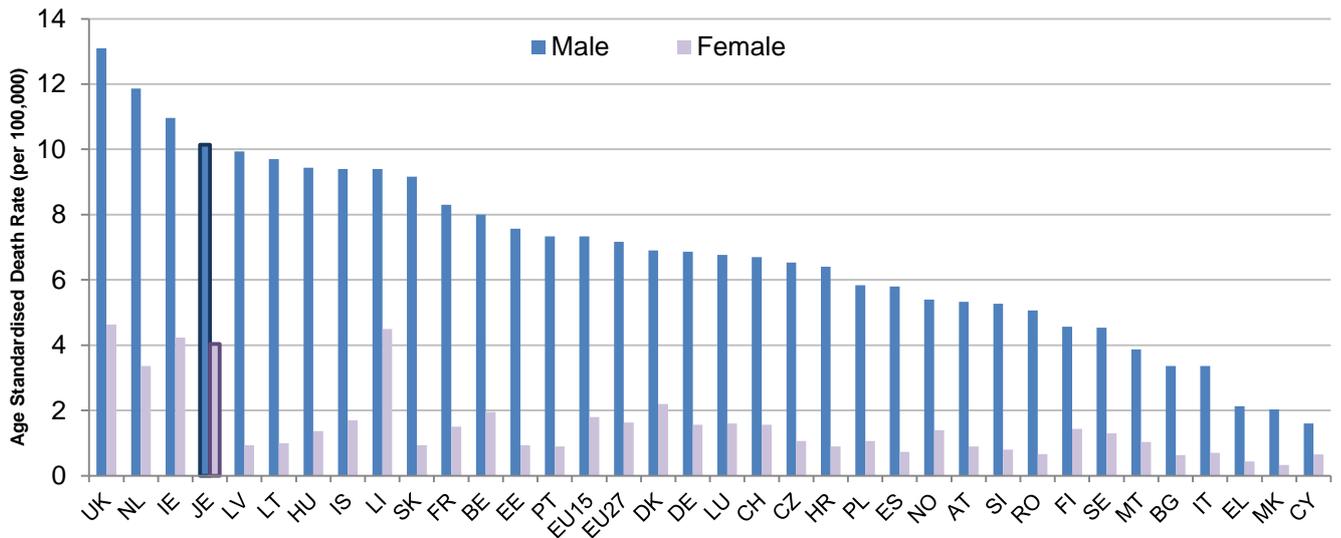
Death rates for oesophageal cancer in men put Jersey high in the European rankings (Figure 6.12), although our rate is lower than that in the UK. More recent data for oesophageal cancer shows there has been a steady increase in the rate of oesophageal cancer in men over the last five years from 7 per 100,000 in 2008 to 15 per 100,000 in 2012. Meanwhile, the rate for women has remained steady at less than 6 per 100,000 each year. In 2010-2012, cancer of the oesophagus accounted for 2% of all male deaths and 1% of all female deaths (including non-cancers).

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<sup>58</sup> 2012 Jersey Annual Social Survey

<sup>59</sup> 2012 Jersey Annual Social Survey

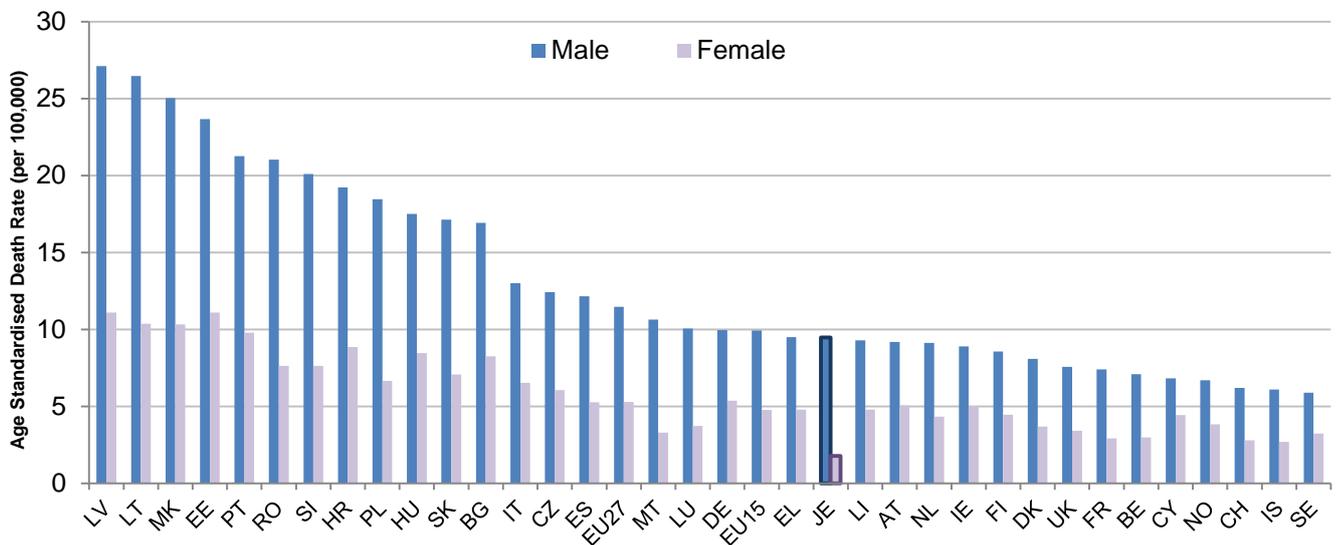
Figure 6.12: Age-standardised Death Rate for Oesophageal cancer (C15), all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

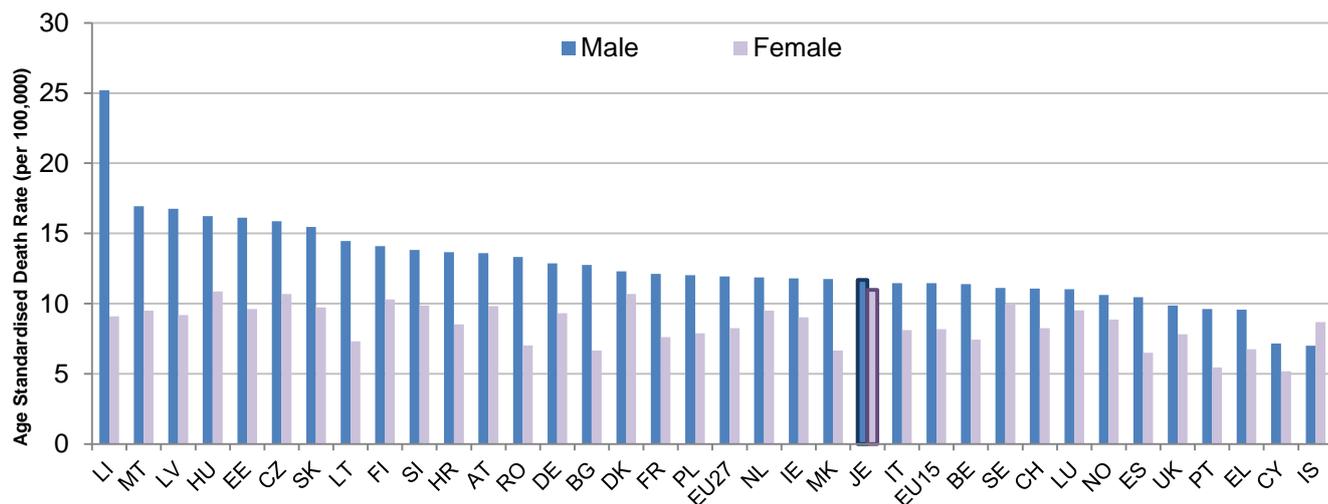
Jersey mortality rates for stomach and pancreatic cancers in men show Jersey to be similar to the EU average (Figure 6.13 and 6.14).

Figure 6.13: Age-standardised Death Rate for Stomach cancer (C16), all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

Figure 6.14: Age-standardised Death Rate for Pancreatic cancer (C25), all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

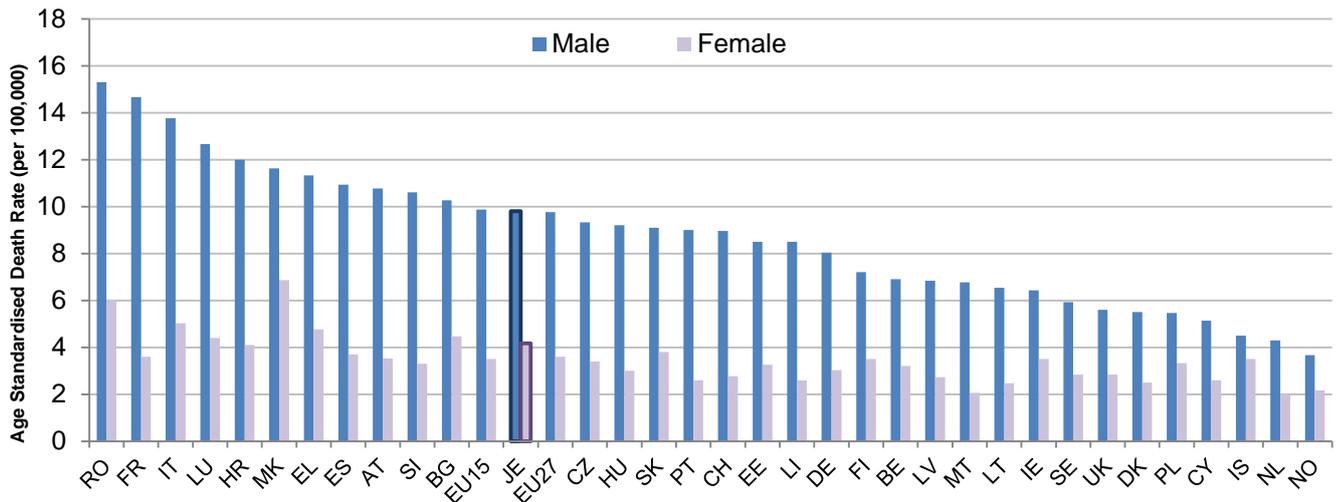
More recent data for deaths indicates stomach cancer rates for men have decreased, whilst the rate of pancreatic cancer has remained stable for men of all ages in Jersey.

## Hepatobiliary Cancer

Hepatobiliary cancers include cancers of the liver and intrahepatic bile ducts, gall bladder and other or unspecified cancers of the biliary tract.

Incidence for these cancers was found to be marginally higher in men (10.4 compared to 3.6 per 100,000 for males and females respectively, 2009-2011), but there are less than five cases diagnosed in males and females annually. Average age at diagnosis is 71, whilst relative survival at one-year post-diagnosis is around a third for both genders but five-year relative survival was found to be higher in men than women in the latest cohort (25% for men compared to 9% for women for 2002-2006 cohort).

Figure 6.15: Age-standardised Death Rate for Liver cancer (C22), all ages, average 2008-2010



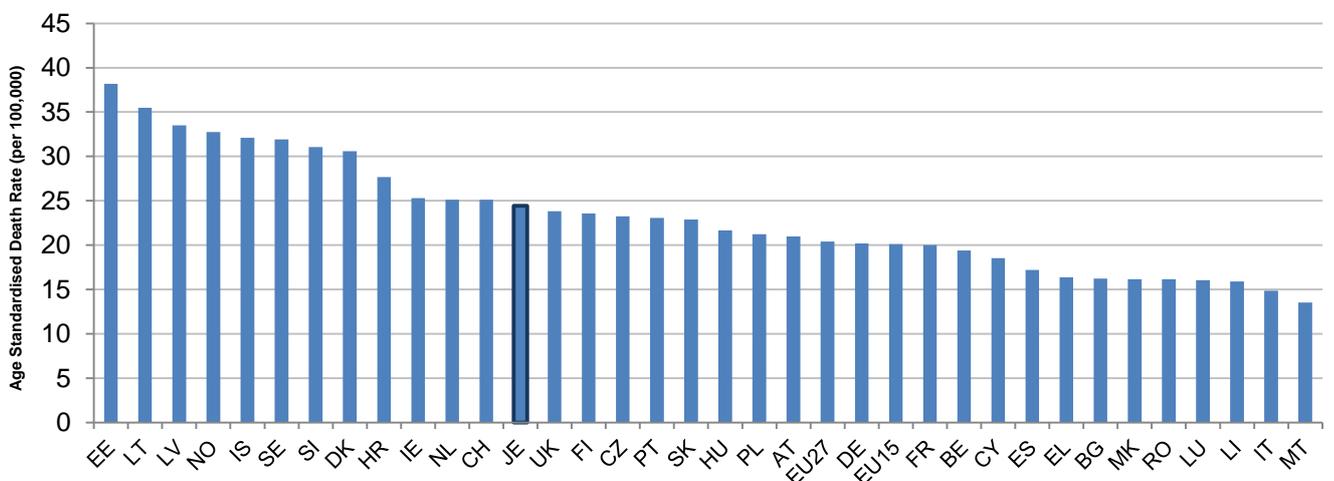
Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

The number of deaths from liver cancers is small, at less than 10 deaths a year in males and less than 5 in females. The rates show a difference between the genders (10.6 males compared to 2.6 per 100,000 females, 2010-2012) with a mortality rate ratio of 4.15 (Figure 6.2).

## Prostate Cancer

In Jersey, around 15 men die from prostate cancer each year, constituting around 4% of all male deaths (a similar figure to the 3% average across Europe).

Figure 6.16: Age-standardised Death Rate for prostate cancer (C61), all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

Death rates in Jersey are in line with the more affluent EU countries (Figure 6.16). The number of male deaths due to prostate cancer is small compared to those due to lung cancer (30 a year).

PSA testing became available in the UK in the late 1980s and although it has never been approved as a basis for screening, rates increased in the late 1990s. Analyses of prostate cancer incidence trends in a number of countries, including Australia, USA, Republic of Ireland and Scotland, indicate that increased detection through PSA and TURP testing is the main driver of apparent increases in incidence in these countries. In the USA, it is thought some 75% of men over 50 years of age have been tested. In comparison, this figure is some 10-20% in Europe.<sup>60</sup>

Worldwide there is no correlation between prostate cancer incidence rates and prostate cancer death rates. There is much less variation in mortality due to prostate cancer but a wide range of variations are observed in incidence. Thus, many countries with a high prostate cancer incidence rate have a similar death rate to countries with low prostate cancer incidence rates.

Around 70 new cases of prostate cancer are diagnosed every year in Jersey, accounting for the largest number of new cases of cancer (alongside breast cancer) each year when NMSC is excluded.

Prostate cancer incidence in Jersey is around 183 per 100,000 for men aged 20 and over (2009-2011) which is significantly higher than the England average of 148 per 100,000 (2006-2010) but similar to that of the South West of England.

The high rate of incidence seen in Jersey is likely to be a reflection of increased diagnosis and data collection compared to other jurisdictions. No major environmental/lifestyle factors for prostate cancer are known, though risks are increased in those having a family member with the disease or in those of black ethnicity.<sup>61</sup>

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<sup>60</sup> Prostate Cancer Incidence Statistics, Cancer Research UK, available from [www.cancerresearchuk.org](http://www.cancerresearchuk.org), accessed 11<sup>th</sup> June 2014.

<sup>61</sup> Public Health England Knowledge and Intelligence Team (formerly the South West Cancer Intelligence Network) Channel Islands Cancer Report 2013 – available [www.gov.je](http://www.gov.je)

## Testicular cancer

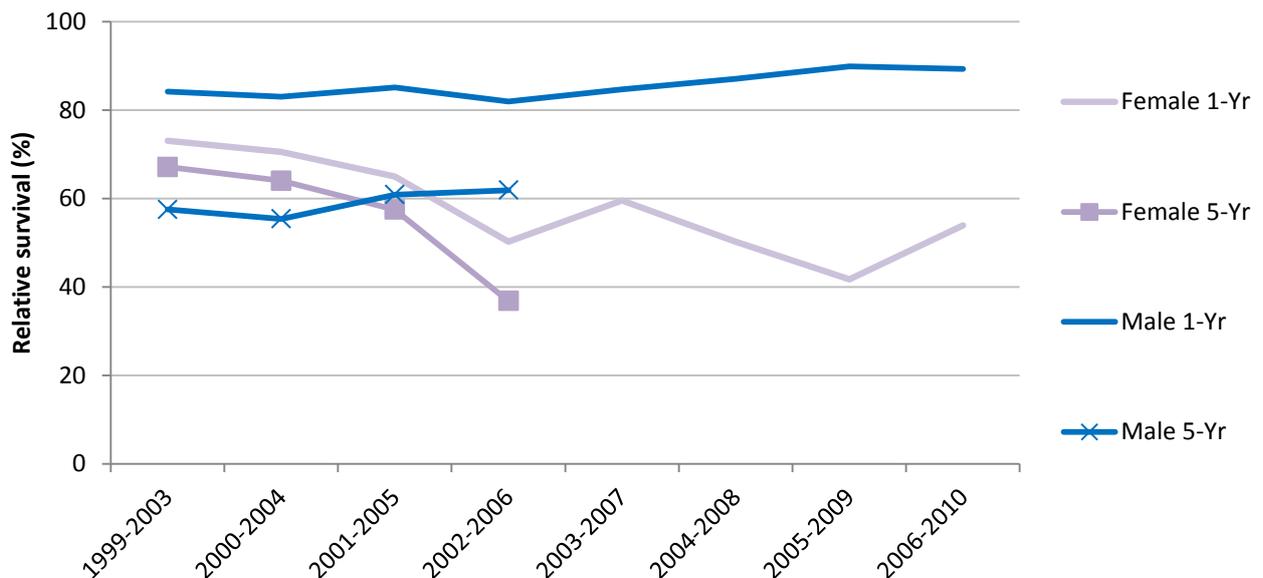
There are fewer than five new cases of testicular cancer diagnosed annually. Deaths from this cancer are rare with no deaths occurring in the last five years.

## Bladder cancer

Around 10 men are diagnosed with bladder cancer annually, with the incidence rate much higher than that for women (23.5 compared to 5.5 per 100,000 respectively).

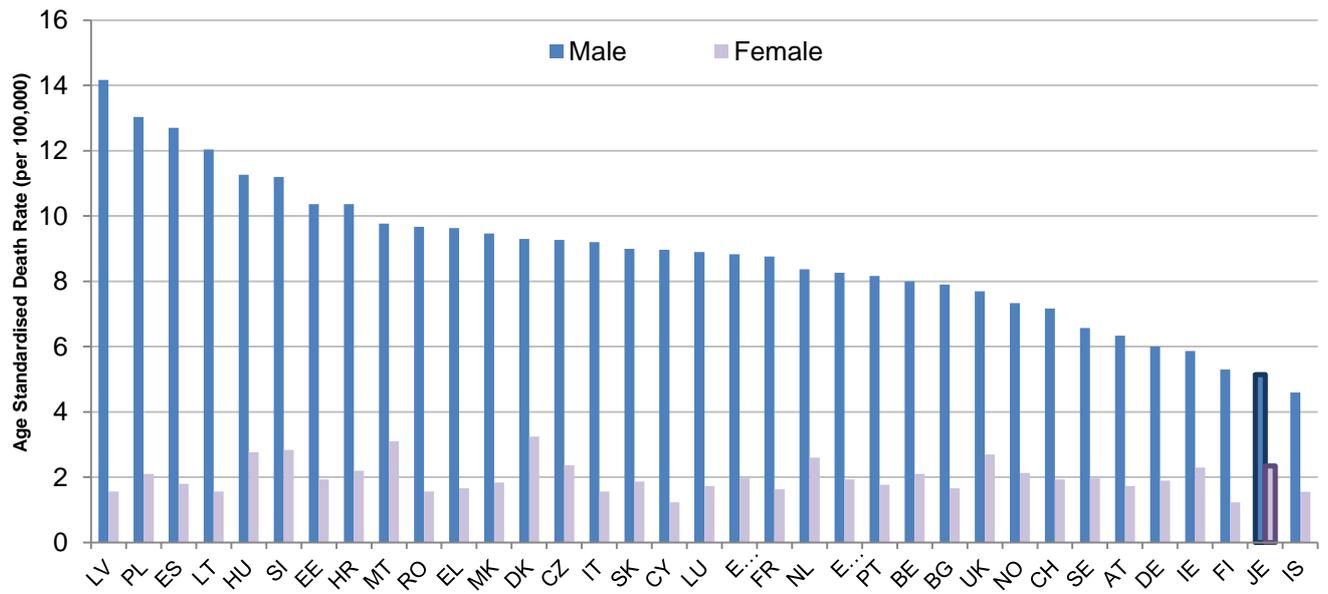
Bladder cancer accounts for around five male deaths annually and mortality rates are also significantly higher than for women. However, one year survival is higher in men (Figure 6.17).

Figure 6.17: Relative survival rates for bladder cancer, persons aged 20 and over (1999-2010)



Source: Public Health England Knowledge and Intelligence Team (South West) Channel Islands Cancer Report 2013

Figure 6.18: Age-standardised Death Rate for bladder cancer (C67), all ages, average 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

CHAPTER  
7

ACCIDENTS





- Injuries and accidents are an important public health issue as they cause premature death, absenteeism from the workplace and strain on the health system;
- Around 4% of all deaths each year are due to external causes of injury, such as accidents or intentional self-harm. 5% for men compared to 3% for women;
- External injuries account for around 500 potential male years of life lost each year, compared with around 240 female years of life lost;
- Accidents account for around half (52%) of all male deaths from external injuries;
- Around 600 males were injured on Jersey roads during 2010-2012;
- In 2013, around 200 men reported a workplace accident to the Social Security Health and Safety Inspectorate.

## Summary

As in the EU, Jersey has higher mortality rates from accidents and violence-related injuries among men compared to women. Accidents and intentional self-harm contribute to a significant proportion of deaths in younger men. More male drivers are killed on Jersey roads than females although more female passengers and pedestrians are killed.

Injuries are the leading cause of death in those under 40 in Jersey, accounting for 48% of all deaths in this age group. For men of all ages, external injuries are the fourth top cause of death, behind cancers, diseases of the circulatory system and diseases of the respiratory system. Around 500 potential male years of life are lost every year in Jersey, compared to around 240 female years of life.

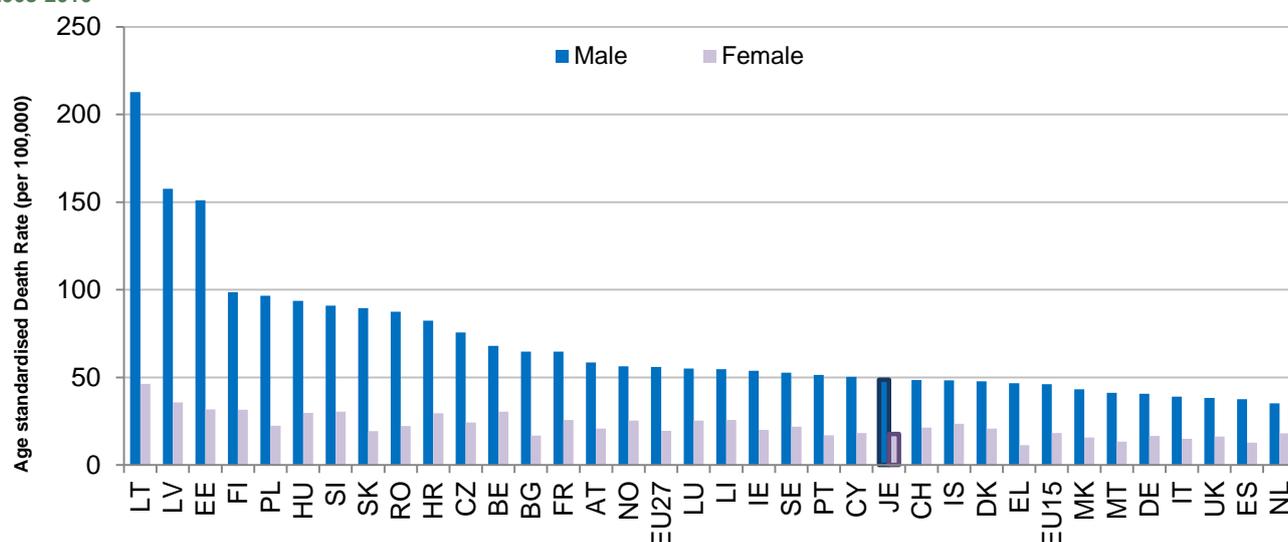
Men's accidents, injuries and violence are a major public health problem within the EU. Male risk-taking, the effect of the anti-social behaviour of some males, male work and play activities and the management of mental and emotional conflict are all implicated in the higher rates seen in men.

## External Injuries

Around 4% of all deaths each year in Jersey are due to external injuries, mainly due to accidents and self-harm. These types of death are slightly more prevalent in males than females; 5% for men compared to 3% for women. For every one female death due to an injury in Jersey, there are 1.7 male deaths. This compares to a ratio of 1:4 in Slovakia and Estonia and around 1:1.5 in Norway and the Netherlands.<sup>62</sup>

Male death rates in Jersey are in line with the EU average (Figure 7.1) and not as high as in Eastern European countries.

Figure 7.1: Age-standardised Death Rate of all deaths for External Causes of Morbidity and Mortality, by sex and country, 2008-2010



Source: Eurostat hlth\_cd\_asdr and Health Intelligence Unit

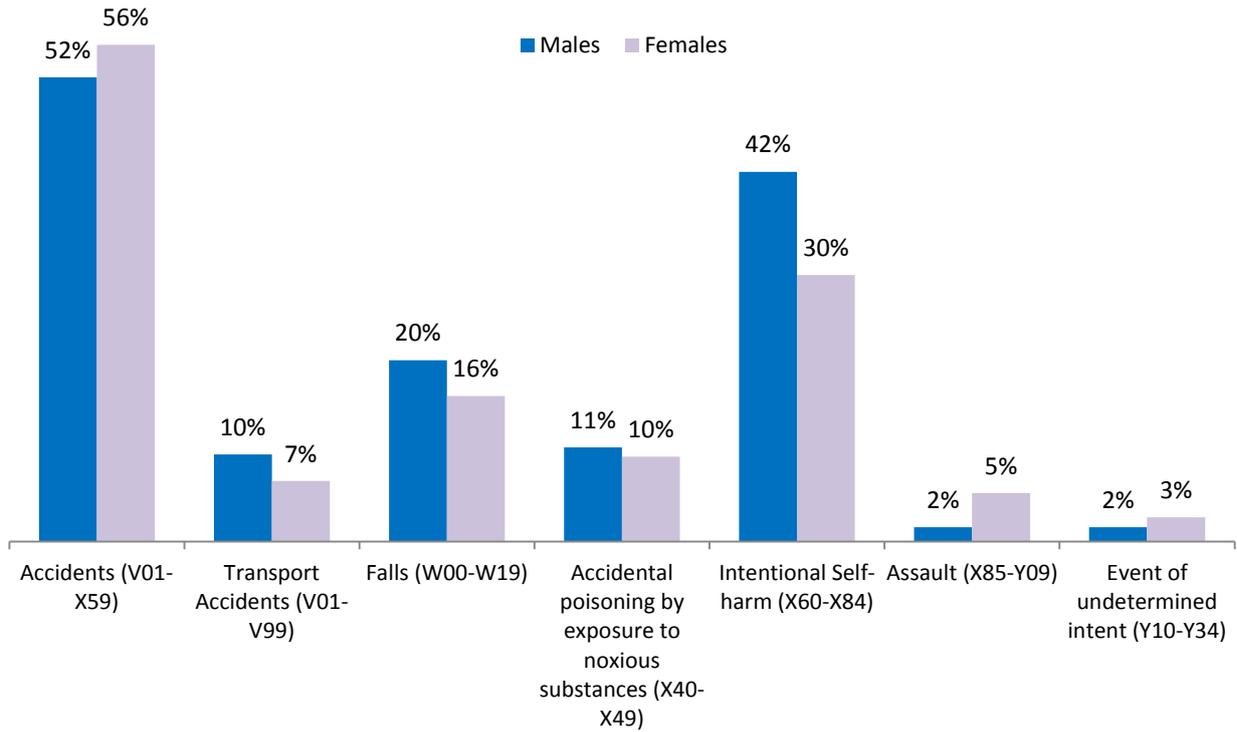
Over the last few years, the rate of deaths from external injury in men has steadily decreased, from 64 per 100,000 in 2009 to 26 per 100,000 in 2013. Conversely, the rate for women has remained steady over this time period, at around 20 per 100,000.

In Jersey, intentional self-harm<sup>63</sup> accounts for two-fifths (42%) of injury fatality in men, whilst accidents account for around half of deaths (52%) as shown in Figure 7.2.

<sup>62</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

<sup>63</sup> In mortality statistics, Intentional self-harm (X60-X84) and events of undetermined intent (Y10-Y34) together are referred to as 'suicide'.

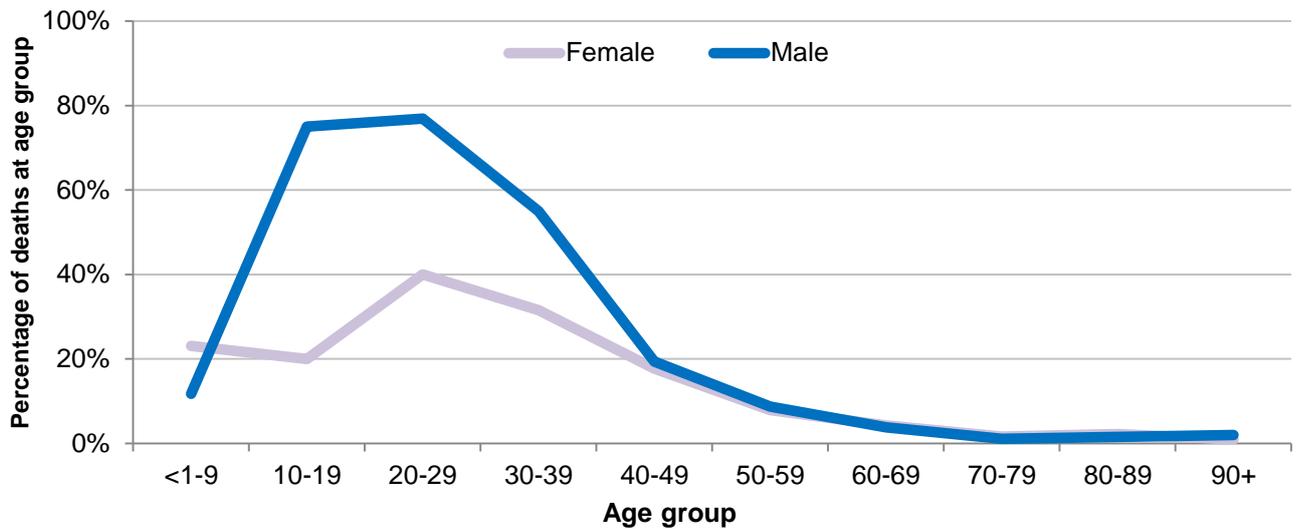
Figure 7.2: Proportion of deaths within External Causes by sex (2008-2013)



Numbers do not sum to 100%  
Source: Health Intelligence Unit

Injuries affect males and females disproportionately throughout the lifespan, as shown in Figure 7.3. For males, around four-fifths of all deaths in the 10-29 age groups are due to external causes.

Figure 7.3: Percentage of all deaths for external causes of mortality at each age, 2008-2013

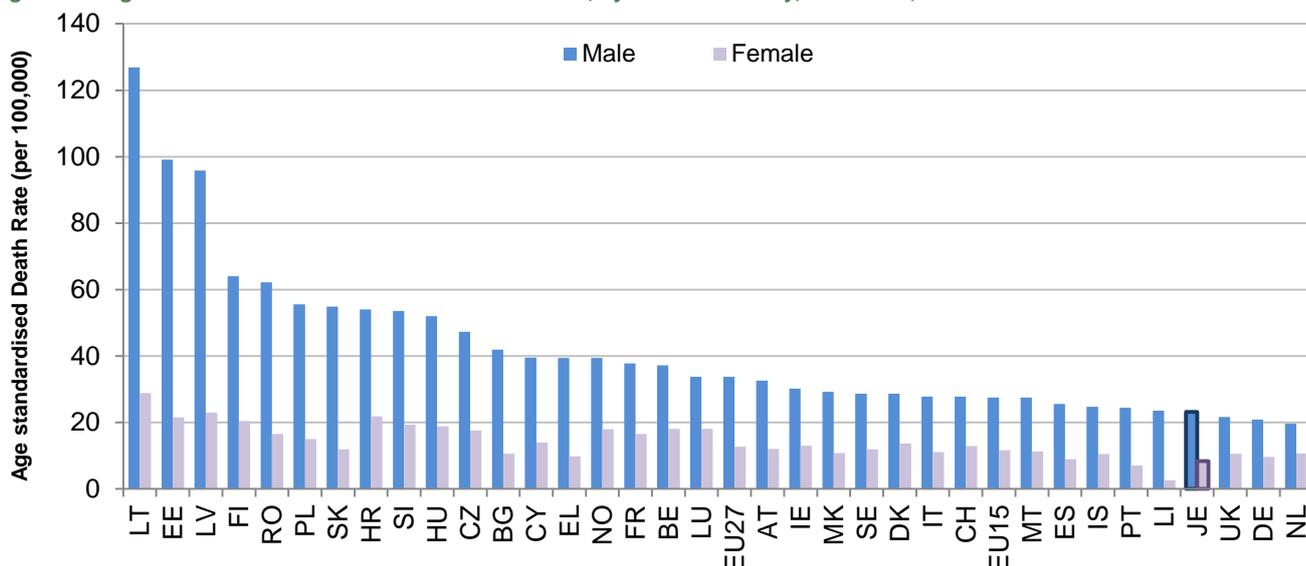


Source: Health Intelligence Unit

## Accidents

Accidents account for around 200 years of male potential life lost each year in Jersey (annual average 2011-2013) compared to around 85 years of potential female life lost. This equates to 9% of all male years of life lost and 6% of all female years of life lost.

Figure 7.4: Age-standardised Death Rates for all Accidents, by sex and country, 2008-2010,



Source: Eurostat hlth\_cd\_asdr and Health Intelligence Unit

Age-standardised death rates for Jersey, when compared to the rest of Europe, show that the Island has low death rates and ranks amongst the best for deaths due to accidents (Figure 7.4).

There were 580 male hospital admissions in 2013 due to accidents, whilst 510 females were admitted. Table 7.1 shows the distribution of accident admissions.

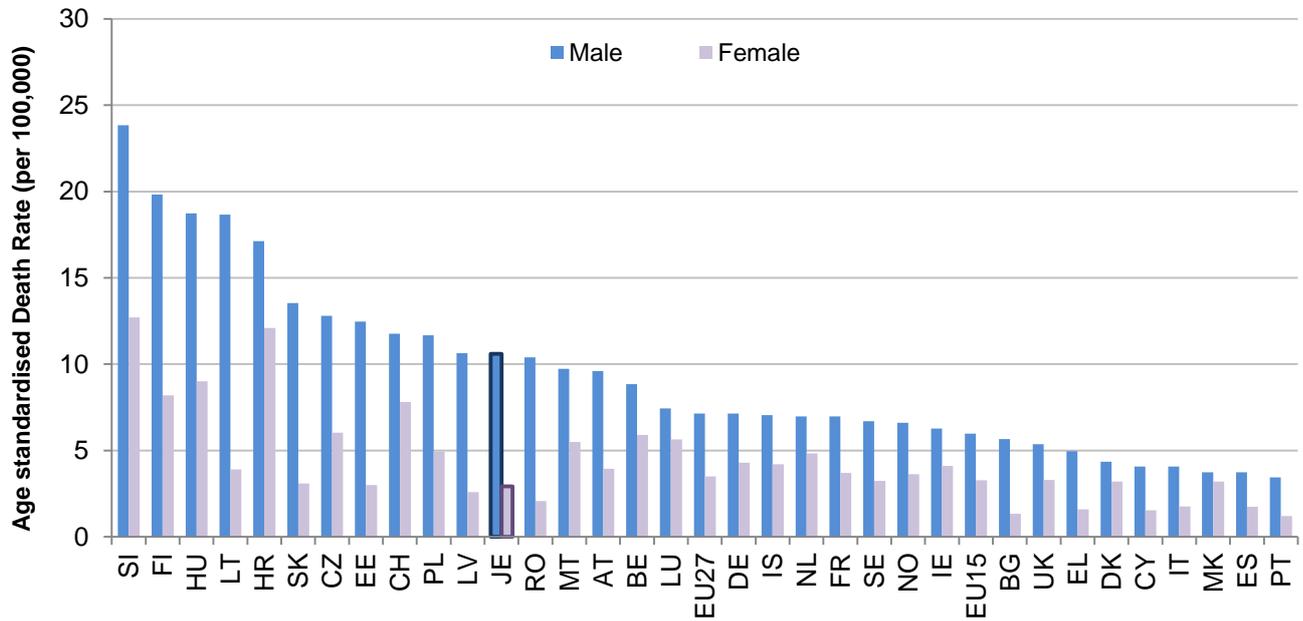
Table 7.1: Distribution of hospital admissions for accidents, by gender, 2013

	Males	Females
Transport accidents	12%	7%
Falls	56%	69%
Other accidents, incl. drowning, fire, leisure and unspecified	33%	24%
<b>Total admissions due to accidents</b>	<b>100% (580)</b>	<b>100% (510)</b>

Figures independently rounded  
Source: TRAK hospital system

Deaths from accidental falls in Jersey is above the EU average for men and ranks the Island relatively high for male deaths from falls (Figure 7.5).

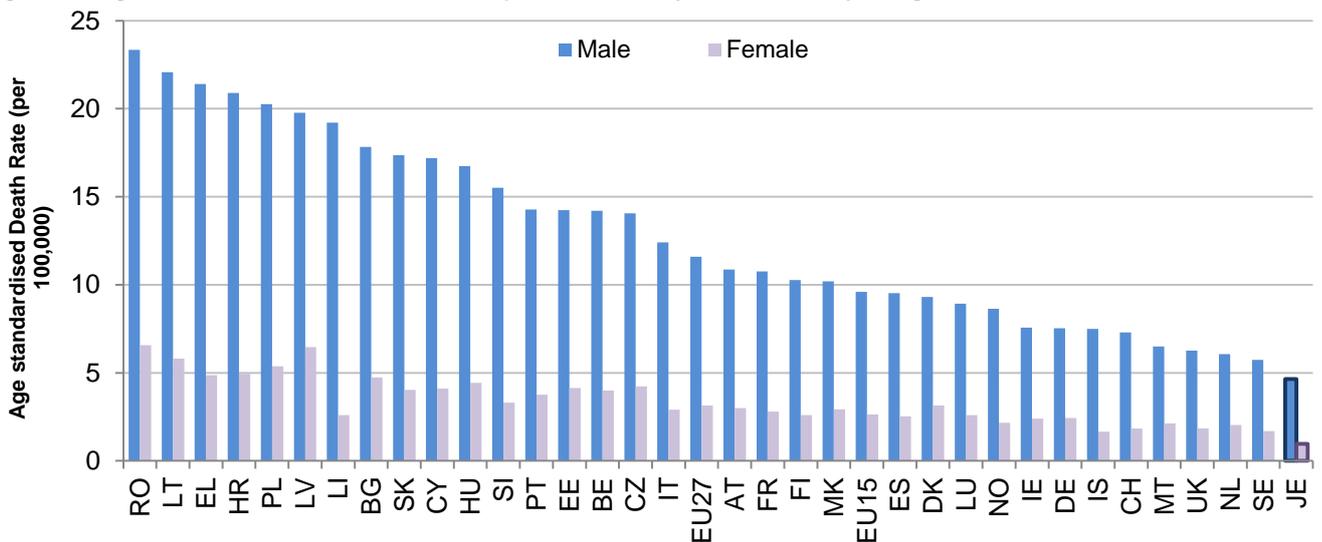
Figure 7.5: Age-standardised Death Rates from Falls, by sex and country, average 2008-2010



Source: Eurostat hlth\_cd\_asdr and Health Intelligence Unit

Conversely, deaths due to transport accidents in Jersey are amongst the lowest death rates in Europe (Figure 7.6) which is possibly an attribute of the lower speed limits in the Island.

Figure 7.6: Age-standardised Death Rates for transport accidents, by sex and country, all ages, 2008-2010

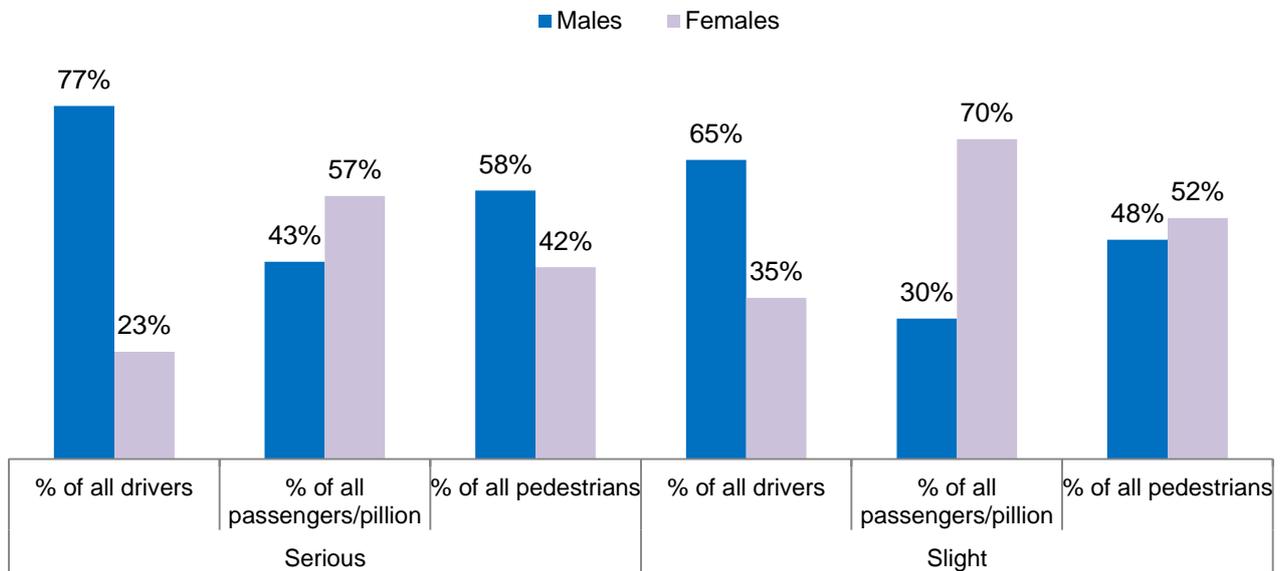


Source: Eurostat hlth\_cd\_asdr and Health Intelligence Unit

Like the rest of Europe, more male drivers are killed in road traffic accidents than female drivers, whereas a greater number of female passengers and pedestrians were killed between 2010 and 2012.

Around 600 males were injured on Jersey roads over a three-year period (2010 to 2012) compared to around 400 females over the same time scale, reflecting the pattern seen across Europe, where men are more at risk than females of being injured in a traffic accident.

Figure 7.7: Percentage of Males and Females slightly or seriously injured in Road Traffic Accidents 2010-2012



Source: States of Jersey Police

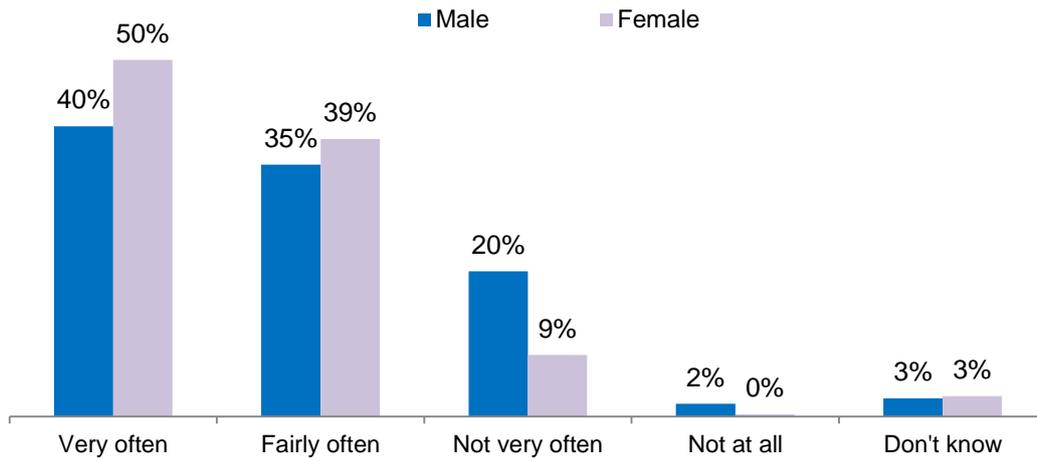
The EU Men’s Health Report<sup>64</sup> found a large disparity across Europe for transport accidents, with low to middle-income countries seeing 1.5 times more deaths than high income countries. The report also found higher rates among men with lower socio-economic status and less education.

When considering the number of males killed or injured on Jersey roads in recent years, the differences in perceptions about road safety are of interest. When asked<sup>65</sup> what respondents thought caused the most crashes, around 9 out of 10 women (89%) thought speeding caused crashes either ‘very often’ or ‘fairly often’ compared to 3 out of 4 men (75%). See Figure 7.8.

<sup>64</sup> European Commission, The State of Men’s Health in Europe, European Union 2011, available from <http://europa.eu>

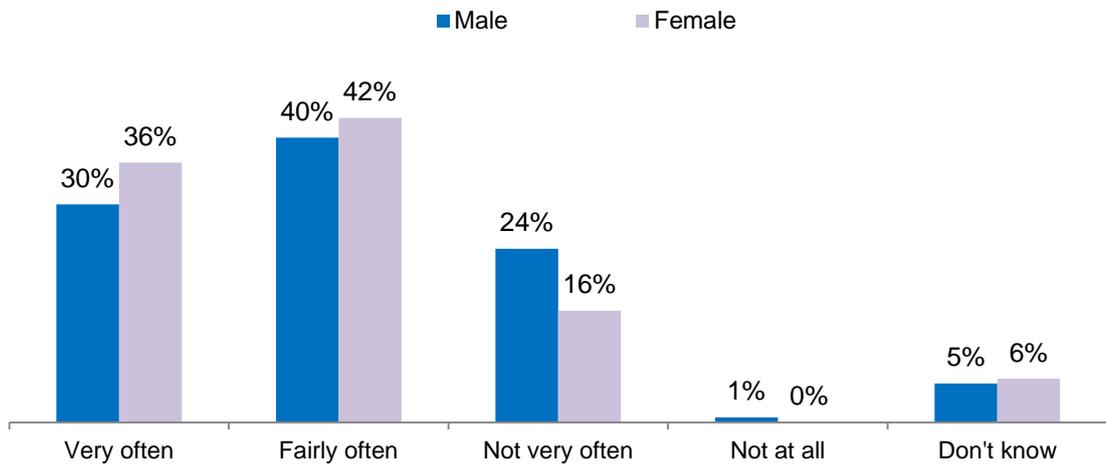
<sup>65</sup> 2012 Jersey Annual Social Survey

Figure 7.8: Road safety perceptions about what causes the most crashes, by gender: speeding



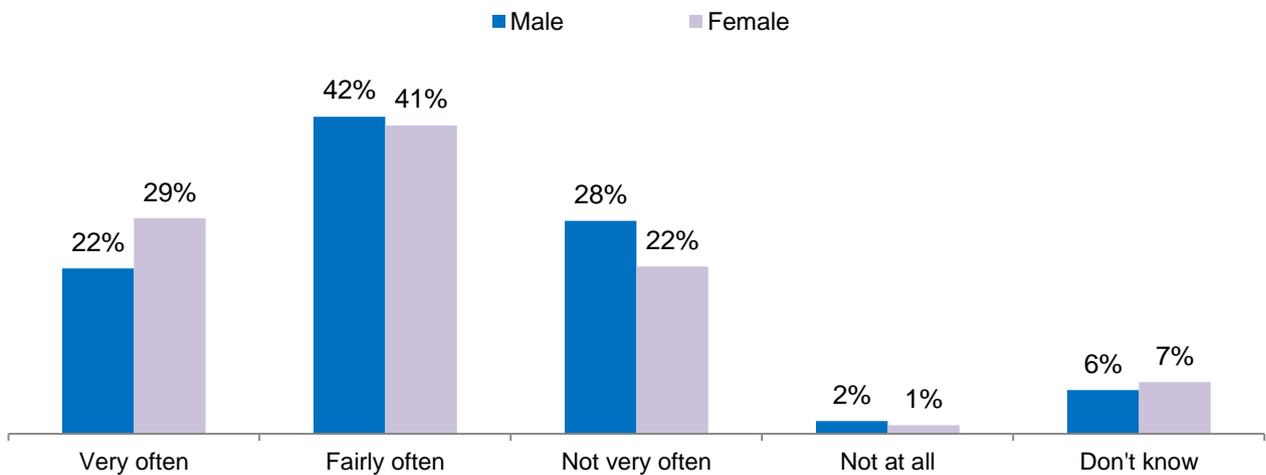
Source: JASS 2012

Figure 7.9: Road safety perceptions about what causes the most crashes by gender: drink driving,



Source: JASS 2012

Figure 7.10: Road safety perceptions about what causes the most crashes by gender: using a mobile phone whilst driving,



Source: JASS 2012

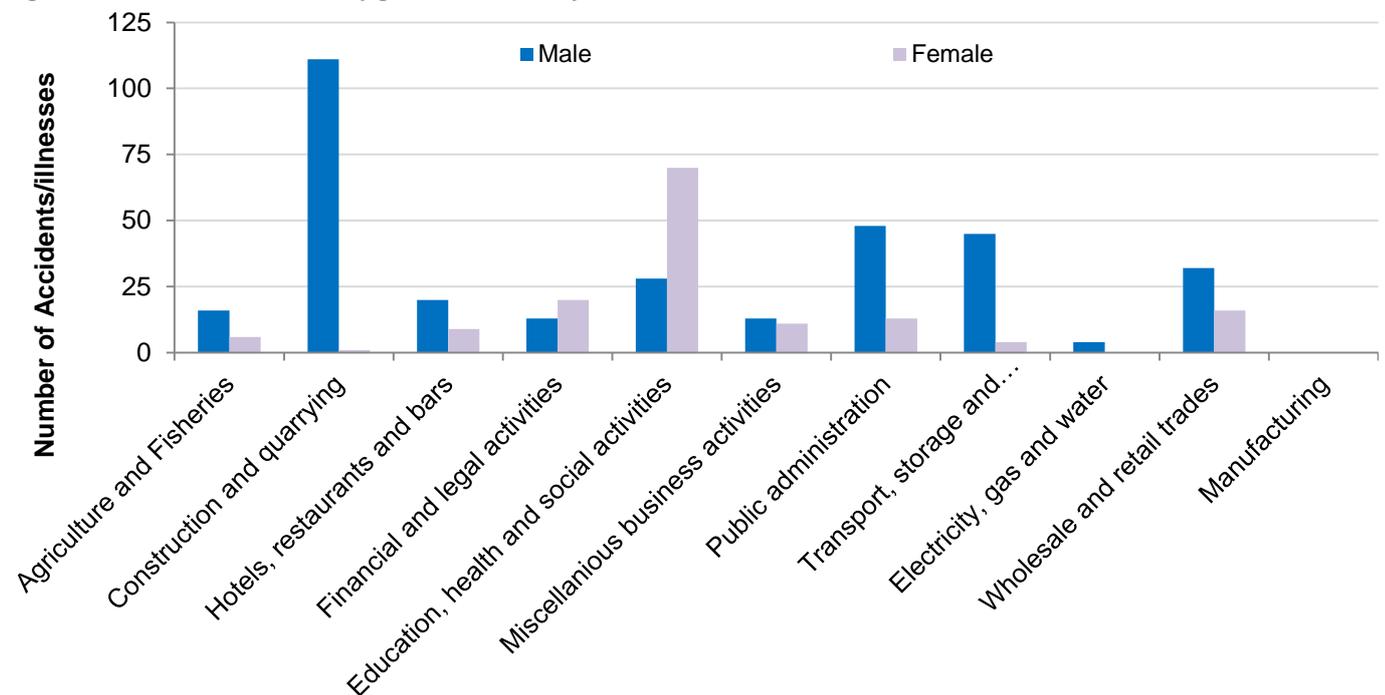
## Workplace Accidents

Around one in twenty workers (6%) in Jersey said they had had an accident at work, or in the course of their work, which resulted in an injury.<sup>66</sup> This proportion increased for those in 'routine' or 'technical' type occupations.

In Jersey, more men than women have accidents at work. In 2013, around 200 men reported a workplace accident<sup>67</sup> (Figure 7.11) whilst another 140 had a workplace illness such as occupational musculo-skeletal disorders. Around 50 women reported a workplace accident to the Health and Safety Inspectorate in 2013.

The majority of workplace accidents locally are reported to occur as the result of: overexertion and strenuous movements; stepping on, hitting or being struck by objects or falls (Figure 7.12). Most occupational accidents result in sprains and strains (50% of male and 58% of female accidents), fractures (18% male, 15% female) or lacerations and open wounds (14% of male accidents). Men are most affected, probably because of the nature of their occupations (see Chapter 1).

Figure 7.11: Accident and illness by gender and industry 2013



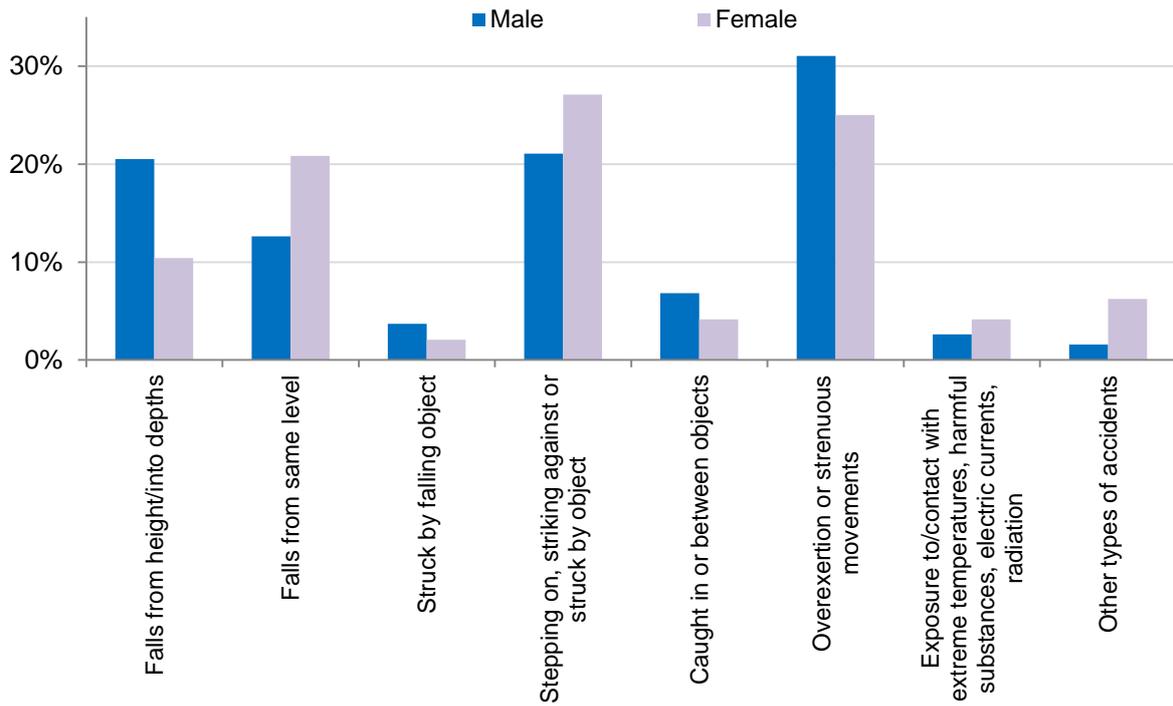
Source: Health and Safety Inspectorate, Social Security Department

Illness includes occupational respiratory diseases, occupation skin conditions and occupational musculo-skeletal disorders

<sup>66</sup> 2009 Jersey Annual Social Survey

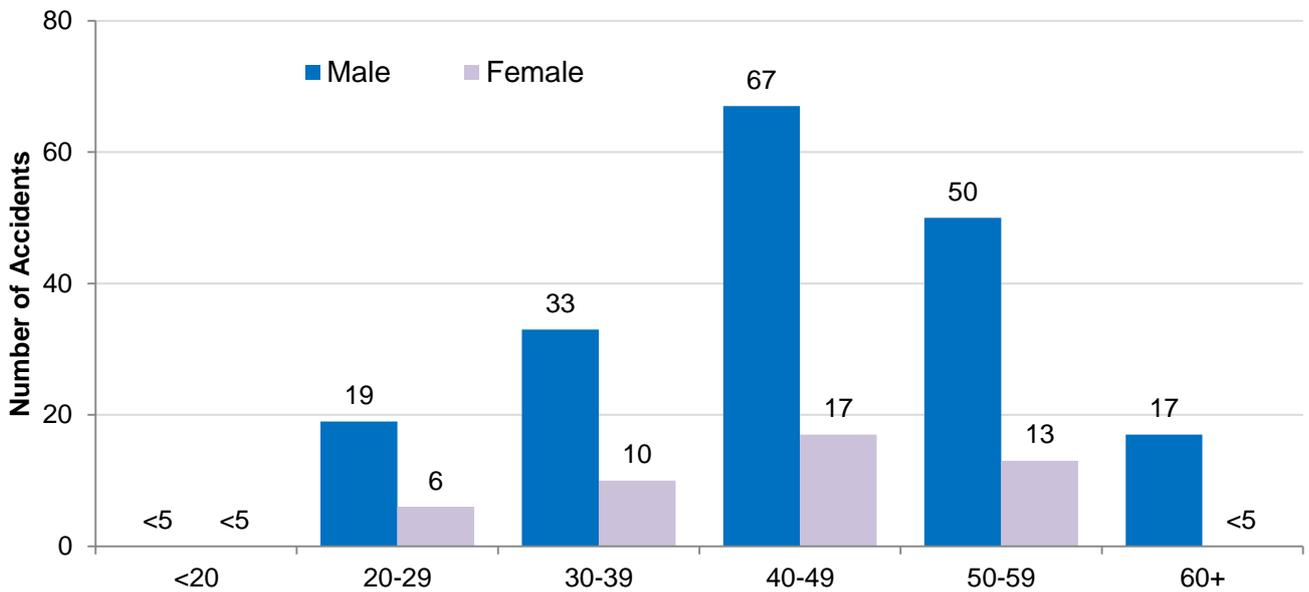
<sup>67</sup> States of Jersey Social Security Health and Safety Inspectorate data based on returned forms (some 63% of known workplace accidents)

Figure 7.12: Work accidents by gender: percentage of reported accidents 2013



Source: Health and Safety Inspectorate, Social Security Department

Figure 7.13: Occupational accidents 2013 by gender and age group



Source: Health and Safety Inspectorate, Social Security Department

CHAPTER  
8

MENTAL HEALTH





- Men's depression and other mental health problems are underdetected and undertreated in all European countries;
- Reported rates of depression and anxiety in Jersey are similar for both men and women, with around 2% reporting extreme anxiety or depression;
- Suicide rates for men have fallen recently in Jersey, but still remain three times higher than the rate for females;
- Self-harm hospital admissions peak in the 20-44 age group for men. However, younger (under 18 years) and older women (55 years and over) make up the highest proportions of admissions locally.

## Summary

Jersey men and women report similar levels of extreme anxiety and depression and have similar mental wellbeing scores. However, locally, men have a much higher suicide rate than women, especially in the 24-30 age group. The European men's health report found that a greater number of women were diagnosed with mental health problems including depression and anxiety while more men commit suicide.<sup>68</sup>

Men's depression and other mental health problems are thought to be underdetected and undertreated in all European countries.<sup>69</sup> This is considered to be due to men's difficulty in seeking help, the limited capacity of health services to reach out to men, and men's different presentation of higher levels of substance abuse and challenging behaviours compared to women.

In Jersey, around 225 potential male years of life are lost<sup>70</sup> each year due to suicides, compared to around 70 potential female years of life.

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<sup>68</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

<sup>69</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

<sup>70</sup> Potential years of life lost (YOLL) 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.

## Men and Mental Health

The Jersey Annual Social Survey (JASS) in 2012 contained questions from the Short Warwick Edinburgh Mental Wellbeing tool<sup>71</sup> (WEMWBS). A person's score on the scale can range between 7 and 35, with a score of 35 representing the most mentally healthy a person can be. The average (mean) mental wellbeing score for men and women in Jersey was the same (26).<sup>72</sup> There was also no difference in the mental wellbeing scores between age groups within each gender.

Both men and women who were unable to work due to long-term sickness or disability, and those unemployed and looking for work showed lower scores than the rest of the population (21 for long-term sick, 24 for unemployed seeking work, compared to 26 for those working or self-employed).

Those men who described themselves as 'very' active had higher mental wellbeing scores (average of 28) than those who were 'not at all' physically active (average of 22). Similar results and scores were seen for women.

Nine out of ten men reported being 'very' or 'fairly' satisfied with the life they lead. A small proportion (2%) of men were 'not at all' satisfied with life.

## Depression

Levels of anxiety and depression amongst the adult population (aged 16+) on the Island are estimated through questions asked in JASS. The EuroQol tool (EQ 5D) is used to measure five aspects of an individuals' quality of life which includes anxiety and depression.

Respondents can report none, moderate or extreme levels of anxiety or depression.

Around 2% of men described themselves as being 'extremely anxious or depressed' in 2012.<sup>73</sup> A similar proportion was found for women answering the survey. This proportion has remained constant for several years (JASS 2006 and JASS 2010).

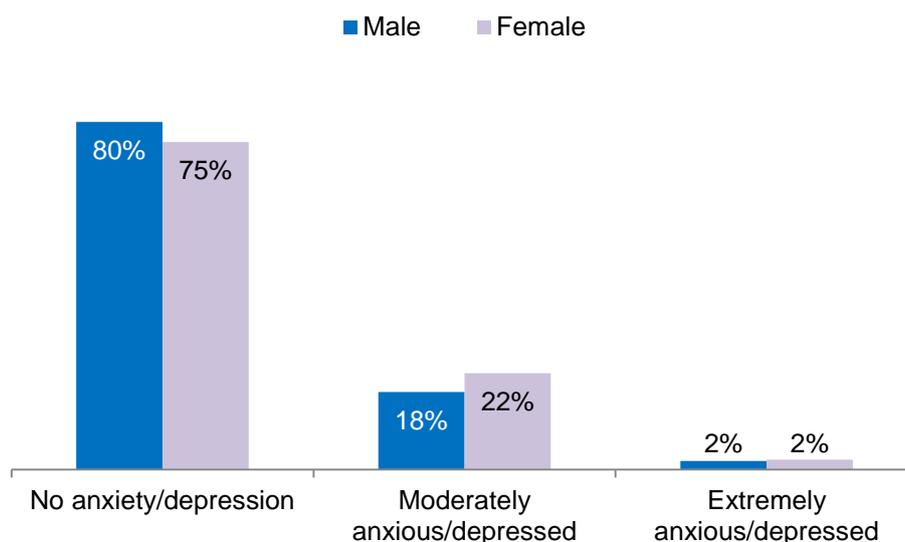
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<sup>71</sup> The Short Warwick Mental Well-being scale is a screening tool that can be used to ascertain the mental-health of a population; more information available from <http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx>.

<sup>72</sup> The WEMWBS questions were repeated in JASS 2013, which showed no change in the mental wellbeing of the population.

<sup>73</sup> 2012 Jersey Annual Social Survey

8.1: 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 compared with 2010.

## Suicide and Self-Harm

Local data shows that although suicide numbers and rates in Jersey have decreased recently, they remain high for men (Figure 8.2).

In 2009, Jersey experienced an unexpected increase in the number of suicides, with 17 males and eight females committing suicide. The highest suicide rate was in young men aged 24-35 years of age.

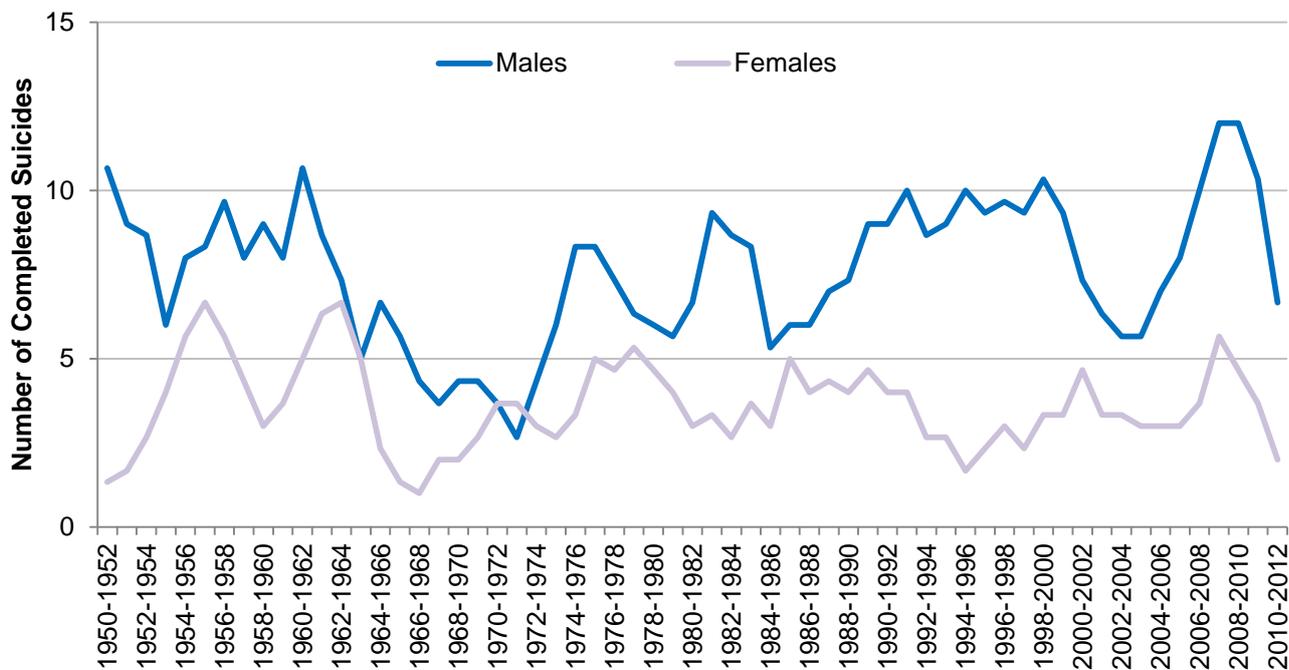
Over the period 2008-2010 (Figure 8.3) the suicide rate in Jersey was significantly higher than England and Wales and amongst the highest in Europe, due to the influence of the particularly high suicide rate observed in 2009.

The 2010-2012 rates are considerably lower, not significantly different to England and Wales, and lower than the latest reported EU average of 12.3 per 100,000.<sup>74</sup>

<sup>74</sup> OECD (2012), 'Mortality from suicide' in *Health at a Glance: Europe 2012*, OECD publications.

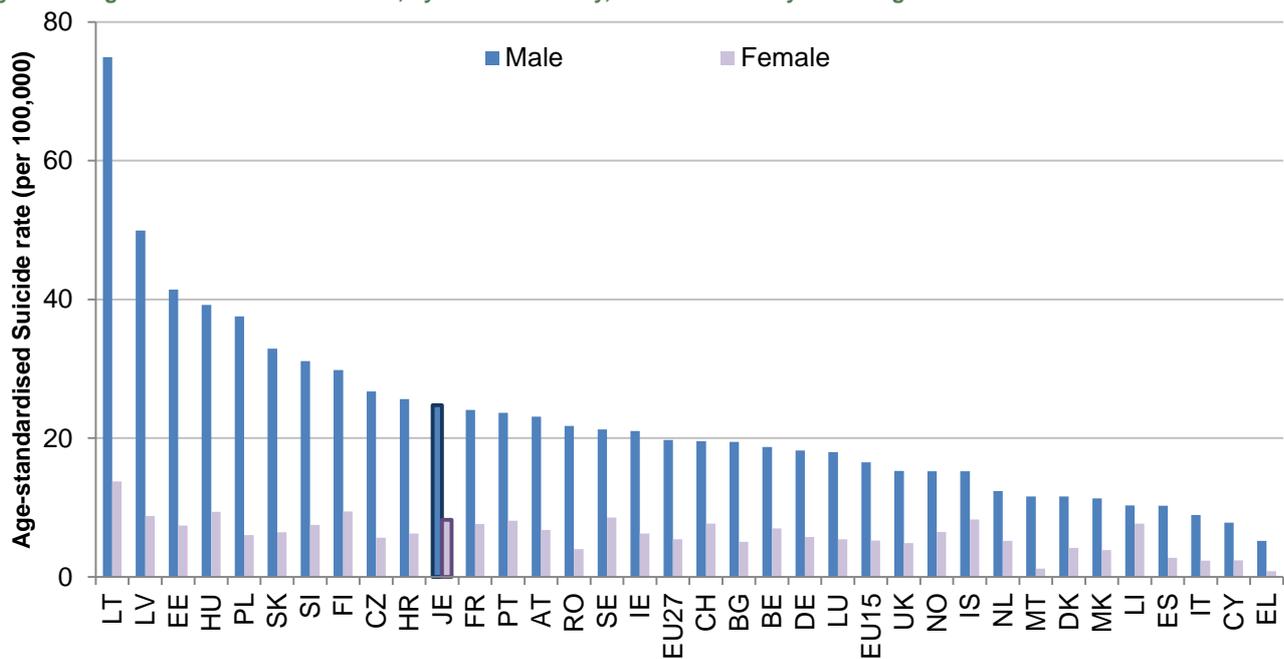
However, suicide rates for men remain relatively high. They are around three times higher than the female death rate, with the highest rate among men aged 30-49. In 2010-2012, there were an average of 7 male suicides annually compared with 3 female suicides - age-standardised rates of 15.9 and 5.0 per 100,000, respectively.

Figure 8.2: 3-year rolling average of number of completed suicides, 1950-2012, by gender



Source: Health Intelligence Unit

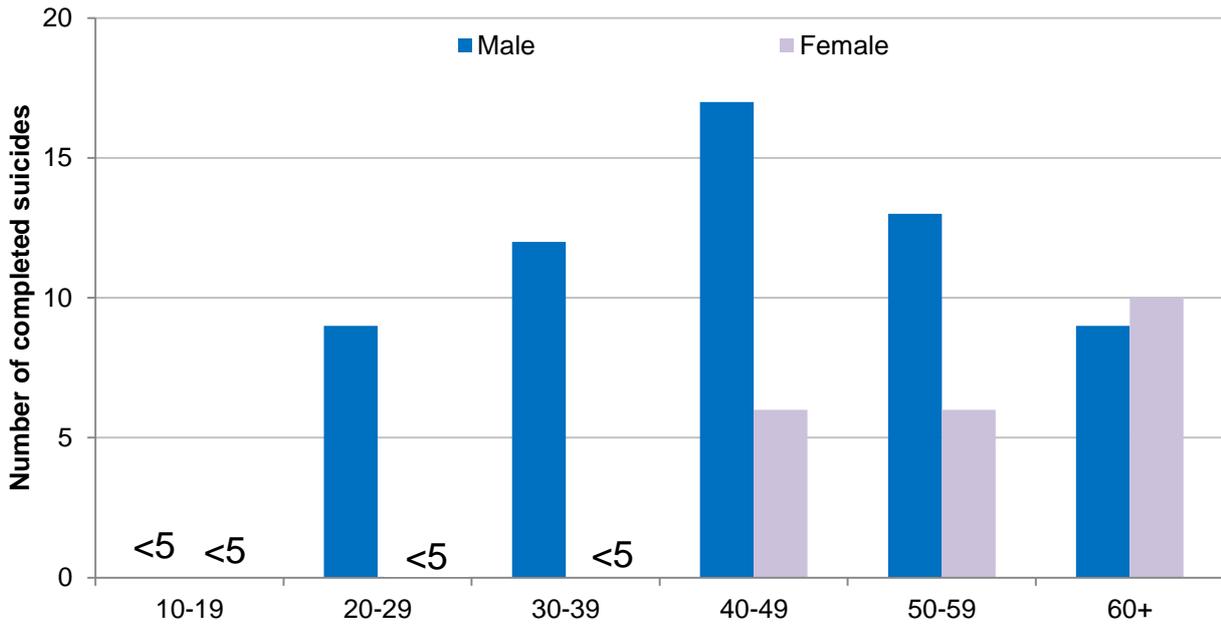
Figure 8.3: Age-standardised Suicide rate, by sex and country, 2008-2010 three-year average



Deaths classified as 'events of undetermined intent' and 'intentional self-harm' as reported jointly as 'suicide'.

Source: Eurostat hlth\_cd\_asdr and Health Intelligence Unit

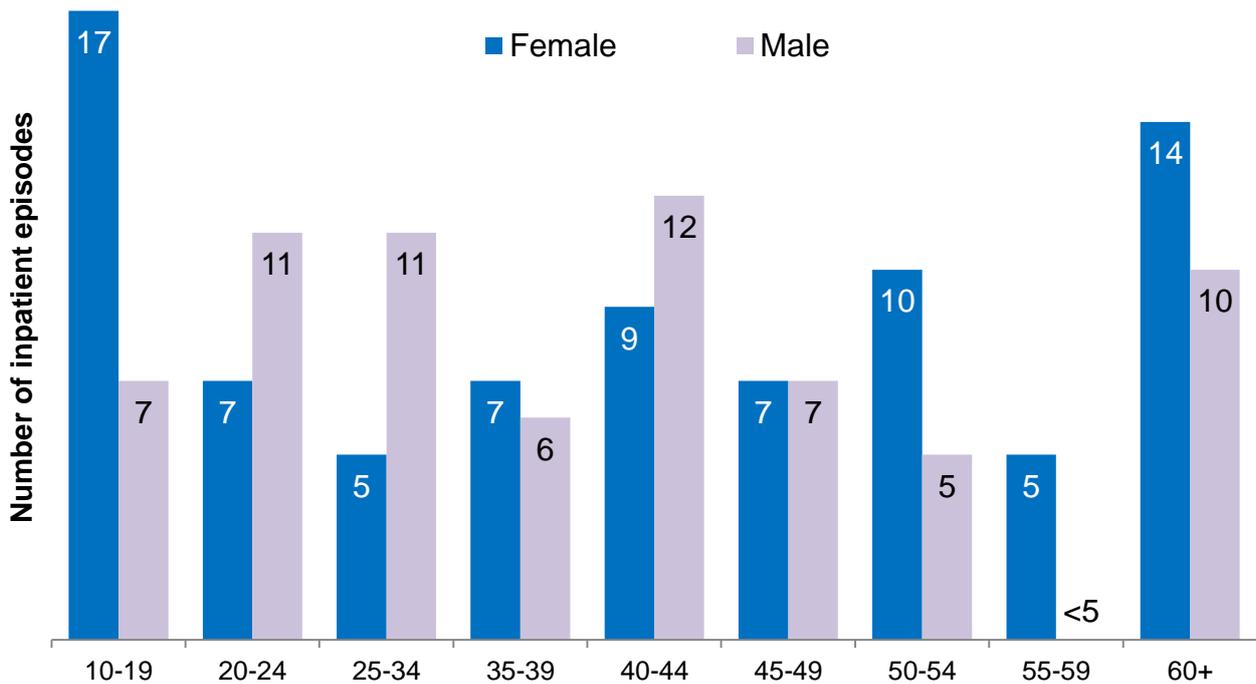
Figure 8.4: Age range of suicides (intentional self-harm and events of undetermined intent), 2007-2012



Source: Health Intelligence Unit

In 2012, there were around 150 discharges from hospital admissions coded as self-harm. This was made up of 130 individuals – 46% male and 54% female. Male admissions peaked in the 20-44 age groups, whilst younger women (18 years and under) and older women (55 years and over) made up the highest proportion of admissions.

Figure 8.5: Self-harm episodes, 2012



Source: Health Intelligence Unit

CHAPTER  
9

COMMUNICABLE DISEASES





- Local deaths from communicable diseases are low. However, men have a higher risk of dying prematurely from the major infections as result of reduced immunity and their greater likelihood to being exposed to a lifestyle or social circumstances that makes them more susceptible;<sup>72</sup>
- Over a quarter (28%) of male deaths from influenza and pneumonia occur before 80 years of age, compared to 1 in 6 (17%) female deaths from both infections;
- TB affects a small number of individuals in Jersey, with less than 5 deaths occurring over the past 6 years;
- Men in Jersey are more likely to be diagnosed with gonorrhoea and syphilis than women;
- Uptake of HIV tests in the Jersey GUM clinic is consistently higher than the UK;
- Four-fifths (80%) of those who started treatment for Hepatitis C in 2013 were male.

## Summary

Within countries undergoing major social upheaval, communicable diseases are still an important cause of premature death. In Jersey communicable disease incidence and deaths are very low, so it is difficult to identify any differences between males and females. Low numbers die from pneumonia annually and very low numbers from tuberculosis (TB). As in the EU the risks from sexually transmitted diseases continue to be a challenge, with higher rates of gonorrhoea and syphilis reported in men than women at the local Genito-Urinary Medicine (GUM) clinic. The majority of diagnosed HIV cases continue to be in men.

Communicable diseases have significantly been reduced in Europe over the last two decades for both men and women, but the gender differences in morbidity and mortality between countries and within the EU are still very significant. Across the lifespan, deaths from influenza and pneumonia are higher in men and boys until the over 80 age bracket,

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<sup>75</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

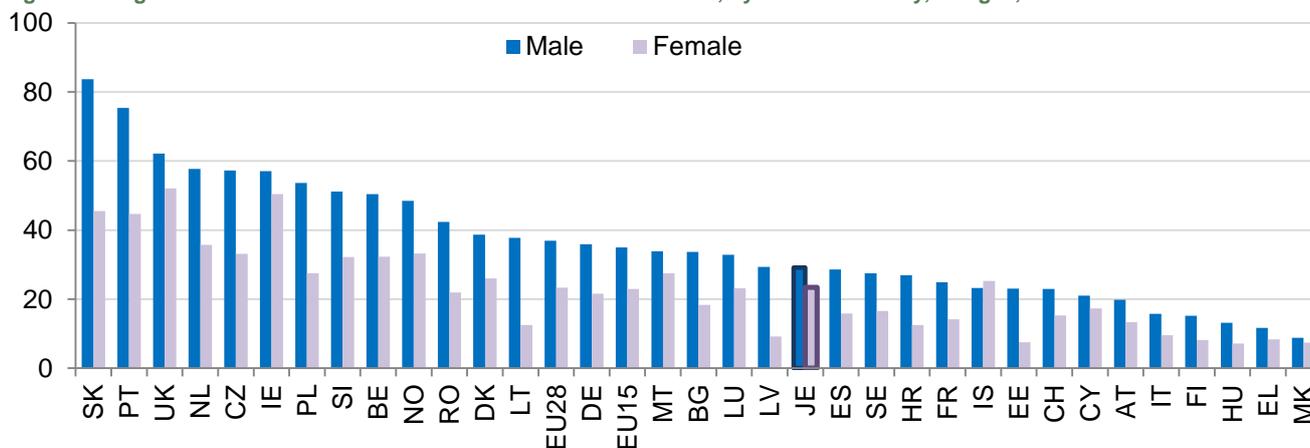
which accounts for 83% of female deaths and 72% male deaths from influenza and pneumonia.

## Influenza and Pneumonia

In 2013, around 3% of all male and 3% of all female deaths were due to influenza and pneumonia, equating to 10 and 11 deaths respectively. The number of deaths from these communicable diseases has fallen over the last few years, from 40-50 annual deaths 2008-2009 to 20-30 deaths annually in recent years.

Jersey death rates are below the EU average for men (Figure 9.1). There is generally an excess of female deaths compared to men, with the average ratio over the years 2007-2013 being 0.7 male deaths for every one female death. More deaths occur in women over the age of 80 (83% of all influenza and pneumonia deaths compared to 72% for men). This pattern is similar to that seen in Western Europe.

Figure 9.1: Age standardised death rates for Influenza and Pneumonia, by sex and country, all ages, 2008-2010



Source: Eurostat hlth\_acdr\_cd and Health Intelligence Unit

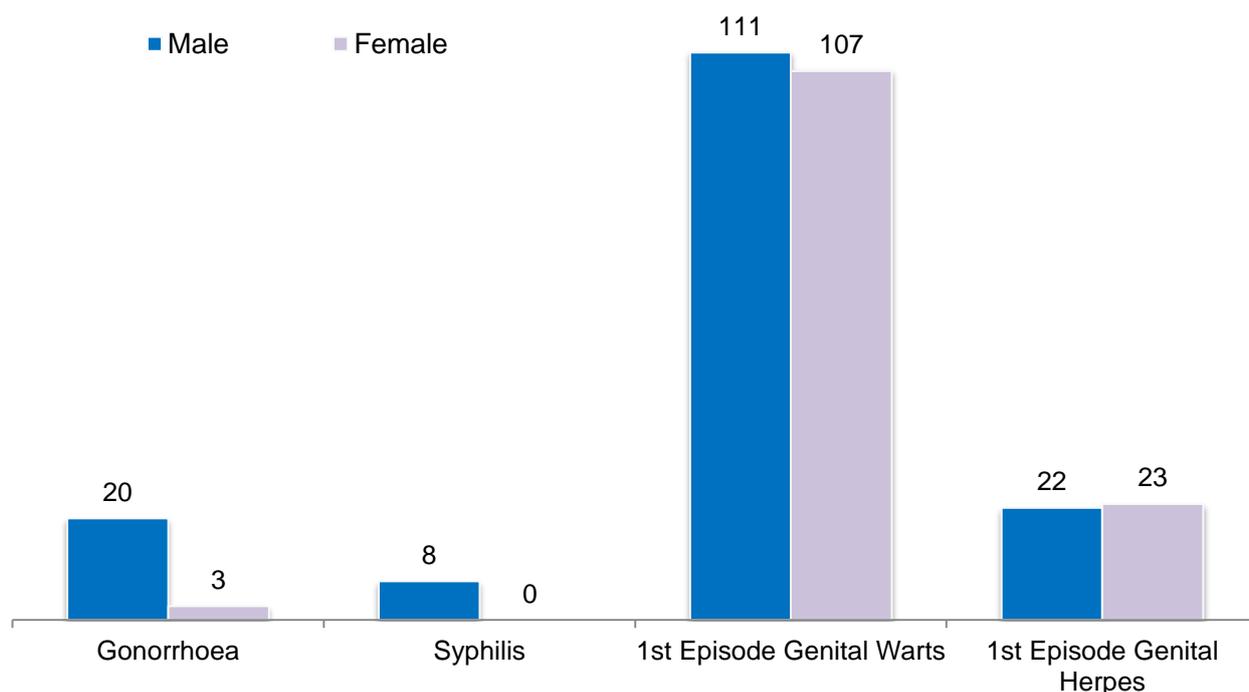
## Tuberculosis (TB)

The number of deaths due to TB in Jersey over the years 2008-2013 is very low (less than five), as are admissions to the Jersey General Hospital (fewer than five a year), so it is not possible to draw specific conclusions about TB in the Island. Across Europe, it had been hoped that the disease was near eradication. However, in some European countries there appears to be a worrying increasing trend.

## Sexually Transmitted Infections

Men have higher diagnosis rates for gonorrhoea and syphilis than women in Jersey, over the period 2011-2013, although rates locally are lower than in England. In contrast, diagnosis rates for genital warts and herpes at the GUM clinic are similar for both men and women (Figure 9.2).

Figure 9.2: Rate of diagnosis at GUM clinic per 100,000 population, 2011-2013



Source: GUM KC60 data

In 2013, 52% of all visits to the GUM clinic were made by males, some 1,200 visits. The number of male visits to the GUM clinic has steadily increased in recent years, from around 800 annually in 2009 and 2010 to 1,200 most recently, indicating a higher number of men now coming forward and being tested. Other services, such as the Community Contraceptive Clinic and Brook see mainly women in the Island.

## HIV/AIDS

The uptake of HIV testing by men at the GUM clinic in 2013 was 97%, a significantly higher rate than the comparative figure for the UK (84%).<sup>76</sup> For men who have sex with men

<sup>76</sup> Public Health England. Sexual and Reproductive Health Profiles 2014. Available from <http://fingertips.phe.org.uk/profile/sexualhealth>

(MSM) in Jersey, this figure has consistently been around 100% over the years 2009-2013, whilst recent figures for England show this figure to be 95% in 2013.<sup>77</sup> The majority (97%) of women offered a HIV test at the Jersey GUM clinic in 2013 took the test, compared to 76% in England.

Less than 100 persons have been diagnosed with HIV over the last 10 years in Jersey. Of those who were diagnosed, three-quarters (76%) were male. Like Europe, the predominant modes of transmission are unprotected sex between men, unprotected heterosexual activity and sharing drug injecting equipment.

Deaths due to HIV/AIDS are very small in Jersey, with fewer than five deaths occurring between 2008 and 2013.

## Viral Hepatitis

In Jersey, deaths due to viral hepatitis are very low, with fewer than five people dying over the years 2008 to 2013. The number of diagnosis made each year at the GUM clinic is also low (less than five in any year).

Of those who started treatment for Hepatitis C in 2013, four-fifths (80%) were male.

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<sup>77</sup> Public Health England. Sexual and Reproductive Health Profiles 2014. Available from <http://fingertips.phe.org.uk/profile/sexualhealth>

CHAPTER  
10

DENTAL & ORAL HEALTH





- Around two-thirds of men reported visiting the dentist at least once in the previous twelve months;
- Around a fifth (22%) of men were not registered with a dentist in 2013, compared to 1 in 7 (14%) of women;
- Half of men not registered with a dentist gave the reason that they couldn't afford to go to the dentist;
- Men in Jersey are more likely to be diagnosed with and die of oral cancer than women.

## Summary

Dental and oral ill-health is linked to systemic diseases as well as being the source of marked discomfort to the individual. The causes of periodontal disease are closely associated with risky health behaviour but, though this was once seen mainly as a problem of the older men, it is now being increasingly seen in the young, especially those who are obese.<sup>78</sup>

Whilst there are variations across the EU with regards to consultation with a dentist by educational level, the EU Men's Health Report concluded that periodontal disease can be prevented through changes in lifestyle behaviours.

Men in Jersey are more likely to die of oral cancer than women. There is a small difference in the proportion of men and women visiting the dentist regularly. However, a greater proportion of men were found to have not registered with a dentist in Jersey.

## Men's Dental Health

Information about dental health of adults in the Island is very limited. Men are more at risk of cancers of the lip, oral cavity or pharynx. In Jersey around 18 new cases of oral cancer are diagnosed each year<sup>79</sup>, with men five times more likely to be diagnosed with an oral cancer than women, (around 15 men a year are diagnosed). Death rates in men locally are

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<sup>78</sup> European Commission, The State of Men's Health in Europe, European Union 2011, available from <http://europa.eu>

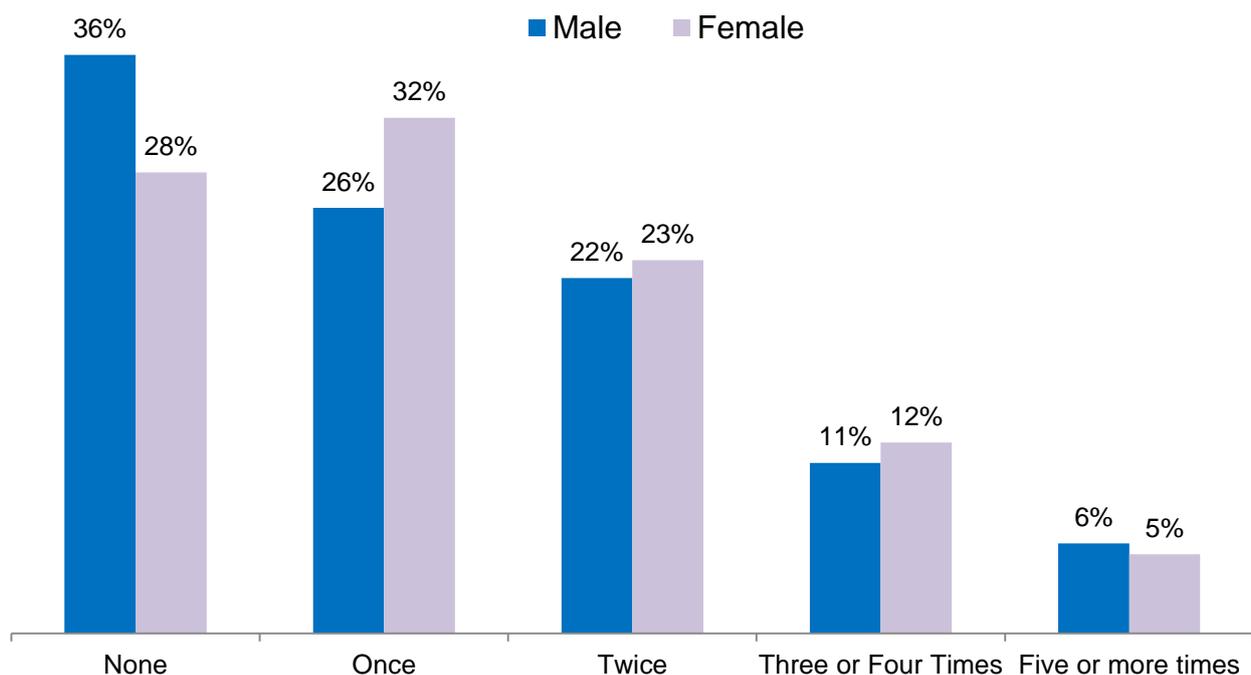
<sup>79</sup> Public Health England Knowledge and Intelligence Team (formerly the South West Cancer Intelligence Network) Channel Islands Cancer Report 2013 – available [www.gov.je](http://www.gov.je)

also higher with an age-standardised rate of 12 deaths per 100,000 males compared to one death per 100,000 females each year in Jersey (2010-2012 figures). It is therefore important that good oral hygiene is maintained. Risk factors for oral health include tobacco use, stress, excessive alcohol consumption and diabetes mellitus.

## Oral Health Care

Around two-thirds of men (64%) reported having been to a dentist once or more in the previous twelve months compared to around three-quarters (72%) of women<sup>80</sup> (Figure 10.1). This small difference in the proportions using a dentist follows the pattern reported in Europe where men are less likely to visit a dentist than women.

Figure 10.1: Number of visits to a dentist in the previous twelve months



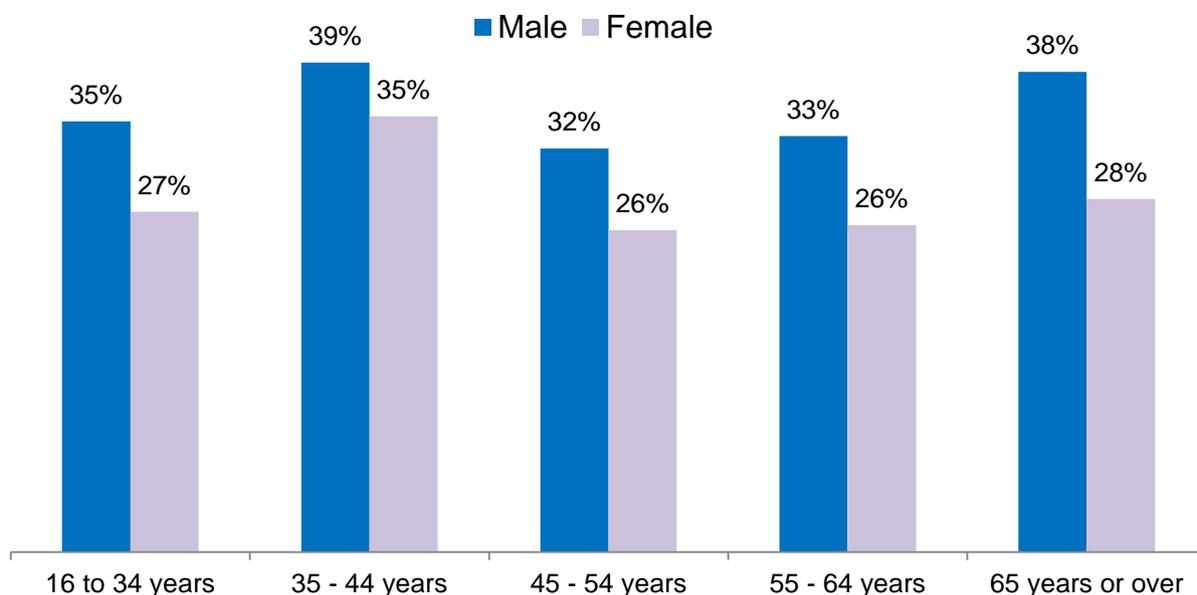
Source: JASS2013

Examining the demographics of those who reported not having seen a dentist, men at all ages were more likely to report not having been to a dentist compared to women (Figure 10.2).

<sup>80</sup> 2013 Jersey Annual Social Survey

Men with no formal qualifications or other qualifications were more likely not to have been to the dentist in the previous twelve months (48%) compared with men with secondary qualifications (34%) or with higher qualifications (27%).

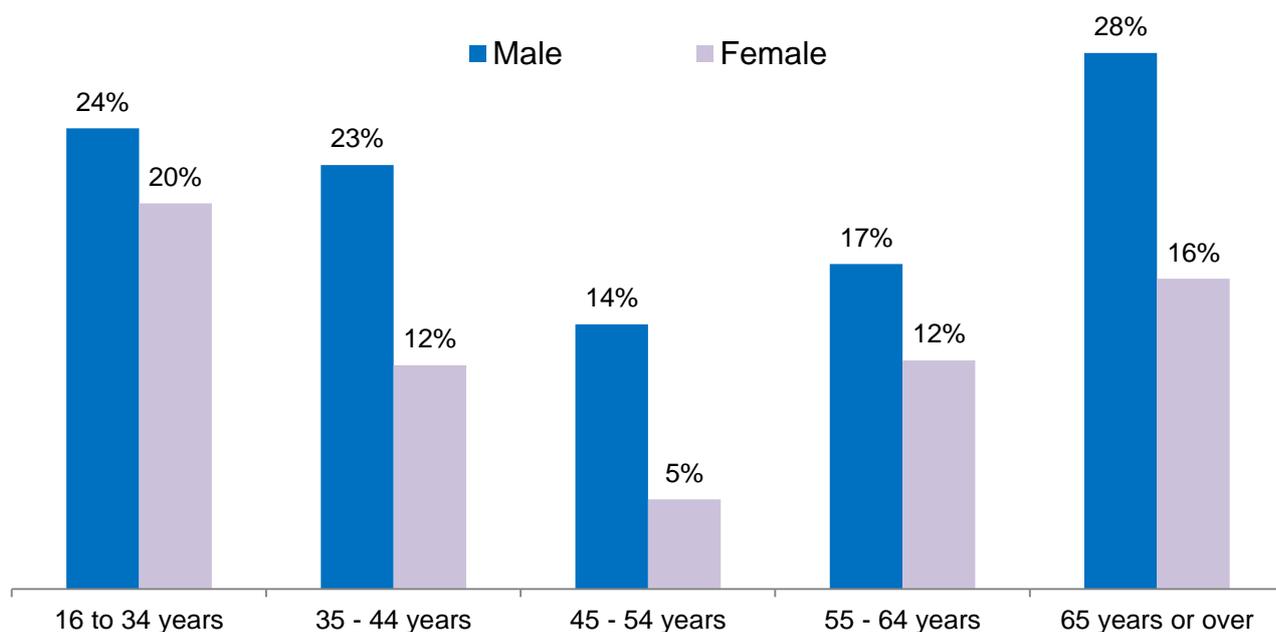
Figure 10.2: Proportion who reported not visiting a dentist in the previous twelve months, by age



Source: JASS2013

Around a fifth (22%) of men answering JASS 2013 were not registered with a dentist in Jersey, whilst one in seven (14%) of women were not registered.

Figure 10.2: Proportion not registered with a dentist, by age



Source: JASS2013

Over half (52%) of men who were not registered with a dentist said this was because they could not afford to go to the dentist (Table 10.1). One in ten men (10%) who were not registered reported not having had time to do so, whilst almost a fifth (18%) were accessing dental treatment elsewhere and 28% reported having no need and generally no dental problems.

**Table 10.1: Which of the following reasons best describe why you are not registered with a dentist in Jersey? (Respondents were able to tick more than one method). Percent of those not registered with a Dentist**

	Male	Female
Can't afford to go to the dentist	52%	49%
No need - generally no dental problems	28%	31%
I access dental treatment elsewhere (abroad)	18%	24%
Don't like going to the dentist	14%	14%
Have not had time to register	10%	2%
I haven't lived in Jersey long enough/don't intend to stay	4%	7%
Don't know how to register	2%	2%

Source: JASS2013

CHAPTER  
11

OTHER HEALTH CONDITIONS





- Chronic Lower Respiratory Diseases account for 6% of local male deaths each year and are a top five cause of death for men;
- Diabetes Mellitus accounts for 2% of male deaths annually in Jersey, and is a contributory condition in 1 in 10 (9%) of male deaths from cardiovascular diseases;
- The local diabetic clinic has more men than women with Type II diabetes.
- There were 240 annual male admissions to the Jersey General Hospital where a fall had been documented. There are less than 5 male deaths from falls each year.

## Summary

In Jersey, slightly more men than women die from chronic lower respiratory diseases which account for 6% of total male deaths. This is higher than the European average of just over 4% of total male deaths.

Type II diabetes is increasing in men in Europe due to the rising tide of male obesity and the metabolic syndrome, causing higher levels of premature mortality. In Jersey, there are more men with Type II diabetes than women. More men are admitted to hospital for diabetes and, although low, there are more male deaths due to diabetes.

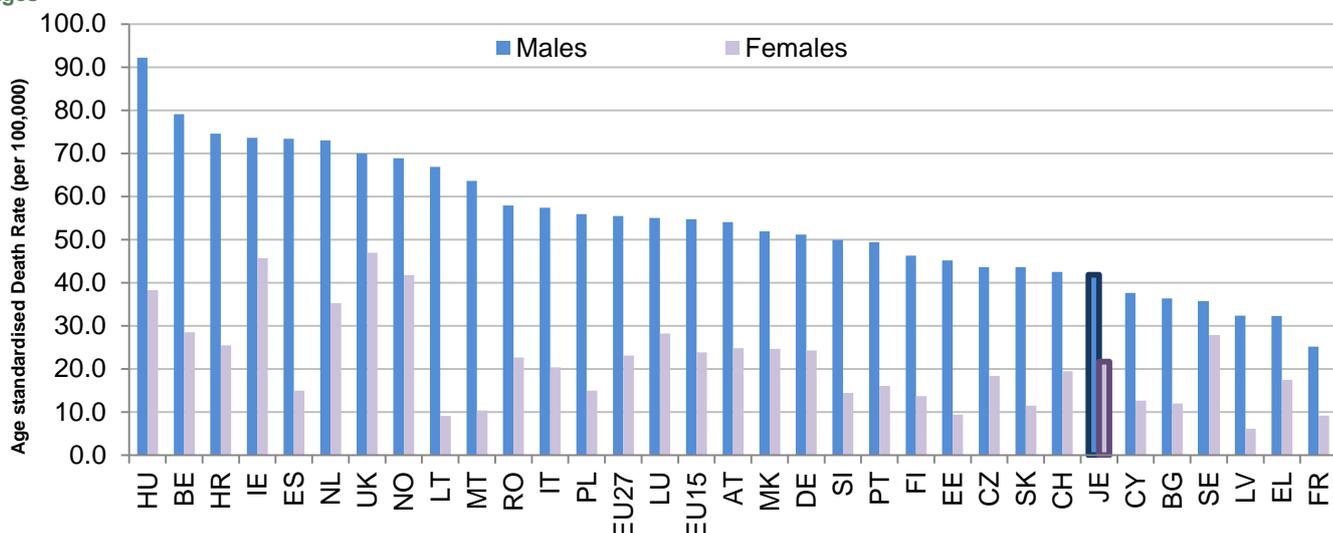
## Chronic Lower Respiratory Disease

This category of diseases encompasses bronchitis, emphysema, asthma, bronchiectasis and chronic obstructive pulmonary diseases. These are conditions that are either caused or exacerbated by smoking.

These diseases caused 25 male deaths and 20 female deaths annually in Jersey in 2010-2012, accounting for 6% of all male and 5% of all female deaths. Chronic lower respiratory diseases account for 4% of all male deaths in Europe, indicating we may have more male deaths than might be expected from these diseases in Jersey. However, Jersey male death rates from these diseases are below the EU average (Figure 11.1) and lower than many European countries.

For men in Jersey, chronic lower respiratory diseases are one of the top five causes of death and for women, it is the seventh highest cause of death.

Figure 11.1: Age-standardised Death Rate (average 2008-2010) for Chronic Lower Respiratory Disease, by sex and country, all ages



Source: Eurostat hlth\_cd\_ysdr1 2008-2010 and Health Intelligence Unit

Chronic lower respiratory diseases form a significant part of diseases of the respiratory system. For men, 53% of deaths attributed to the respiratory system are due to chronic lower respiratory diseases, compared to 41% of female deaths. Premature deaths for respiratory diseases (J00-J99) in Jersey were worse than the England average for the period 2010-2012. Two-thirds of premature respiratory deaths were due to chronic lower respiratory diseases. Jersey ranks 81<sup>st</sup> out of 150 English Regions<sup>81</sup> with 60% of these deaths being male individuals.

Hospital admissions for chronic lower respiratory diseases account for around 1% of both male and female episodes (2012-2013). One in ten (10%) of all hospital admission episodes were people who have chronic lower respiratory diseases as a co-morbidity over this period.

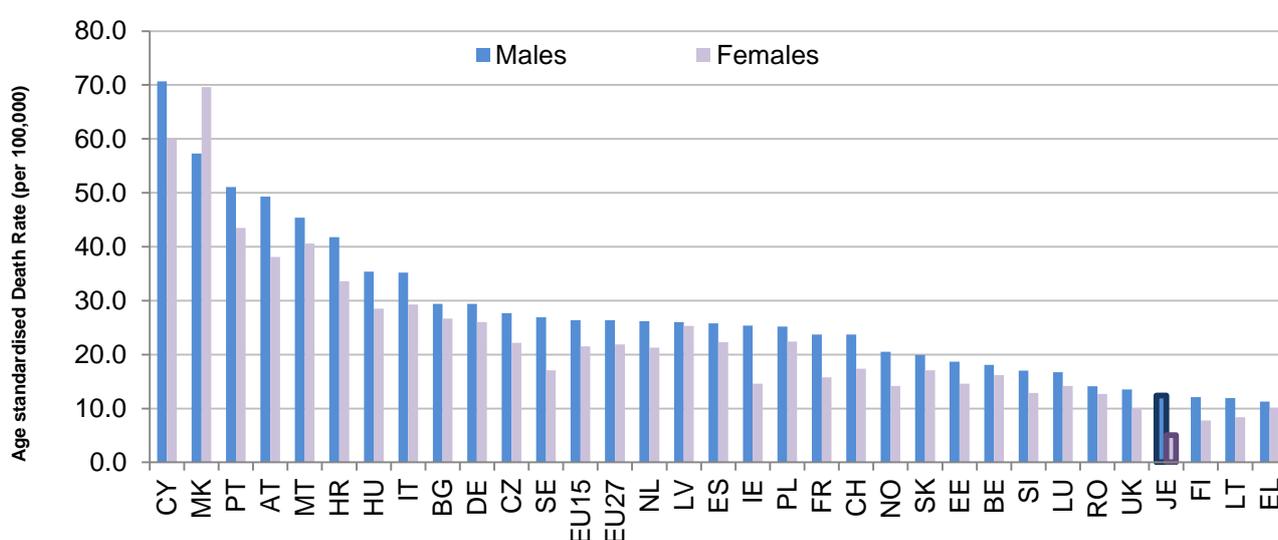
The EU Men's Health Report predicts that it is likely that there will be an increase in morbidity and mortality among women in the future due to the increasing number of women smoking.

<sup>81</sup> For further information, see Premature Deaths of Jersey Residents 2010-2012, Health Intelligence Unit, April 2014, available from [www.gov.je](http://www.gov.je)

## Diabetes

Type I diabetes refers to a form of the disease which usually first presents in childhood or in those whose pancreas is unable to produce insulin through damage or infection. Type II diabetes, known as maturity onset diabetes, is associated with resistance to insulin. Being overweight or obese are risk factors for Type II diabetes. The World Health Organization considers diabetes to be an epidemic and predicts diabetes will be the 7<sup>th</sup> leading cause of death by 2030.<sup>82</sup>

Figure 11.2: Age-standardised Death Rate (average 2008-2010) for Diabetes, by sex and country, all ages



Source: Eurostat hlth\_cd\_ysdr1 2008-2010 and Health Intelligence Unit

Locally Type II diabetes is increasing and more males are being diagnosed with this. The diabetic clinic had around 1,800 males on their database with Type II diabetes in 2012 compared with around 1,300 females. Diabetes accounts for 2% of all male deaths (average 2010-2012) and 1% of all female deaths on the Island. Our male death rates from diabetes are among the best in Europe (Figure 11.2). However, diabetes also increases the risk of heart disease and stroke. Fifty percent of people with diabetes die of cardiovascular disease (mainly heart disease and stroke).<sup>83</sup> Over the period 2010-2012, around one in ten (9%) of men dying from cardiovascular diseases had diabetes<sup>84</sup>, compared to 6% of female deaths from heart disease.

<sup>82</sup> World Health Organization, Factsheet No. 312 Diabetes. Available from [www.who.int](http://www.who.int)

<sup>83</sup> World Health Organization, Factsheet No. 312 Diabetes. Available from [www.who.int](http://www.who.int)

<sup>84</sup> As per the Medical Fact and Cause of Death certificate

Diabetes accounted for less than 1% of all hospital admissions in 2012 and 2013. Yet one in seven (13%) of male hospital episodes had diabetes as a co-morbidity, compared to 6% of female admissions over the same period.

## Osteoporosis

Data on osteoporosis in the Island is not easily available. In the EU, an awareness that osteoporosis does not just affect women is leading to research on the number of falls and the risk in men<sup>85</sup>. Risk factors for men include low body mass, smoking, weight loss, treatment for prostate cancer, physical inactivity and chronic alcoholism.<sup>86</sup> In Europe they found that although there are a higher number of women falling, men have a higher mortality rate after a fall<sup>87</sup>. Locally, there were 220 male hospital admission episodes where a fall was documented in 2013, compared with 355 female episodes that year. The number of deaths due to falls in Jersey is very low (around 6 annually) and makes quantifying male mortality after a fall using local data difficult. Looking at hospital admission episodes where osteoporosis is documented, between 15% and 24% are male (2012 and 2013). Osteoporosis in men is something to examine further in the future.

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<sup>85</sup> Geusens P & Dinant G (2007) Integrating a Gender Dimension into Osteoporosis and Fracture Risk Research. *Gender Medicine* 4 (supp.B):S147-S161

<sup>86</sup> European Commission, *The State of Men's Health in Europe*, European Union 2011, available from <http://europa.eu>

<sup>87</sup> European Commission, *The State of Men's Health in Europe*, European Union 2011, available from <http://europa.eu>

## Glossary and Abbreviations

ASR	Age-standardised rate (see also Statistical Methods)
Binge drinking	Drinking more than twice the recommended number of units on one day
BMI	Body Mass Index
CHD	Coronary heart disease
CNS	Central nervous system
CVD	Cardiovascular disease
EQ-5D	EuroQol 5D – a standardised instrument to measure health outcomes
EU	European Union
FAST screening tool	A four test screening tool for identifying harmful or hazardous drinking behaviour
GP	General practitioner
GUM	Genitourinary Medicine
HIV/AIDS	Human immunodeficiency virus / Acquired immunodeficiency syndrome
HSSD	Health and Social Services Department
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10 <sup>th</sup> revision – international deaths coding convention
IHD	Ischaemic Heart Disease (coronary heart disease)
ILO	International Labour Organisation
IRR	Incidence rate ratio
JASS	Jersey Annual Social Survey
MRR	Mortality rate ratio
NMSC	Non-Melanoma Skin Cancer
MSM	Men who have sex with men
ONS	Office for National Statistics
PHE	Public Health England
PHE KIT	Public Health England Knowledge and Intelligence Team
PSA Testing	Prostate-specific antigen test
TB	Tuberculosis
TRAK	Jersey General Hospital computer system

UK	United Kingdom
UV	Ultraviolet radiation
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
WHO	World health organisation
YOLL/YWLL	Years of Life Lost/ Years of Working Life Lost (see also Statistical Methods)

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World Health Organisation: [www.who.int](http://www.who.int)

## Statistical Methods

Age standardised rates	<p>An age-standardised rate is the rate of events that would occur in a population with a standard age structure if 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 standard population is used for males, females and all persons and rates are expressed per 100,000 population.</p>
BMI	<p>weight (in kilos) / square of height (in metres)</p>
Crude Rates	<p>A crude rate refers to the number of events per 1,000 or 100,000 population</p>
Life expectancy calculations	<p>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.</p>
YOLL/YWLL	<p>Years of life lost (YOLL) 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 <b>not</b> 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.</p> <p>The age range of 16-64 can also be used to calculate years of working life lost (YWLL) which is a useful indicator of the economic impact of premature deaths. Any deaths below 16 years of age are assumed to lose 49 years of working life regardless of how young they are when they die, for instance at death at age 5 or age 10 would see 49 years of working life lost each.</p>

## Background Notes

1. This report provides facts about how the health of men in 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 cardiovascular diseases, cancer and other health conditions chapters as the comparative data for England uses this standard population. It is anticipated that future health reports will use the 2013 European Standard Population as more of the comparative data is revised.
5. 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 notified 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 as detailed.
  - (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

- 6. 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.
- 7. 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  $\pm 2\%$  for results for the overall population. For further details see [www.gov.je/JASS](http://www.gov.je/JASS)
- 8. All enquiries and feedback should be directed to:

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