A Commentary on Results from the Guernsey and Alderney Wellbeing Survey 2018

What do the results tell us?

WORKING TOWARDS A PARTNERSHIP OF PURPOSE

States of Guernsey
Public Health Services

Contents

What do the results tell us?

In 2018 Public Health Services carried out a population Survey, the Guernsey and Alderney Wellbeing Survey 2018, with the help of local company, Island Global Research. Here we give a high-level overview of how the survey was conducted and why we did it. We summarise some of the key results and consider what those might mean and what implications they may have.

The survey has given us a rich source of data on many health and related topics. While the report of results from the survey runs to more than one hundred pages and tells us an enormous amount about the health of today's islanders, there is inevitably more to say. Over the coming months and years the Public Health team will return to the survey dataset to undertake further analyses. In particular we will be interested to look at long-term patterns of change and how the people of Guernsey and Alderney compare to people from other jurisdictions in different aspects of their health and wellbeing.

We are extremely grateful to all those who gave up their time to complete the survey and to Island Global Research who assisted with planning for, carrying out and analysing the results of the survey.

What we did

The Guernsey and Alderney Wellbeing Survey 2018 was the seventh in a longitudinal series of health surveys —formerly known as the Guernsey and Alderney Healthy Lifestyle Survey— which have been carried out every five years since 1988. The survey consisted of a 67-item questionnaire containing a series of questions, arranged in themed groups.

The 2018 survey was developed by reviewing the questions used in past surveys, retaining those with on-going relevance and adding new items designed to give a broader consideration of wellbeing and the many background factors that influence health. New or revised questions were posed around:

- care given to others and care received;
- health conditions (including longstanding illness, disability and incontinence);
- use of health services (including flu vaccination and frequency of visits to a GP);
- the affordability of healthcare (including insurance coverage and care foregone due to cost);
- out of home eating;
- use of UV sunbeds;
- e-cigarettes;
- life satisfaction, loneliness, and social inclusion;
- sources of anxiety and stress;
- household finances;
- use of digital and social media; and
- health literacy (including trust in different sources of health information).

The survey was brought up to date by giving respondents the option of online completion as an alternative to paper completion and demographic question items were reviewed and updated to ensure best practice was followed and to promote inclusivity. An example of this was the revision of the 'sex' response category to include non-binary and self-describe options.

In keeping with the 2013 Lifestyle survey invitations to complete the 2018 questionnaire were initially sent to a random selection of 2,500 households, and for the first time general online entries were also accepted from anyone meeting the eligibility criteria who wished to take part.

In previous survey rounds residential and nursing home addresses were excluded from the sampling frame meaning that results from past surveys did not reflect the experiences of islanders living in communal care settings. This resulted in an in-built bias towards people —possibly, we theorised, healthier people— living in their own homes. We felt it was important to hear from all islanders so that our findings would reflect as closely as possible the true range of lived health experiences, opinions and needs across our populations, whatever those might be.

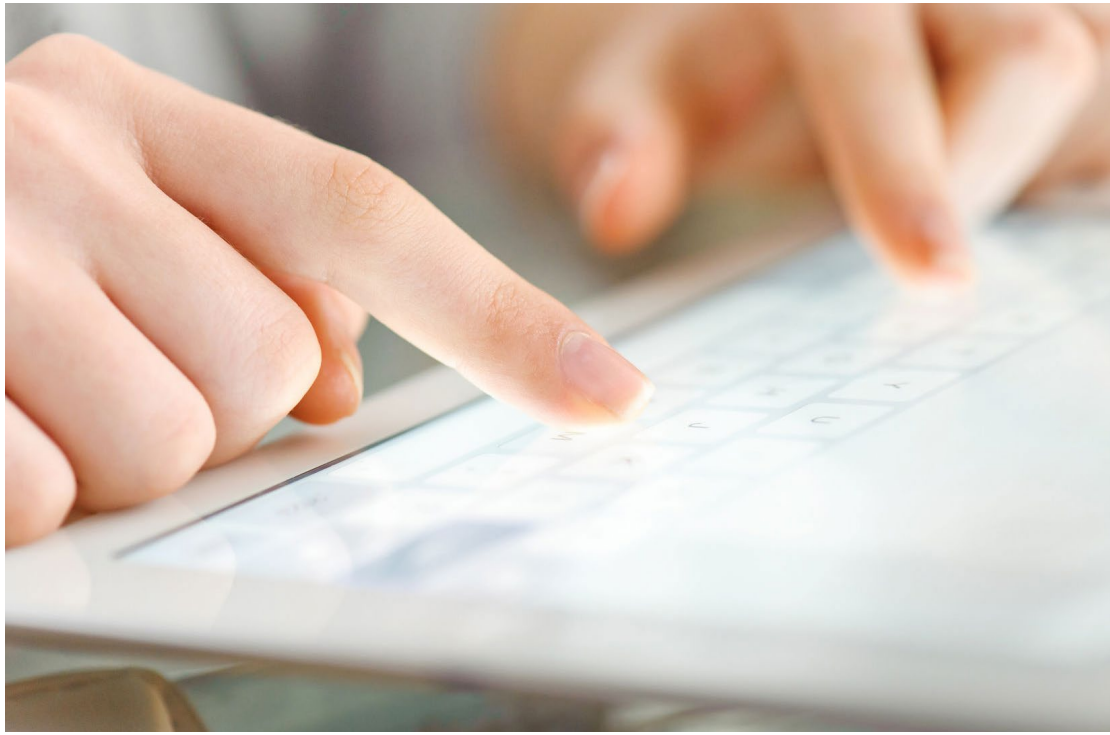
To this end we sought to actively boost responses from previously under-represented groups by taking our surveys to:

- a selection of residential and nursing homes;
- a selection of day centre sessions; and
- people's own homes, via the Guille-Allès library home-delivery service.

We also sought to encourage more young islanders (aged 16 or over) to have their say by publicising the survey via the Youth Commission and school sixth forms.

A concern with past surveys was that islanders who cannot read with confidence, those who don't have a good command of written English, and those with visual or other impairments, may have struggled to participate because past questionnaires had only ever been available in one standard format. In an attempt to address these issues and make the survey more accessible, publicity materials for the 2018 survey (posters, invitation cards) displayed instructions for completing the survey in multiple languages and the survey was publicised across a variety of media, including on the radio. Potential respondents were invited to contact the project team to discuss alternative formats or to request help to complete the survey. In the event only one request was made for assistance and this was received long after the survey had closed. We will continue to work with third sector and partner organisations and give more thought to how we can engage hard-to-reach islanders in our future projects to ensure their voices do not go unheard.

Prior to analysing the survey results, statistical weighting techniques were used to compensate for different patterns of non-response from selected subgroups. Overall this improves the degree to which responses from the survey respondents can be generalised back to the whole population. However in this commentary, as in the main report, we will point out where findings are derived from small numbers of people which has resulted in high weights being applied. In these cases we must be cautious in how much store we put by results that could be atypical.



Why we did it

The survey gave the opportunity for islanders to tell us about their health and the issues that matter most to them.

Our main aim was to acquire up-to-date information from a representative sample of islanders about their:

- current health status;
- level of knowledge, understanding and practise of factors that contribute to better health; and
- use of and access to health services.

We believe this is crucial to ensure that Public Health Services, along with other health and care professionals, the community and voluntary sectors and policy-makers:

- have a solid evidence base from which to carry out their work and plan new initiatives;
- can identify the health needs of our populations (and subgroups within them);
- can measure changes over time (by comparing to previous surveys); and
- can identify emerging trends in community wellbeing.

A secondary aim was to glean quantitative data on the health needs of islanders aged over 50 for use in another Public Health Services research project, the Joint Strategic Needs Assessment for People Over 50, which ran concurrently with the survey[1].

1 https://www.gov.gg/jsna

What we found out

Response Rate

As in previous survey rounds, the level of participation in the 2018 survey was high. The core household sample generated 956 responses (38% of the selected 2,500 addresses). Whilst this was a lower response than in 2013 —where 1,197 questionnaires were returned from the same number of addresses, giving a 48% response rate— general online survey entries more than compensated for the difference. In total the final survey dataset for 2018 comprised of 2,656 unique responses, 148 of those from the targeted sampling at day centres and care homes.

Of the 956 people from the core household sample who returned a questionnaire, there was an even split between online entries (51%) and paper questionnaires (49%). We were pleased with the number of people who opted to complete their entries online because, as well as promoting choice for respondents, online submissions result in substantial cost savings for the project. This is because, compared to paper entries, there are no associated return postage costs and responses are automatically entered into the survey dataset removing the need for manual data entry.

A comparison of the profile of respondents from each entry stream (core household sample, versus general entry, versus targeted sample) showed that our efforts to reach different groups of respondents in different settings were largely successful. Opening the survey to general online entries meant that more young people took part: close to one-in-four respondents from the general online entry stream (23%) were under-35, whereas in the core household sample just one-in-ten (10%) were under-35. Taking the survey to day centres and care home settings resulted in a greater number of responses from those living with a longstanding illness, disability or infirmity.

General Health

Results from the General Health chapter have shown us that:

- The vast majority of survey respondents reported good or very good health with just one-in-twenty reporting bad or very bad health. Health status declines with advancing age as one might expect, however most people consider themselves to be in good health until at least the age of 75.
- People living in affordable housing[2] and the unemployed reported worse health than average.
- A 7 percentage point decrease was seen in the proportion of people who rated their health as good or very good (76%, down from 83% in 2013). Our first thought when attempting to interpret this change was to wonder whether the baseline for average health status had been 'reset' at a lower level by including a more representative cross-section of older aged islanders through the targeted survey sample. In fact, when we looked

2 Defined by Island Global Research as Partial Ownership and Social Housing

closely at the level of change in different age groups, we found that change was most noticeable among the under-55s and was especially pronounced among the 16–24s, who were better represented in the 2018 survey than they had been previously. This needs to be further investigated.

- Levels of excess weight are high across all age groups and have increased significantly in the age category 55-64 since 2013 (Appendix of Tables, Table 4.25). The increase for this subgroup is due to an increase in both overweight and obesity. However, there is an increase in obesity when looking at the overall population, as opposed to increases in levels of overweight. Results suggest that just over half of all islanders (56%) are now living with overweight or obesity. On average, men were more likely to have excess weight than women, with men aged 55–64 having the highest rate —77% with overweight or obesity.

Having excess weight is linked with a number of adverse health conditions including Type 2 Diabetes, heart disease and stroke, depression, joint and back pain and several cancers, together with stigmatisation, bullying and low self-esteem[3]. As in 2013, we remain in a position where fewer people have a healthy weight than an unhealthy weight. In other words excess weight is now the more normal condition for adults living in our islands. We can expect that the personal and economic costs of this fact will be —and probably are already— substantial. Encouragingly many of those with excess weight reported a readiness to make positive lifestyle changes like losing weight and doing more physical activity. The task now will be to capitalise on this motivation to change by ensuring that in our islands we create the right overall environments to allow people to live in ways for healthy weights to be easily sustained. Additionally it will be important to provide people with the right support services for them, at the times they need them, so that intentions to change have the best possible chance of becoming a reality.

- One-in-three people reported having a longstanding illness, disability or infirmity and as we expected this was higher, rising to 46%, among respondents from the targeted sample (those attending day centres or living in residential care homes). Nevertheless, a relatively low proportion of people (17%) reported that their health problem or disability limits day-to-day activities a lot. Overall we interpret this as a positive result because it implies that most people, even when faced with health challenges, are not severely limited by them in their day-to-day lives.

- Our new question about caring responsibilities revealed that 9% of people care for someone close to them who needs help because of ill health or old age. Applied to our total population count this would equate to approximately 4,800 carers (aged 16+) across Guernsey and Alderney. Compared to non-carers, carers are more likely to report high levels of stress; have excess weight; have poorer sleep quality; have worse self-reported health and have lower expectations for their future life satisfaction. While some of these results may relate to the age profile of carers rather than their caring duties *per se* (carers were older, on average, than non-carers), others are likely to be true effects of the impact of caring

3 https://www.nhs.uk/conditions/obesity/ [Accessed 23/10/19]

duties. Defining health needs and offering the right kinds of support for carers are key aims of the Partnership of Purpose[4]. More detail of how the States of Guernsey is working to support carers can be found in the Carers Action Plan[5].

- Overall about one-in-five islanders rated their sleep quality in the month before the survey as poor or very poor but this rose to almost one-in-two (47%) for those with a low mental wellbeing score. A marked downturn in sleep quality was seen since 2013. These findings should not be dismissed lightly since we know that sleep is important for multiple aspects of health including reducing risks of obesity and heart disease.
- Problems of incontinence were shown to affect relatively few islanders, and among those who do experience this condition episodes of incontinence were reported to be relatively infrequent (once a week or less). Results show that women are three times more likely to be affected by this issue than men and a marked increase in reported incontinence issues occurs for women aged 35 and above compared to those aged under 35. These results merit further investigation to find out whether local women, as they age, have adequate access to services that can help to treat and manage incontinence.

4 https://www.gov.gg/CHttpHandler.ashx?id=110820&p=0 [Accessed 23/10/19]
5 https://www.gov.gg/CHttpHandler.ashx?id=118910&p=0 [Accessed 23/10/19]

Food and Diet

Surveys in this series have long included questions about fruit and vegetable consumption as one way of assessing dietary quality and the impact of community-based actions taken to support good nutrition. For the first time in the 2018 survey respondents were asked to report the number of portions of fruit and the number of portions of vegetables they ate the previous day. This gave separate tallies as opposed to a combined figure for both fruit and vegetables.

Whereas our suspicion was that people would be getting more of their total fruit and vegetables each day from fruit, the results showed that the opposite is true for most people: 44% ate more vegetables than fruit while just 26% ate more fruit than vegetables (with the rest eating equal amounts). This is a positive finding because vegetables tend to contain less sugar than fruits, and in most cases have more beneficial nutrients, making them, in simple terms, a healthier option.

In the UK it is recommended that people should try to eat at least 5 portions of fruit and vegetables per day in total in order to lower their long-term risk of serious health conditions like heart disease, stroke and some cancers. Past surveys, both local and national, have shown that a relatively low proportion of people meet this target. For example, the Health Survey for England, 2017, found that just 29% of adults were eating their five-a-day while the figure for Guernsey and Alderney in 2013 was 20%. Results from the 2018 Survey showed a very sharp increase to 50%. An increase of this magnitude —30%

over just five years— immediately stands out as an 'outlier' and requires careful consideration. While such a steep increase could theoretically be possible, one would only normally expect to see this occurring where there had been a major shift in cultural norms or, more likely, a sweeping policy change enacted at population level. Radical change of this nature has not occurred locally in the past five years and therefore the result probably overstates the magnitude of any change.

So what has happened? The most likely cause of the much increased percentage seen in the 2018 results relates to the rewording of the question and the need to sum the separate tallies for fruit and vegetables to arrive at a grand total. It is well known that self-reported diet recall questionnaires have many limitations, including both under- and over- reporting; difficulty with recall; knowledge of what one portion is, and of what counts. When people fill in surveys their responses are often influenced by 'social desirability'. This is a type of response bias where people tell the researcher —usually without conscious effort— what they want to hear. In this case if a person has eaten 2 portions of fruit/vegetables on a given day but knows that eating more would be good for them —perhaps they know of the 5-a-day campaign— then they may well round that figure up to 3 portions. Ordinarily and when using the traditional combined question on fruit and vegetable consumption, this would not make much of a difference, since the overall total would still fall below the target threshold of 5. However, if a person is asked to think separately about their fruit consumption and then their vegetable consumption they are given two opportunities to slightly overstate their consumption for both elements. When the two counts are summed to produce a final tally (3 portions of fruit and 3 of veg =6, as against 2 of fruit and 2 of veg =4) the result very easily pushes more people over the 5-portion target. Regrettably, it seems that as an unintended consequence of trying to look separately at contributions of fruit and vegetable consumption we may have introduced this methodological issue into our survey data.

This issue notwithstanding, the results of the 2018 Survey still show us (consistent with previous years[6]) that women more often consume the recommended number of fruit and vegetables per day than men. If we add in what we know from a question about soft drinks consumed we can also see that in the case of women, less of the daily total is comprised of fruit juice than it is for men.

A new question on the composition of meals (prepared at home versus pre-prepared) and where meals were eaten (at home or elsewhere) showed some important differences, including by age and by gender. People in the younger age ranges tended to prepare fewer of their meals from basic ingredients than older people and men did more of their eating 'on the go', compared with women. More work will be needed to better understand these findings and tailor services appropriately: is it that these groups do not have the food-preparations skills they would need and like to have? Or is it a shortage of time, low motivation to cook, or some other factor? The findings relating to the increase in out of home eating indicate a need to work with food vendors to increase availability and affordability of healthy food on sale.

6 https://www.gov.gg/article/154885/Healthy-Lifestyle-Survey [Accessed 23/10/19]

Leisure Time

- Questions on physical activity revealed that 39% of people reported doing at least moderate physical activity for 30 minutes or more on 5 or more days in the week before the survey. It is difficult to understate the positive health effects for all age groups that come from incorporating physical activity, even modest activity, into daily life and the findings indicate that continued and enhanced actions to create supportive environments for physical activity across our communities are warranted.

  Some patterning of physical activity by age and gender was seen. On average women reported less activity than men across all age groups and this was particularly pronounced in the under–35s and the over–75s. In these groups higher proportions of women had not undertaken activity on any days compared to men in the same age groups.

  Intention to do more activity was shown to be highest for those who had undertaken activity on 1–2 days in the previous week. We interpret this as an encouraging finding as it perhaps suggests that once people get over the initial hurdle of becoming physically active, the motivation to do more increases.

- Fifty-eight per cent of respondents reported that they had regularly taken part in a social or community activity during the 12 months before the survey —a figure judged to be at a similar level to 2013. Building stronger, wider social connections can help people feel happier and more secure, and give a greater sense of purpose[7]. Whilst our survey question only related to activities attended regularly —and we acknowledge that many may have attended similar activities sporadically— we will nevertheless wish to return to this finding, giving more consideration to what barriers to community activity people may be facing locally.

Wellbeing

In the 2018 survey the number of questions relating to mental and emotional health and wellbeing was increased to allow us to examine these important issues from several different angles. As well as probing about mental wellbeing and stress as we have done in previous surveys, respondents were also asked about their life satisfaction (now and in the future), loneliness, and levels of emotional support and social exclusion. In evaluating the results from this section as a whole, what stands out is that several subgroups emerge with poorer results than the average —most notably those living in affordable housing, those aged 16–24 and those who reported drinking alcohol to levels of high risk (see table overleaf).

7 https://www.nhs.uk/conditions/stress-anxiety-depression/connect-for-mental-wellbeing/ [Accessed 23/10/19]

	Lower life satisfaction scores	Low Mental Wellbeing	Loneliness	Feeling lonely, isolated, lacking companionship	Feeling excluded from activities/events
Occupants of affordable housing	✓	✓	✓	✓	✓
Young people (16-24)		✓	✓	✓	✓
Those with high-risk drinking scores		✓	✓	✓	
Those reporting a mental/emotional health condition	✓		✓		

People living in affordable housing were:

- markedly less likely than owner-occupiers to rate their current life satisfaction as 7 or 8 out of 8 (12% compared to 36%);
- more likely to have 'low mental wellbeing' (45% among affordable housing tenants compared to 18% among all respondents and 12% of owner occupiers);
- more likely to be intensely emotionally lonely (40% compared to 15% of all respondents) or intensely socially lonely (50% compared to 32% of all respondents).

Respondents aged 16–24 were one of the most likely groups to expect better life satisfaction in five years' time but, in terms of current health:

- were significantly more likely to have low mental wellbeing compared to the average for all respondents (this was especially pronounced among young women who, at 37%, were twice as likely as the average to have low mental wellbeing);
- were more likely than average to experience high levels of loneliness, especially emotional loneliness;

- were the most likely age group to report feeling lonely, isolated, or lacking in companionship often or all the time (45% compared to 25% or less for other ages);
- were the most likely age group to feel excluded or left out of activities/ events (25% compared to 18% or less for other ages).

Levels of low mental wellbeing in the under-25s were shown to have doubled since 2013. Because the 2018 survey included 16 and 17-year-olds, whereas the 2013 did not, we will want to look more closely at mental health in this age group to ascertain what difference this may have made and better understand this important issue.

Those who reported drinking at levels that are classed as 'high risk' (as measured by the Alcohol Use Disorders Identification Test 'AUDIT' score):

- were more likely than low risk drinkers to have 'low mental wellbeing' (36% compared to 15%);
- were more likely to be intensely emotionally lonely (34% compared to 15% of all respondents);
- were more likely to feel lonely, isolated or lacking in companionship (42% compared to 26% among abstainers and 15% among low risk drinkers).

Self-reported mental ill health was shown to correlate with the mental wellbeing category assigned from the short Warwick-Edinburgh Mental Wellbeing Scale. Those with 'low mental wellbeing' were more likely to have reported having a mental or emotional health problem compared to those with 'moderate mental wellbeing' (27% of those with low mental wellbeing, 6% with moderate mental wellbeing). Those with low mental wellbeing also had lower levels of life satisfaction and were more likely to feel lonely. This highlights a complex web of inter-connected health outcomes and influences. The survey demonstrated that:

- 51% of those with a mental/emotional health condition reported feeling lonely, isolated or lacking companionship (the highest of all subgroups considered); and
- 39% of those with a mental/emotional health condition reported feeling excluded from activities/events (the highest of all subgroups considered).

Thirty-six per cent of respondents reported having experienced a large amount of stress in the past 12 months (up from 25% in 2013). Work, financial pressures and health problems of family or friends were all important causes of stress in 2018, as they were in the 2013 survey. In all cases increasing proportions of respondents identified these issues as ones that always or often cause them stress. Pressure to always be available, included as a response option for the first time in 2018, emerged from the current survey as the third most important cause of stress.

Those who are retired were least likely to have experienced large amounts of stress. Risk factors for experiencing large amounts of stress included:

- living in affordable housing, or renting privately;
- being a current smoker or vaper;
- drinking to a level of high risk;
- having caring responsibilities; and
- living with obesity.

These findings demonstrate that there are important links between different types of health risks and stress. It is possible that certain health-damaging behaviours (e.g. smoking and drinking) are used as ways of coping with adversity (of which stress is another sign). This has important implications for how we can encourage behaviour change at a population level. Simple health messaging exhorting people not to smoke, or drink to excess may not prove effective without tackling the underlying, complex reasons why people do these activities in the first place.

Alcohol

The harm to physical and mental health caused by alcohol is a major global public health issue. When we think about alcohol consumption from a Public Health view point we are concerned both with the total amount of alcohol that people drink and the patterning of that drinking. Our concern is for drinkers themselves and the health risks they suffer personally, as well as the impact on the health and wellbeing of relatives of dependent drinkers and victims of crime and injury linked to alcohol.

People who drink alcohol incur the greatest risk when there is a high level of regular drinking sustained over a long period of time. The NHS advises that 10 to 20 years of regularly drinking more than 14 units a week can lead to the development of:

- cancers of the mouth, throat and breast;
- stroke;
- heart disease;
- liver disease;
- brain damage;
- damage to the nervous system; and
- worse mental health[8].

8 https://www.nhs.uk/live-well/alcohol-support/the-risks-of-drinking-too-much/ [Accessed 23/10/19]

By contrast the riskiest pattern for short-term harms, for example acute injuries or crime, is to drink a lot of alcohol on one occasion —so-called 'binge drinking'.

To try to quantify the level of harm incurred locally from alcohol, people who took the 2018 survey were asked about how much alcohol they consume, where they drink (at home or out), and on which days of the week they drink. They were also asked to complete a series of questions about their drinking (the AUDIT tool) which allowed us to assess the level of health risk from alcohol.

The results tell us that:

- eleven per cent of people in Guernsey and Alderney never drink alcohol whereas 89% do drink;
- of those who do drink alcohol, many (65%) were doing so within 14 units per week which is the UK Chief Medical Officers' guidance for reducing risk, however 35% drank more than 14 units per week;
- twenty-two per cent of people drink at 'risky' level while a further 5% drink at 'high risk' from their drinking.

Men were more likely to exceed the 14 units per week recommendation than women and were more likely to be in the risky and high risk categories. There is some evidence to suggest that drinking behaviour is related to age with younger adults (aged under-35) tending to drink more out of home and at the weekend, compared to older adults (over-35).

Comparison of results from the 2013 and 2018 Surveys shows relatively few changes though with a slight reduction in the proportion of respondents who reported drinking on 2 or more days in the week before the survey: 47% drank twice a week or more in 2018 compared to 54% in 2013. The distribution of respondents across the drinking risk categories was similar in 2018 and 2013.

To gauge attitudes to drinking locally, respondents were asked how much they agreed or disagreed with the following statements:

"Getting drunk is a perfectly acceptable thing to do"
"It is easier to enjoy a social event if you've had a drink of alcohol"

Support for the first statement (attitudes to getting drunk) was relatively low overall with just under one in five (18%) agreeing or strongly agreeing. This low average masks a polarisation of attitudes between younger and older people where the acceptability of getting drunk was confined largely to the under-55s: While 51% of respondents aged 16-24 agreed or strongly agreed that getting drunk is acceptable, support for the statement declined incrementally with increasing age and was less than 5% among all age groups over-55. Overall getting drunk was more acceptable to males (compared to females) and those with risky levels of drinking (compared to low risk drinkers and abstainers).

A slightly different picture emerges about alcohol as an aide to enjoying social events. While support for the statement was again highest among males and was higher in younger age groups compared to older ones, there was not —in contrast to the 'getting drunk' question— the same very steep drop-off with age. Levels of support for the statement declined with age from a high of 64% among 16-24s, but remained at 31% among those aged 75+. These findings suggest that alcohol has a role in how we interact socially with other people that holds value within local culture across all age groups.

Smoking and Vaping

Tobacco is unique in being the only product that kills when used as intended[9] and is the single largest avoidable cause of premature death globally. Negative health effects for smokers and those who involuntarily inhale tobacco smoke are numerous and come at a high price (see table). For individuals the cost is measured in personal suffering and the financial burden of an addictive habit. For health services the cost burden is economic, associated with treating smoking-related diseases.

Health risks to smokers and passive smokers:

Passive smokers
In babies: increased risk of low birth weight and cot death
Smokers
Nicotine addiction
Increased risk of cancers (including lung, bladder, oral, oesophageal, stomach, pancreatic)
Increased risk of vascular diseases like coronary heart disease, cardiovascular disease, abdominal aortic aneurysm)
Chronic lung diseases like COPD
Increased risk for cataract, hip fracture, periodontal disease and type 2 diabetes
Increased risk of miscarriage, ectopic pregnancy and still birth for pregnant women

9 Gilmore *et al* In Sim and McKee (eds.) Issues in Public Health (2011)

Results from the 2018 survey show that smoking prevalence remains at the same level as in 2013 with 13% of respondents stating that they smoke daily or occasionally. A further 30% of people told us they used to smoke but no longer do so. As one would expect, smokers and ex-smokers were more likely to rate their health as bad or very bad compared to those who have never smoked.

Tobacco use around the world tends to follow a continuum where smoking rates initially increase rapidly when tobacco products enter a new market. After a period of sustained popularity smoking then tends to decline, dropping off as public support for smoking wanes and robust tobacco control measures are put in place. About 30 to 40 years after peak smoking prevalence comes the period of peak smoking-related deaths.

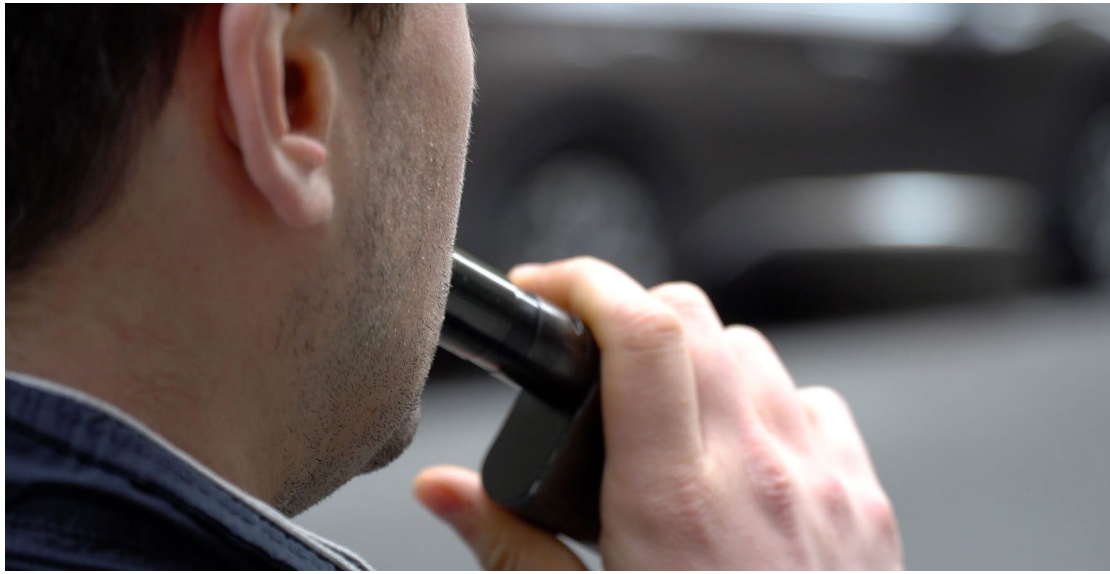
The ratio of current to ex-smokers in our population confirms that we are past the point of peak smoking prevalence. Closer examination of cause of death data for our population will allow us to estimate whether peak smoking mortality has also been reached, or if this is yet to come.

Tobacco control measures in the Bailiwick are framed in the Tobacco Control Strategy 2014 to 2020 and include fiscal, legislative and awareness-raising measures to prevent the uptake of smoking, protect people from second-hand smoke and help smokers who would like to quit.

As well as supporting current smokers to give up smoking, it is crucial to try to prevent younger adults from taking up smoking in the first place. Results from the 2018 survey show that there is still more work to do in this area.

Among women, smoking rates were highest, at 20% (one-in-five), among the 25-34 age group. For men smoking was highest, at 22%, among 35-44 year-olds with levels likely to be similar among 16-34s (noting some uncertainty due to low base sizes).

Six per cent of respondents reported that they vape (use e-cigarettes) and vaping was shown to be more prevalent among young people than older people. Of those who vape 32% (approximately one-third) are also current smokers, 59% are ex-smokers and 9% have never smoked tobacco products. This last figure is important because it reveals that some people have taken up vaping as a habit itself and not as a way of quitting tobacco products.



E-cigarettes are still a relatively new product and work to fully understand how they affect health is still on-going, though Public Health England's position on e-cigarettes is that they are likely to be at least 95% safer than smoking[10]. Findings from the 2018 survey show that, locally, this message has not been widely taken on board. Among non-smokers, smokers and ex-smokers over 20% of respondents agreed or strongly agreed with the statement that, "e-cigarettes are just as harmful to health as normal cigarettes".

These findings indicate there is work to be done to raise greater public awareness of the greatly reduced health risks of using e-cigarettes compared to regular tobacco products. At the same time we will wish to give more consideration to the potential negative effect on young non-smokers of being drawn into e-cigarette use through attractive promotion and marketing. Furthermore, the recent cluster of cases of severe pulmonary disease in the USA associated with vaping has indicated the need for caution in relation to the use of new products, particularly those that are unregulated.

Drug Use

Respondents to the 2018 survey were asked to indicate their use of cannabis and any other illegal drugs within the last month and the last year. Across all age groups 11% of people reported that they had used cannabis within the last year, while 4% had used other illegal drugs. In both cases (cannabis and other drugs), drug use was higher in men than women and was strongly related to age with highest levels of use among the youngest age groups. Drug use in Guernsey and Alderney is further considered in the forthcoming Joint Strategic Needs Assessment of Drugs, Alcohol and Tobacco use, due for publication later this year.

Unfortunately from the point of view of having confidence in our data, the age group where drug use was reportedly greatest (16-24s) is also the age group where we received the fewest responses. The sample is very small and the biggest statistical weights had to be applied. This reduces the level of confidence we can have that the findings are a good representation of the general population. Because of this we must be wary of accepting them as fact until we can repeat the questions, sampling more young adults.

Taken at face value, cannabis use has increased by 6 percentage points, up from 5% in 2013 to 11% in the 2018 survey. However since much of this difference was driven by change among the 16-24s —the group where there is most statistical uncertainty— we must again view this result with caution.

10 https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update [Accessed 23/10/19]

Sun Protection

Responses to questions about sun protection were, on the whole, encouraging. Positive findings were that:

- the majority of people (92%) reported taking at least one measure to protect themselves from sunburn;
- most people (87%) were aware of at least one of the potential signs of skin cancer; and
- very few people reported that they currently use a UV sunbeds (1%).

Despite these good headline findings, it was of concern that 44% of all-age respondents (rising to 78% of 16-24s) reported having been sunburnt in the last 12 months. This is particularly concerning when coupled with the findings that:

- approximately 30% of under-35s reported that they do not routinely use sunscreen; and
- 21% of 16-24s said they had not heard of any of the signs of skin cancer that were listed.

This evidence of risky behaviour combined with a lack of knowledge shows a clear need for targeted health promotion messaging about sun safety among younger islanders.

Health Literacy

People taking the survey were asked to indicate where they would go to for information about health or medical topics. Interesting findings were that:

- overall 3 out of 4 people (76%) said they would find out what they needed to know from a doctor or health professional. The likelihood of consulting this source was related to age, with 16-24 year olds least likely to do so (57%), and those aged 75+ most likely to do so (92%);
- people were very likely to report that they would consult the internet for health information: over 80% of those up to the age 64; 65% aged 65-74 and 33% aged 75+; and
- pharmacists/chemists were shown to be an important provider of information, particularly for those aged 65-74 and 75+ (where 49% and 43%, respectively, said they would consider consulting this source).

Respondents were then asked to indicate the level of trust they had in different information sources. Results show that:

- doctors were the most trusted source and levels of trust were consistently high across all age groups;
- government health agencies were the next most trusted source, although levels of trust in this source were shown to diminish with age; and
- low proportions of people across all age groups said they would trust internet sources 'a lot'.

We consider it encouraging that people report high levels of trust in healthcare professionals and government agencies. Health information on the internet varies widely in accuracy and quality. It is encouraging that most people are showing some caution in how much trust they put in health information from the internet and many people commented that they only trusted particular websites that they judge to be reputable. The finding that young respondents (aged 16-24) are the least likely to actually get their health information from a doctor despite having high levels of trust in doctors indicates possible barriers to access for this age group. These are considered more in the next section (Use of Health Services).

Use of Health Services

Respondents were asked a number of questions about their use of health services and about their health insurance coverage. The results from this section showed that:

- most people (87%) have seen a GP about their own health within the past year. This is an important finding because it confirms that for most islanders there is an opportunity, at least once per year, where a health professional could —as well as addressing the immediate health concern presented to them— initiate important conversations about health promoting behaviours or lifestyle advice. Introducing the Making Every Contact Count initiative in the future will give front-line clinicians and other healthcare providers the information and skills they need to offer very brief health advice whenever such a contact occurs.
- In all age groups up to 55 years women were more likely than men to have seen a GP and young men were the least likely to have seen a GP.
- Frequent GP attendance (5+ visits in the last year), perhaps indicating poorer health, was more often seen among older people; women; those living in affordable housing; those living with obesity; those living with a long-term illness, disability or infirmity; those with low mental wellbeing and those with private health insurance.

Seasonal flu immunisation

Public Health England sets a target immunisation rate, for annual seasonal flu, of 75% among those aged 65+. To help achieve this aim the States of Guernsey makes annual flu vaccines available to local primary care practices free of charge and the practices are encouraged to invite their eligible registered patients to go to their surgery and get vaccinated where they will only have to pay the administration charge (unless covered by insurance). Immunisation for two and three year olds and all Primary School children —both the vaccine and the administration— is available free from the States of Guernsey.

Survey results suggest that 62% of island residents aged 65+ had had a flu vaccine in the past 12 months — a shortfall of 13% from the target. Given that over 90% of over-65s reported having seen a GP in the past year we feel there would be value in working more closely with GPs to see how those contacts could be used most effectively as opportunities for discussing and promoting flu immunisation.

Unmet health need

In order to gauge possible unmet health care need at Primary Care level, we asked respondents whether they had any current health concerns that they had not seen a doctor about. Overall 18% of respondents said they had a health concern they had not seen a GP about. This was higher in certain subgroups, including:

- those under the age of 35;
- those who reported drinking to high risk levels;
- those who smoke or vape;
- those who don't have private health insurance;
- those with low mental wellbeing; and
- those with a long-term illness, disability or infirmity.

People living in affordable housing were also more likely to have a health concern they hadn't seen a doctor about. When we consider that this group were also more likely to have been to the GP 5 or more times in the past year we get a mixed picture of frequent visits and unmet need occurring side-by-side. Further work would be needed to better understand this.

Those with one or more child aged under-16 in the household were also significantly more likely to report having a health concern they had not seen a GP about (23% with U-16s in the house compared to 17% with no U-16s in the house). This seems counterintuitive to the fact that households with under-16s were less likely to pay for their own GP appointments and more likely to have private health insurance compared to households with no under-16s (see below). These conflicting results are currently difficult to interpret. Is it that households with children struggle to find the time to go to the doctor even when they have health insurance? Does this reflect the effect of a ceiling cap on the number of annual visits covered under some insurance schemes? Is there a high level of unmet need concentrated among uninsured families in this group? Or a combination of these and other factors? More research is needed.

Cost barriers

We looked at cost as a barrier to accessing healthcare and related services by asking people whether they had been prevented from using a selection of services in the past 12 months due to the cost. Overall 47% of people had been prevented from using one or more service for reasons of cost, and this figure rose to 61% for people living in households with one or more child under age 16.

Adult dentist appointments were the type of service most likely to be foregone due to cost (32% of people stopped from accessing in the last 12 months). The second most likely service to be foregone was an adult GP appointment (where 23% were stopped from accessing in the last 12 months). The relatively high proportion of people who are prevented from seeing a dentist for an adult appointment may relate to the fact that even those who have private health insurance will have to pay 'out of pocket' for dental appointments as many private insurers do not cover dental care. Maintaining good dental health and having regular check-ups with a dentist is important for our overall health. Seeing a dentist can alert people to the presence of gum disease, for example, and gum disease has been shown to be associated with increased risk for a number of conditions including cardiovascular disease, dementia, some cancers and premature birth[11]. Quantifying the level of unmet dental health need in the population will be an important task for the future.

More than one-in-ten people said that cost had stopped them from accessing:

- out of hours GP or Emergency Department
- optician
- physiotherapy

This shows that local people also face cost barriers to urgent assessment/ treatment and use of allied health services.

Low proportions of people had been stopped from accessing a hearing test or hearing aid fitting (3%), or using chiropody services (4%) and this was a consistent finding for all age groups.

As household income increased people were generally less likely to report that cost had stopped them accessing services of most types (most significantly GP and Emergency Department). Nevertheless there were some services —dental and physiotherapy appointments for example— where the cost still emerged as an off-putting factor even with increasing household incomes.

Public Health Services are mindful of the sorts of cost barriers highlighted above. We will continue to try to simplify access to our services, to include self-referral where possible. We are delighted that Healthy Minds, a service offering short-term therapeutic interventions for adults aged 17 plus who have mild to moderate anxiety and depression, recently began

11 https://www.dentalhealth.org/gum-disease [Accessed 23/10/19]

accepting self-referrals, giving direct access for those wishing to benefit from the service. For more information go to: www.gov.gg/healthyminds

Paying for health care

Respondents were asked who pays the consultation charge for a nurse or GP appointment. 50% of people reported that their primary care charges are covered by a private insurer, while 46% pay 'out of pocket' for their own appointments. The remaining 4% receive support from the States of Guernsey (3%), or pay privately via a pre-pay arrangement with their practice (1%). Among the 50% with private insurance there was a roughly even split between those who have cover via their employer (25%) and those who pay the premiums as individuals or households (24%).

Private health insurance was more common for households with one or more child aged under-16 compared to those without children (58% v 47% respectively). Insurance coverage was also more prevalent in households with higher incomes. This highlights an inequality where those in our populations who could most afford to pay for primary healthcare are the least likely to have to do so.

When comparing the experiences of those who have private health insurance to those who pay for their own appointments, results show that those who pay for their own appointments are:

- less likely to have seen a GP in the last 12 months (80% compared to 93%);
- more likely to have reported that the cost stopped them from having an adult GP appointment in the last 12 months (45% compared to 4%); and
- more likely to have a health concern they had not seen a GP about (21% compared to 16%).

Comparing the results of the 2018 survey to the 2013 survey we see that:

- the proportion of people who reported having seen a GP in the last year was constant at 87% in both survey years;
- the proportion of people with private medical insurance was slightly lower in 2018 in all age groups than it had been five years previously; and
- among the uninsured, a higher proportion reported having foregone an adult or child GP appointment in 2018 compared to 2013 because of the cost.

Access to Services and Transport

As well as people's individual behaviours, their access to healthcare and their genetic makeup, Public Health practitioners recognise that other factors exert a strong influence on people's health. These factors —the so-called 'wider determinants of health'— operate in the background but nevertheless correlate strongly with physical and mental health outcomes.

One factor that we felt could be an important health determinant locally was transport and related access issues. We asked survey respondents to tell us which of a list of transport-related issues had prevented them from getting where they needed or wanted to go within the last 12 months. The list included:

- bus routes or timings;
- cost of buses and taxis;
- cost of owning and running a car;
- feeling unable to walk or cycle safely;
- having to stand to wait for a bus;
- being unable to get somewhere by oneself/needing to ask for help; and
- availability of transport to suit physical needs.

Results show that:

- more than one-third of people had been prevented from getting where they needed or wanted to go in the last 12 months because of one of the factors listed;
- groups that were more likely than average to say they had been prevented by one of the listed factors included: those living in affordable housing (69% prevented); those who reported having a mental or emotional health condition (59% prevented); those with a physical disability (52%) and those with a household income under £20,000 (52%); and
- the most frequently selected issues were unsuitable bus routes or timings (selected by 16% of people) and cost of taxis (15% of people).

These results show that some people are disproportionately affected by transport or mobility issues, compared to others. When we examine the breakdown of responses by age we can see that, overall, younger people reported facing more transport barriers than older people. For example, 24% of 16-24 year olds reported that bus routes or timings had prevented them from getting where they needed to go, whereas this was cited as a preventative factor by just 6% of over-75s. Focussing just on the over-75s we can see that the factors most frequently selected were feeling unable to walk safely and needing to ask for help, though these were only selected by 15% and 11%, respectively within that age group.

Eight per cent of people said that feeling unable to cycle safely had prevented them from getting where they needed or wanted to go and this proportion was found to be fairly consistent across all age groups. This finding will be important for future discussions about how best to promote cycling for active (and zero-carbon) travel.

Money Matters

Many physical and mental health outcomes are known to be associated with financial resources and income. For this reason respondents to the 2018 survey were asked about their household income; how well-off (or otherwise) they felt compared to 12 months ago; whether they could afford unexpected but necessary expenses of £100 and £1000; whether they found it hard to meet the cost of a range of household bills and expenses; and whether they could heat their home to a level where they could keep comfortably warm in at least one room.

Results from this section have shown us that:

- asked whether they felt better off, worse off or about the same, financially, as 12 months ago, 50% of people felt about the same, 29% felt worse off and 19% felt better off;
- the feeling of being worse off was proportionately higher for those with lower household incomes (42% of those where income was <£20,000); households with one or more child aged under 16 (34%); those categorised as having low mental wellbeing (43%); and those with a long-term illness, disability or infirmity (36%);
- overall 6% of people said they couldn't afford an unexpected expense of £100. A further 20% of people said they could afford £100 but it wouldn't be easy;
- the inability to afford a £100 expense was higher among those living in affordable housing and —in common with the feeling of being worse off— among those with household incomes of <£20,000, those with children under age 16 and those with low mental wellbeing.

These findings, where approximately one in four households would struggle to, or couldn't, find £100 for an essential expense, highlight that our populations —on average considered to be affluent— include many individuals and families who are operating to extremely tight, perhaps precarious, household budgets. This gives some perspective to why many people reported having avoided accessing the Emergency Department or Out of Hours healthcare since even the lowest charges for these services would be unaffordable for many.

Thirty-nine per cent of people said they had had difficulty meeting the cost of one or more of a range of listed household expenses meaning that they had needed to pay late, borrow money or go without. The top three most frequently cited expenses that people found difficult were holidays (selected by 24% of respondents); home maintenance/repairs (19%) and medical expenses (13%). Ten per cent of people had found it difficult to meet the cost of clothes or shoes, while 8% had found it difficult to pay for food, electricity/heating bills and credit cards.

When we examine the results by household composition we find that households with children were by far the most likely to report difficulty in meeting the costs of each of the factors listed, when compared to working-age adults with no children and pension-age adults. For example, the proportion of people who reported difficulty with meeting the cost of clothes and shoes was 19% among working aged adults with children, compared to 8% among working aged adults with no children and 2% among pension age adults. Difficulty meeting the cost of electricity/heating bills was reported by 12% of working aged adults with children compared to 8% and 4% among working age adults with no children and pension age adults respectively.

The vast majority of people (94%) said that they had been able to keep comfortably warm in at least one room in their house during the past winter. Inability to keep warm was not found to be associated with older age. In fact, younger people (aged 25-44) as well as those on lower household incomes and those reporting a mental or emotional long term health condition were proportionately more likely to report that they were unable to keep warm in at least one room.

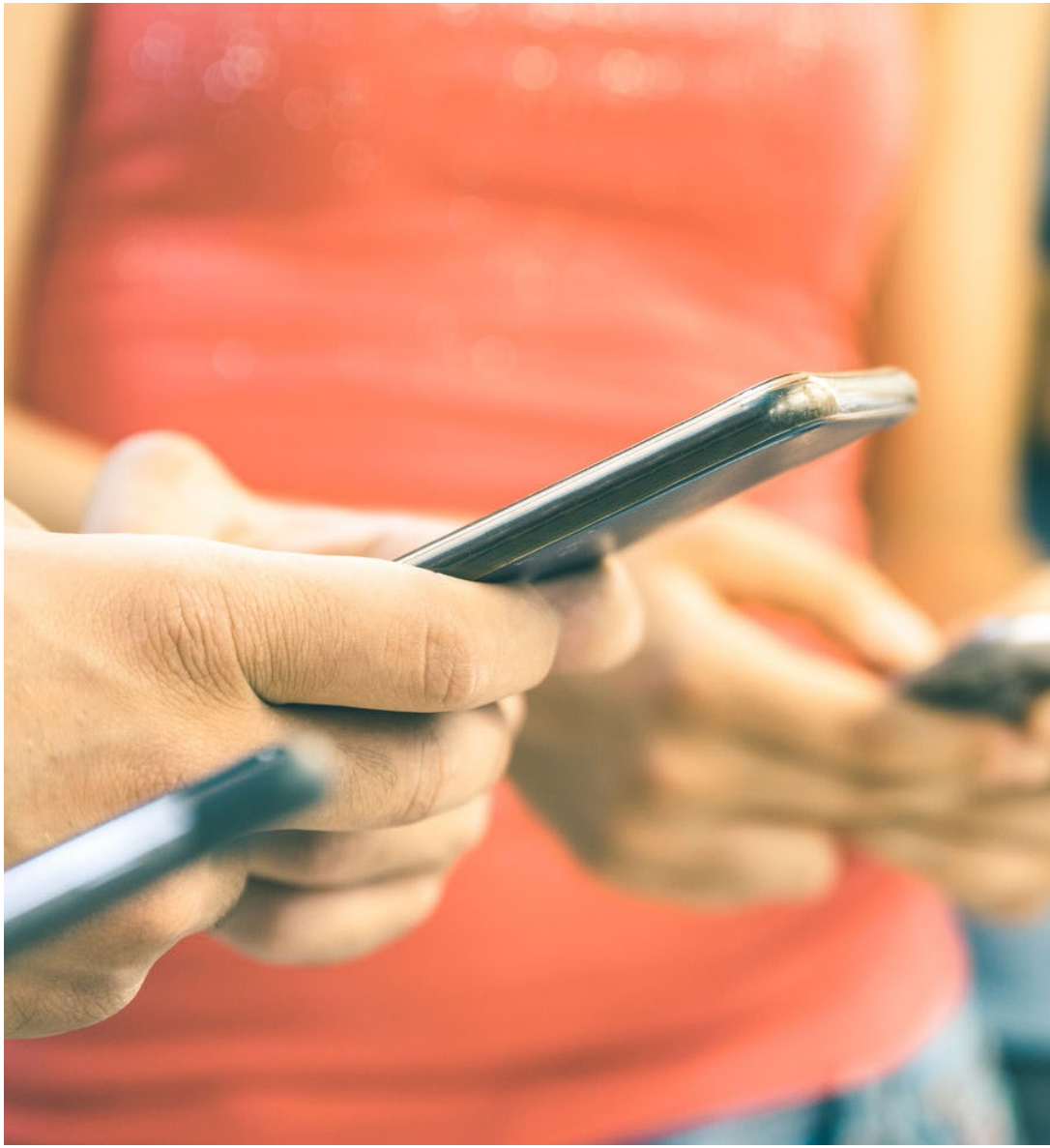
Digital and Social Media

In the final section of the 2018 Wellbeing Survey we asked people about their access to the internet at home, how they use the internet and how they feel about their current level of internet use.

From this section we learnt that:

- the vast majority of people (95%) reported having internet access at home and 88% of people go online every day;
- the proportion who don't have access to the internet was higher than average among people aged 75 and over (26%) and among those living in affordable housing (14%);
- people were most likely to use the internet to communicate (emails, messaging, video calls -89%) and general browsing (84%). More than 70% of people use the internet for shopping, banking, use of social media and reading the news. Some age specific variations were seen in tasks performed online; and
- when asked about their current level of internet use, people were more likely to say that they would like to use it less than they do now (18%), than more than they do now (5%). Younger people were more likely to want to use the internet less (reaching 38% among 16-24 year olds), whereas older people were more likely to want to use it more (15% among those aged 75+).

The internet has given us new ways to explore the world, to learn, to share information and to communicate with other people. We are encouraged that the internet is being used widely, including by older people in our islands, and that people are going online to carry out a wide range of transactions and processes. This may have many positive benefits like helping people to overcome physical limitations (e.g. paying a bill online where reduced mobility would have made it difficult to pay in-person). Nevertheless, we are also concerned for the higher proportions of younger adults who are reporting a desire to reduce their internet use. For a growing number of people, spending hours on the internet each day is now a normal part of daily life. When internet use becomes a distraction, or when it displaces other health-positive behaviours, or impacts mental health in a negative way, it can start to become a harmful influence to health. Knowing how best to support people, especially young people, to manage their internet use in a way that safeguards their health will be a high priority for Public Health in the near future.



Alderney

Seventy-seven Alderney residents took part in the survey. While this represents a good level of participation for the islands' population it is still difficult, in statistical terms, to be confident of drawing reliable conclusions about the health of people in Alderney as a stand-alone group. This is because when a population is small, the results you get from samples drawn from that population are more volatile —random variation is more evident than it would be in a larger sample from a bigger population. This makes it easier to mistake a chance variation for a real difference. To avoid possible misinterpretation the favoured option would be to combine Alderney and Guernsey results and only report for the two islands together, indeed this is the approach taken in the main 2018 Survey report. This presents a conundrum because in doing this we would never get to see, or call attention to, areas of health need that may be uniquely different for Alderney residents. We felt that Alderney's geographical isolation and the benefits and challenges of living in such a small community could well produce real differences that are worthy of our attention. To that end we looked at how Alderney results compare to results for Guernsey.

Bearing in mind the limitations discussed above, our comparison of results for the two islands showed reasonable to strong evidence for a statistically significant difference from Guernsey in the following areas:

Weight status —Analysis of the survey data suggests a higher proportion of Alderney residents have an overweight weight status compared to Guernsey residents (70% Alderney; 56% Guernsey).

Sleep —A significantly higher proportion of Alderney residents (57%) reported good or very good sleep quality compared to Guernsey residents (43%), however this may be an effect of age since older respondents reported better sleep and Alderney respondents were, on average, older than Guernsey residents.

Meal preparation and out-of-home eating —Some differences in patterns of out of home eating were detected. In Alderney, the proportion of people who reported never eating pre-prepared meals at home was higher than in Guernsey. However, when respondents from Alderney did report eating pre-prepared meals out of home, they did so relatively frequently (10–14 times per week). There is also some evidence that in Alderney a higher proportion of residents never eat out at a café/restaurant, compared to Guernsey.

Physical activity —In Guernsey and Alderney combined, our questions on physical activity revealed that 39% of people reported doing at least moderate physical activity for 30 minutes or more on 5 or more days in the week before the survey. This proportion was significantly higher —54%— among Alderney residents.

Sun safety —For those who had been sunburnt in the last year a higher proportion of Alderney respondents, relative to Guernsey respondents, had been burnt three or more times (18% Alderney; 6% Guernsey).

Health Insurance and Use of Health Services —Alderney residents were significantly more likely to pay for their own GP/nurse appointment costs

compared to Guernsey residents (68% of Alderney residents; 45% of Guernsey residents). The proportion of Alderney residents who had insurance cover paid by an employer was correspondingly and significantly lower than for Guernsey residents (9% for Alderney residents compared to 26% for Guernsey residents). This fits with our understanding of the demographic of Alderney and the Island's ratio of working-to-non-working residents. Alderney residents were also more likely than Guernsey residents —at levels that reached significance or borderline significance— to say that cost had prevented them from accessing appointments with Emergency Department, nurse and dentist.

Transport —Alderney residents were significantly more likely than Guernsey residents to say that they had been prevented from getting where they needed or wanted to go because of:

- the cost of running a car (selected by 20% of Alderney residents, compared to 9% of Guernsey residents); and
- other factors (selected by 21% of Alderney residents , compared to 4% of Guernsey residents).

The difference in 'other' factors suggests that transport barriers for Guernsey residents were adequately captured by the response options listed, but that barriers for Alderney residents were not well captured. When we looked at the 'other' factors named by Alderney residents the key themes were: the cost of getting off the island, poor reliability of air/boat travel and the absence of bus transport.

Concluding Remarks

The Guernsey and Alderney Wellbeing Survey 2018 has yielded a wealth of information about the health and lifestyles of people living in our islands which we hope will be of use to providers of health services, those involved in directing and making policy for our islands and to members of the general public alike. Some results from the survey are positive, while others are not so positive. The clear and inevitable message is that there is much more work to be done to help improve health and wellbeing for local people. In particular, the 2018 Survey has highlighted the financial barriers to accessing healthcare faced by some groups and complex pictures of health outcomes, health need and health risk among certain subgroups, notably:

- young adults;
- those living in affordable housing;
- those living with low mental wellbeing; and
- working age adults with children.

Health experiences that may be unique to Alderney residents including some of the so-called wider determinants or background factors likely to affect health, have also been discussed for the first time. Returning to these topics, and working to understand the experiences of these groups in greater depth, will be important priorities for Public Health Services in the near future.

WORKING TOWARDS A PARTNERSHIP OF PURPOSE

States of Guernsey
Public Health Services