

# Our Island Our Health 2007



Annual Report of the  
Medical Officer of Health

States  
of Jersey

## Foreword

This is my second annual report on health in Jersey. Again, I have the opportunity to offer some insights in the four domains of public health activity:

- health intelligence - finding out about health and disease in Jersey
- getting upstream - preventing illness before it starts
- infectious and environmental hazards - protecting the public
- improving health services.

It is a privilege to contribute to making Jersey a better place.

### Good health in Jersey

It is clear that health in Jersey is generally good and improving. Looking back at the L'Inspecteur Medical's report from 100 years ago, we can see how dramatically the health of Islanders has improved. From recent survey data, I found that

the modern health problems of smoking, alcohol and drug abuse are also moving in the right direction. The results of the 2006 schools' lifestyle survey are particularly encouraging: you could say, we have never had it so good.

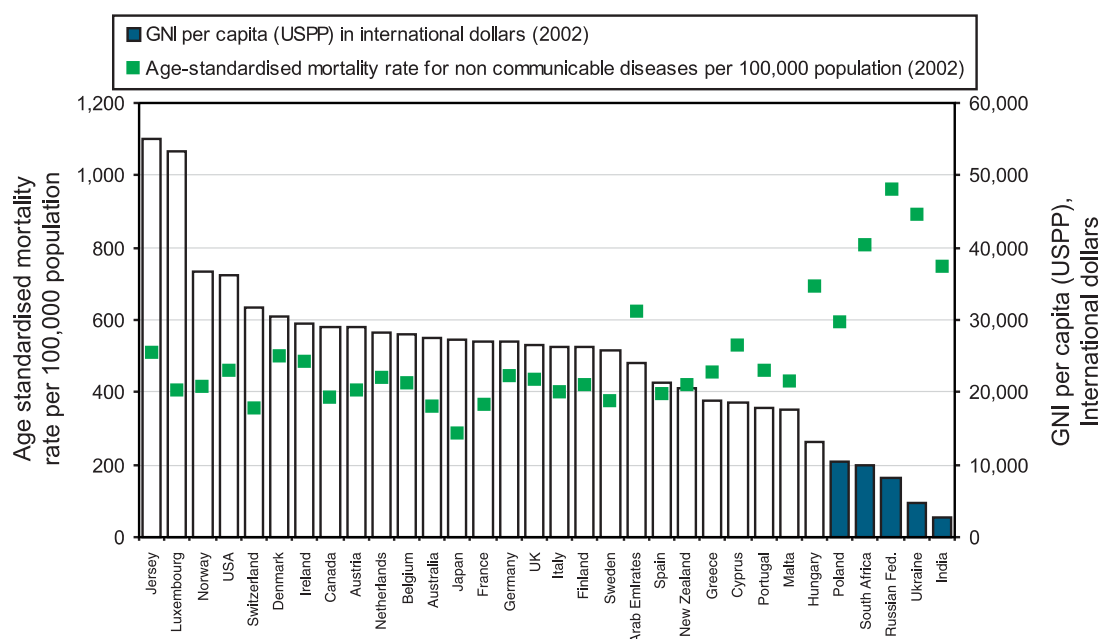
### We could do better?

Comparing our Island's health, using international health indicators, also leads me to the conclusion that health is good in Jersey. It seems, however, that given the Island's wealth, we have higher death rates than other affluent countries (*figure 1*).

### Obesity - a twenty first century challenge

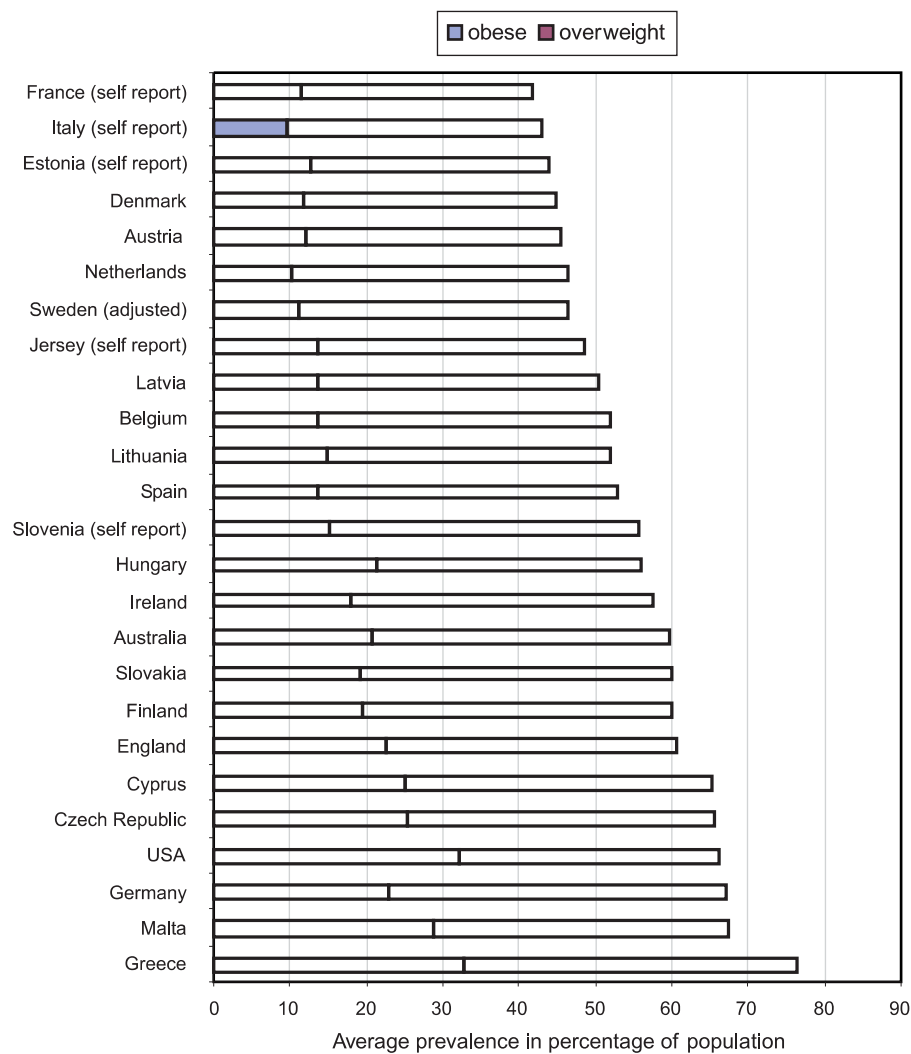
There are, however, clouds on the horizon. The biggest of these clouds is the burgeoning levels of obesity in both children and adults. Last year, I highlighted the alarming levels of overweight and obesity both at home and internationally (*figure 2*).

Figure 1 International comparisons of wealth and health



Source: Jersey Deaths Database, Public Health Intelligence Unit (PHIU), States of Jersey Statistics Unit and WHO Statistical Information System

Figure 2 **Obesity - an international epidemic**



Source: Jersey Annual Social Survey 2005 States of Jersey Statistics Unit

I think about obesity almost every day as the all pervading public health challenge for the 21st century. All developed countries are facing this threat: none have as yet taken sufficient action to slow the inexorable upward trend. Obesity will contribute to the already increasing health and economic burden of chronic diseases. Reflecting on the successes we have already had with our strategies to reduce smoking, alcohol consumption and drug misuse, I have concluded that we need to:

- tackle obesity on all fronts simultaneously
- mount a large-scale, comprehensive, cross-governmental campaign
- ensure that economic policy works to reduce obesity including food marketing to change buying behaviour
- change the food culture
- change the built environment, making it harder to choose an unhealthy lifestyle
- expand effective health education
- provide weight-reduction services.

## **Pandemic flu**

The threat to the Island from pandemic flu remains very real. The question is not 'whether' there will be a worldwide pandemic but 'when'. Experts from the World Health Organisation predict a pandemic soon.

I am pleased to report that Jersey is well prepared with new vaccine on order and stockpiles of the antiviral drug 'Tamiflu' for every Islander who might need it for the prompt treatment of severe flu.

## **Islanders are receptive to wide-ranging action to improve public health**

The debate on the nature of effective public health measures has dramatically changed during the last few years. The public want positive action. Measures that would not have been on the political agenda a decade ago now have broad political support. For example, the vast majority wanted the smoking ban and the smooth implementation and positive public feedback has surprised even me.

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# Summary and recommendations

This is my second annual report on health in Jersey. I have concluded that health is generally good in Jersey, and improving, but could be even better given Jersey's strong international economic position (*figure 1*).

Clouds on the health horizon include obesity and a potential flu pandemic. Increasing levels of obesity could reverse the improving health trends of the past. The threat to the Island from pandemic flu remains very real. I am pleased to report that Jersey is well-prepared.

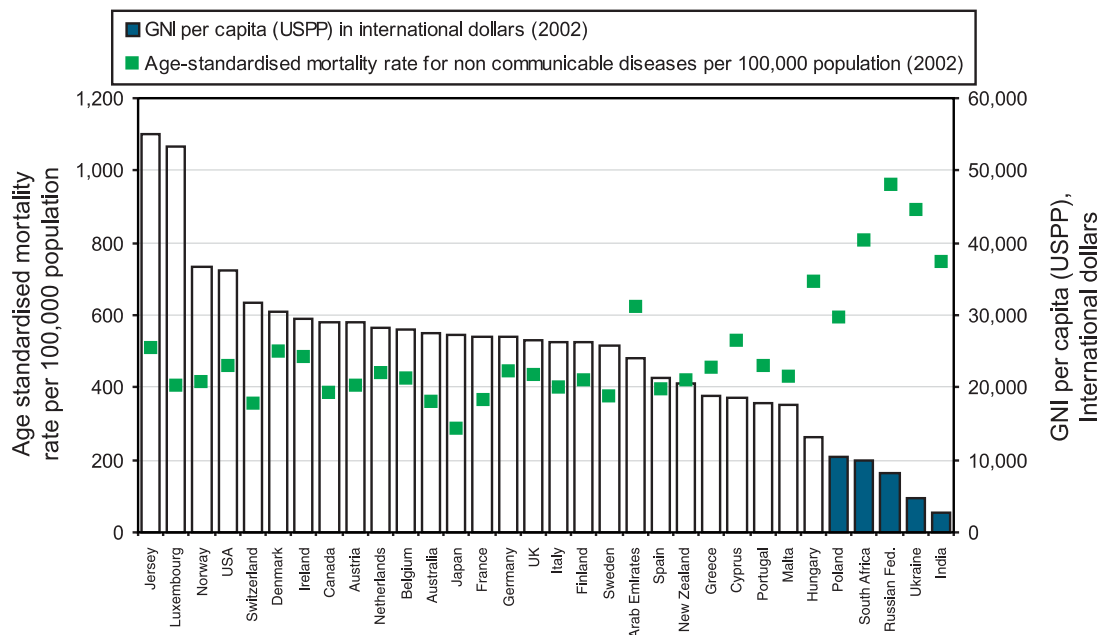
## Health variations in Jersey

Some people have better health than others. We have less data than we would like to study these health variations in the Island. In this report we have made a start in understanding this topic.

Social disadvantage and poor health tend to go together. Our 'social deprivation index' demonstrates that, on average, Islanders are more affluent than their counterparts in England and Wales, and that there is a narrower gap between the poorest and wealthiest Jersey communities. Jersey's poorer communities tend to live in St Helier town, which should focus our attention to improve health here (*figure 2*). We also know that children from urban schools have more tooth decay and poorer lifestyles in general.

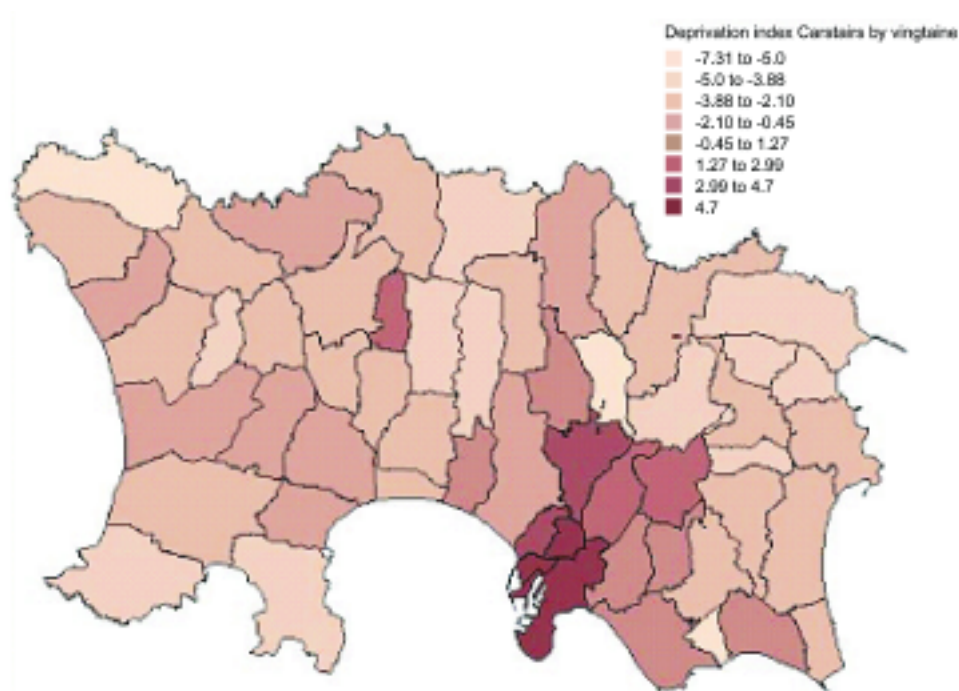
Gender also makes a difference to health. Women have a life-expectancy advantage over men, who suffer more from lung cancer, heart disease, accidents and suicides. A worrying trend is emerging, however, for our young girls who are more likely than boys to smoke, drink too much, be sedentary and worry.

Figure 1 International comparisons of wealth and health



Source: Jersey Deaths Database, Public Health Intelligence Unit (PHIU), States of Jersey Statistics Unit and WHO Statistical Information System

Figure 2 Hot spots for socially deprived communities in Jersey



Source: States of Jersey Statistics Unit and Jersey Health Intelligence Unit (JHIU)

**I recommend:**

1. that the States Statistics Department and the Public Health Intelligence Unit devise and collect an expanded data set to describe better health variations in Jersey
2. that the States address the economic, social, lifestyle and environmental determinants of health to narrow the gap between the 'haves' and the 'have-nots' focussing particularly on St Helier communities.

**Health 1907 - the good old days?**

I have found it interesting to look back 100 years at my predecessor's annual report which shows how far public health has come over the last century. Dr Paul Chappuis, L'Inspecteur Médical, reported that life was short, with an average life expectancy of 46. Infectious diseases, including measles, typhoid and diphtheria, were the big killers. Remarkably today's vaccination programme, had it been in place in 1907, could have saved the lives of 356 people that year.

L'Inspecteur Sanitaire, Mr G Goold Walker, prevented infectious diseases through such means as condemning oyster beds in Gorey infected with typhoid, stemming the supply of infected milk and improving housing conditions and sewage systems.

**I recommend:**

3. that the annual reports of the L'Inspecteur Médical, L'Inspecteur Sanitaire and the Medical Officer of Health for Jersey should be archived with the Jersey Heritage Trust for safekeeping and future reference.

**Tracking terminations**

In 1997 a new law allowed pregnancy terminations to be legally carried out at the Jersey General Hospital. Despite worries at the time, since then terminations of pregnancy have gone down from 300 per year to 200 per year. Jersey's termination rates are now low, by national standards: very few terminations are carried out after the 13th week of pregnancy; very few



women having more than one termination and low teenage pregnancy rates for girls under 20. This paints a positive picture for Jersey. The downward trend is probably due to the success and combination of good health education, contraceptive services and the introduction of the morning-after pill.

### Suicide - a family tragedy

Suicide is a devastating event, both as an individual tragedy and because it is felt intensely by loved ones left behind. On average each year, 9 Islanders take their own lives. Young men are particularly vulnerable. Jersey's Suicide Prevention Strategy began in 2002 focussing on preventing suicide and supporting those bereaved by suicide. Good progress has been made in implementing this strategy and we are starting to see a gradual downward trend in suicide.

**I recommend:**

4. carrying out a suicide audit to determine the key reasons for, and methods of, suicide in Jersey.

### Alcohol: Too much of a good thing?

In Jersey we drink too much alcohol. We are not alone in this problem, but, alcohol consumption here outstrips consumption in the UK and in France quite considerably (*figure 3*).

Over indulging in alcohol can cause severe health problems. We estimate that about 3% of adults in Jersey have a serious drinking problem which is likely to damage their health.

Binge drinking is the new-style drinking culture among young adults in Jersey. Binge drinking entails drinking large quantities of alcoholic drinks in one session. Over a third of young Jersey adults binge drink. In Jersey, unlike the pattern in the UK, young women are keeping pace with their male peers.

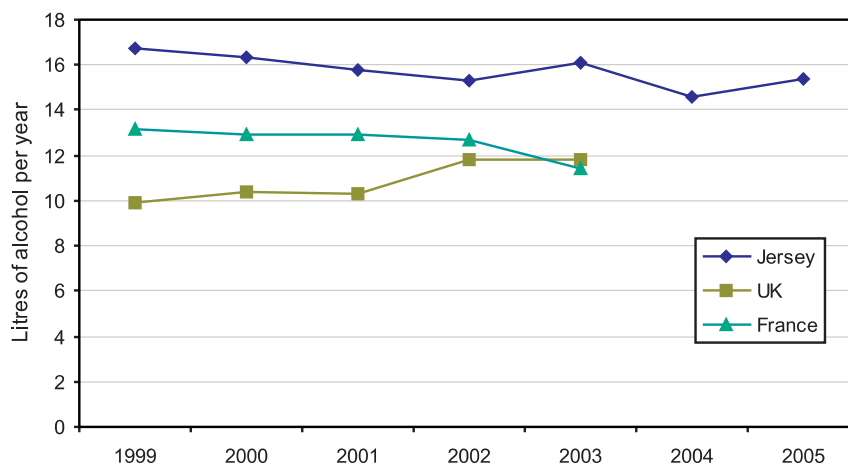
Encouragingly, childhood drinking is decreasing in Jersey; according to the results in the most recent schools' lifestyles survey. We attribute this success to the Jersey Alcohol Strategy: the proof of age scheme, the pub watch scheme and increases in impôts taxes on alcoholic beverages.

Like all complex public health problems, tackling the various forms of alcohol abuse will mean hitting the problem from all angles, reducing availability, increasing price, educating and promoting safe drinking and health and social services for people with alcohol dependency.

**I recommend:**

5. that the forthcoming licensing law includes measures to reduce alcohol consumption
6. that the new 'Healthy Schools' programme includes an alcohol education component.

Figure 3 Alcohol consumption per capita



Source: States of Jersey Statistics Unit and WHO Statistical Information System

## Life after the smoking ban

The smoking ban law is the most significant legal advance to benefit public health in my living memory. All went well from 4.00am on 2nd January 2007 with smooth implementation and tremendously positive public feedback. Fears that smokers, proprietors and employers might not comply were unfounded, as were fears of a drop in trade for the hospitality sector. Employees feel better at the end of the working day and the majority of customers seem to like it. We have had a few teething problems with discarded cigarette butts and smokers gathering in passageways and porches.

The 'Help 2 Quit' smoking service started on the 29th January 2007. The team were inundated by 468 callers during the first two months. Early results are encouraging, with 74% of clients achieving their dream of becoming a non-smoker, four weeks after their quit date.

## Safe as houses?

Our home is central to our life. For some Islanders, however, home is not a source of comfort and good health. During the last five years, householders' discontent has worsened with lack of space topping the worry list. Inadequate heating and problems with damp come next as important issues.

Many health problems can be associated with poor housing. In a recent survey, 7% considered that their housing conditions had made their

health worse. 29% of those who felt they lived in unsatisfactory accommodation also felt anxious or depressed. Young adults were most likely to feel their housing was a problem, which may reflect the situation for those living in tied accommodation in the hospitality sector and in agriculture.

Improving housing conditions should improve health and in turn reduce the burden on the health care system. Better housing could reduce falls and chest problems and improve mental health.

Radiation in the home continues to be a high profile issue with the spotlight now on mobile phone masts. My department has studied this potential threat to health in a thorough and detailed manner in liaison with national and international bodies and standards. We can conclude that mobile phone mast emissions are well below internationally accepted standards and are therefore unlikely to affect Islanders' health. Other sources of radiation are radon gas, which is reduced by better ventilation, and major nuclear sites such as Cap de la Hague and Flamanville: levels for Jersey continue to be low.

### *I recommend:*

7. introducing a new housing law to address shortfalls in Island housing
8. carrying out a survey of a sample of houses to assess condition, air quality and accident risk
9. to consult with key stakeholders responsible for development, and regulation of development, to ensure the provision of appropriate space standards in new houses being built/planned.

## Immunisation: our children, our future

Immunisation is a simple, safe and effective way to protect Island children against harmful diseases that can kill or cause serious illness. All Jersey children are offered vaccination throughout their childhood. Regrettably coverage in Jersey is suboptimal for pre-school children and is considerably poorer than for the UK. We are aiming to vaccinate 90% or more children for 'herd immunity' to protect each vaccinated child and the small minority of children who cannot be vaccinated for medical reasons.



Source: Health Protection, Housing Photographic Album

The damaging media coverage, which made a false link between MMR vaccine and autism and bowel disease, has dented parents' confidence, contributing to low MMR coverage which has in turn led to measles' outbreaks in Surrey, Sussex and South Yorkshire. Jersey's vaccine coverage hit an all-time low at 73% for MMR in 2003. We dread a measles outbreak in Jersey.

Following considerable efforts by all those involved in immunisation services last year, we have started to reverse the downward trend. The immunisation service needs to be better co-ordinated in future to reach our target.

### ***I recommend:***

10. improving the system to report and monitor infectious diseases
11. improving vaccination coverage rates and information technology systems
12. transferring immunisation services into primary care, once infrastructure and governance arrangements are in place.

### **Primary care - public health in action**

Excellent primary care will be the cornerstone of the new Jersey health strategy 'New Directions'. Islanders deserve a world-class primary care service and whilst Jersey GP services have many strengths, there are also limitations. These are holding back the full potential for primary care to:



Dr Philippa Venn with Claire Boleat and baby Frances

- improve patient safety through clinical governance
- systematically care for people with chronic disease
- prevent illness and keep people well.

### ***I recommend:***

13. the 1967 Health Insurance Law needs to be rewritten to promote multi-professional primary care teams to prevent illness and keep patients with chronic disease well and living independently
14. safety (governance) arrangements in primary care are brought into the 21st century, taking account of English recommendations and linking to the General Medical Council
15. more systematic services for chronic conditions are needed, including the necessary computer systems and information flows
16. primary care services for preventing illness need to be expanded, offering patients help and advice before they become ill
17. the Island develops processes to facilitate patient and public involvement within healthcare in Jersey.

### **Patients as experts**

*"My patient understands their disease better than I do."*

This is a view expressed by many healthcare professionals after their patients have taken part in an expert patient programme (EPP).

The EPP is a user-led self-management programme for people who live with a chronic disease like diabetes, arthritis or heart failure. Each programme is run by a trained 'lay' tutor who offers a toolkit of fundamental techniques.

The end result is a person better able to cope with the daily challenges of living with their chronic disease. The EPP is an important component of good chronic disease management, with the potential to maximise good health, lengthen life and reduce the need for emergency medical treatment.

***I recommend:***

18. introducing an EPP in Jersey, on a small scale, with full evaluation, expanding the service subsequently should it prove to be successful.

### **Disability from back pain**

Back pain has always been around and is not increasing. Disability and disability claims have, however, risen dramatically over the last 20 years. Not only does back pain cause considerable human misery and suffering but it is also a drain on the public purse. In Jersey, back pain is the second commonest reason for claiming short-term incapacity allowance and invalidity benefit, costing the Social Security Department just under £3m in 2006.

A new Jersey back assessment clinic will specifically target help for those patients most at risk of developing chronic pain and disability. The new service will apply patient assessment and treatment fashioned on international research. The service will focus on physiotherapy and mental health. This should result in a quicker recovery, less pain and distress, less time off work, less disability and better use of States' resources.

***I recommend:***

19. prevention of long-term disability from back pain through the Jersey Back Assessment Service.

### **Deaths from prescribed fentanyl misuse - a Jersey problem**

In the last year there has been a spate of untoward deaths in Jersey as a result of abuse of the drug fentanyl. Fentanyl is an opiate drug, similar to heroin, which is prescribed to patients to control severe pain. Fentanyl abuse appears to have become a problem in Jersey because police and customs have been successful in keeping heroin off our streets.

Drug addicts shop around in Jersey until they find a GP who agrees to prescribe fentanyl. Fentanyl prescribing has doubled since 2002. The deputy

MOH, Dr Susan Turnbull, issued a public health alert on the 28th February to all GPs urging them to prescribe fentanyl sparingly and to alert us to any drug addict trying to obtain prescriptions by deception.

***I recommend:***

20. that the Public Health team and the Social Security Department study and quantify the extent of 'doctor shopping'
21. that a new system of patient registration with a general practice is introduced.

# Chapter 1 Health Statistics

**“Measuring health helps us to plan better services.”**





# Health variations in Jersey

Some people have better health than others. Some communities tend to live longer than others. We have chosen to call these differences 'health variations'. Many health problems are worse for socially disadvantaged communities - 'health inequalities'. Some, however, are caused by other factors such as genetic predisposition.

Health variations are a reality in Jersey. We can see variations in health both within Jersey and when we compare Jersey with UK health figures, and with other countries internationally. Identifying these differences in health is important because health education, services and neighbourhood initiatives can make a difference in bridging the gap between those with the poorest health and those with the best.

We don't have Jersey data for many of the health issues that we want to study, to look for variations in the health of Islanders and Island communities. In this Chapter, we have used the data which is available to make a start on this important topic. New data will be needed in order to present a comprehensive picture of Jersey health variations in the future.

## What causes variations in health?

People are different in lots of ways so, not surprisingly, is their health. An individual's health is the result of a complex combination of influences, among them:

- where they live
- genes they have inherited
- their age and gender
- their lifestyle
- their social class and educational attainment
- their ethnic origin and culture
- the amount of social disadvantage they experience
- their access to effective health services and other services.

Some of these factors, such as lifestyle or social environment, can be changed. Others cannot be

changed, for example being a man or a woman, your age, genetic inheritance, or ethnic origin. Thus there are different ways of tackling health variations:

- improving lifestyles, education, physical and social environments and services
- targeting services to those most at risk, for those factors that can't be changed, e.g. breast screening for women over 50.

## Where you live

The question of whether living in Jersey makes us more or less healthy is a complicated one to answer. Associations between illness, deaths and place of residence have been known about for a while. Research suggests that where we live does impact on our health, but why this is so is often difficult to interpret.

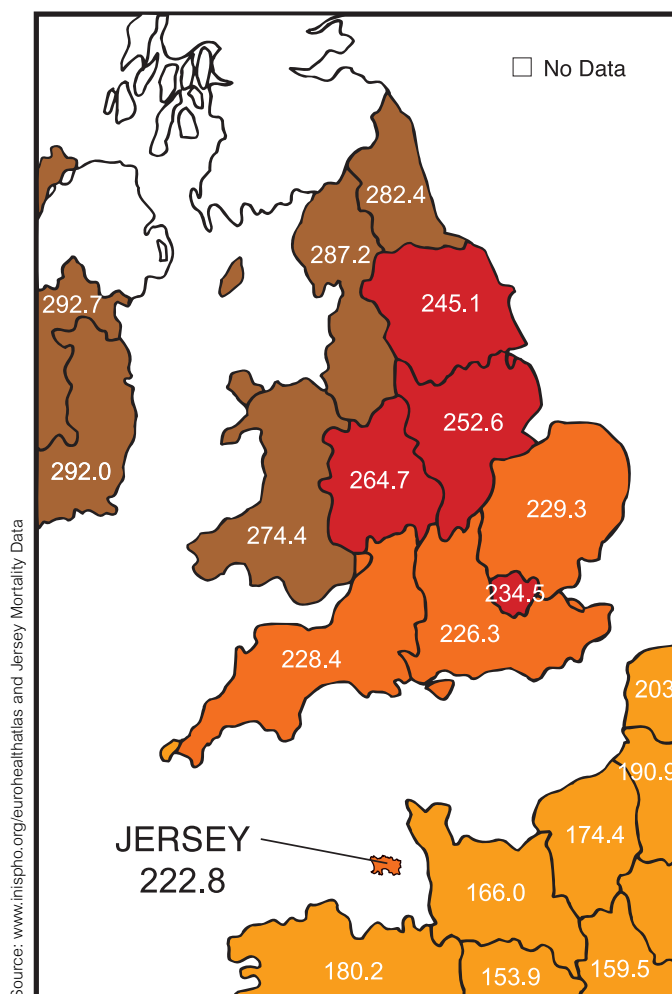
## Comparing Jersey with the UK

People in Jersey have good life expectancy, on a par with the top ten regions in the UK. Local surveys indicate that Jersey compares well with England on a number of other health indicators. In the UK there is a strong 'North/South divide' for most causes of death. This includes the major causes of death: heart disease (*figure 1*), cancer, chest disease, accidents and suicide. Jersey death statistics are similar to the Southwest of England. Jersey residents have similar death rates from heart disease, stroke, lung cancer and childhood accidents, but have worse suicide rates.

## Comparing deaths

It is not possible to compare death rates across the parish residents because deaths are registered in the parish of death. Most deaths occur in St Helier, St Saviour and St Brelade (which have the largest populations), the hospitals and the majority of the nursing homes. A person's place of death may not be related to where they have spent most of their life, so it is difficult to draw any meaningful comparisons using local mortality figures.

Figure 1 **North/South divide for heart disease**  
Deaths from circulatory disease 2000 - 2002  
(Age standardised rates per 100,000 population)



### Comparing cancer incidence

The Public Health Intelligence Unit are mapping cancer incidence in the Island. This project will be completed in 2008.

### Children's tooth decay

We have good comparative data available to compare the dental health of Island children. The British Association for the Study of Community Dentistry (BASCD) carries out a survey in Jersey on alternate years with 5-year-olds, 12-year-olds and 14-year-olds. The local community dental

service also carries out an annual dental screening audit in primary schools.

Oral health is not only important to our appearance and sense of wellbeing, but also to our overall health. Oral disease can cause pain, tooth loss and lead to serious infections. Yet, tooth decay is the most common preventable chronic disease of childhood in the developed world.

Overall Jersey compares well with the UK (table 1) with a lower incidence of diseased teeth (dt) and a higher proportion of treated (filled) teeth (ft).

**Table 1 Dental health of five-year-olds**

|               | Average number of teeth per child |                      |                                 |
|---------------|-----------------------------------|----------------------|---------------------------------|
|               | dt<br>(diseased teeth)            | ft<br>(filled teeth) | dmft<br>(overall dental health) |
| Jersey        | 0.67                              | 0.28                 | 1.09                            |
| Isle of Man   | 1.40                              | 0.20                 | 1.89                            |
| England       | 1.12                              | 0.18                 | 1.49                            |
| Great Britain | 1.19                              | 0.19                 | 1.62                            |

Source: Oral Health of 5-year-old school children in Jersey, PHIU

**NB** A lower dmft indicator means better dental health

There are large variations among schools across the Island (*figure 2*). Schools with an urban catchment area fair the worst. A fifth of urban children have active tooth decay (*figure 3*).

While the incidence of tooth decay has decreased since the 1970s and 1980s it has increased again recently (*figure 4*).

**Figure 2 Variations in tooth decay between Jersey primary schools**

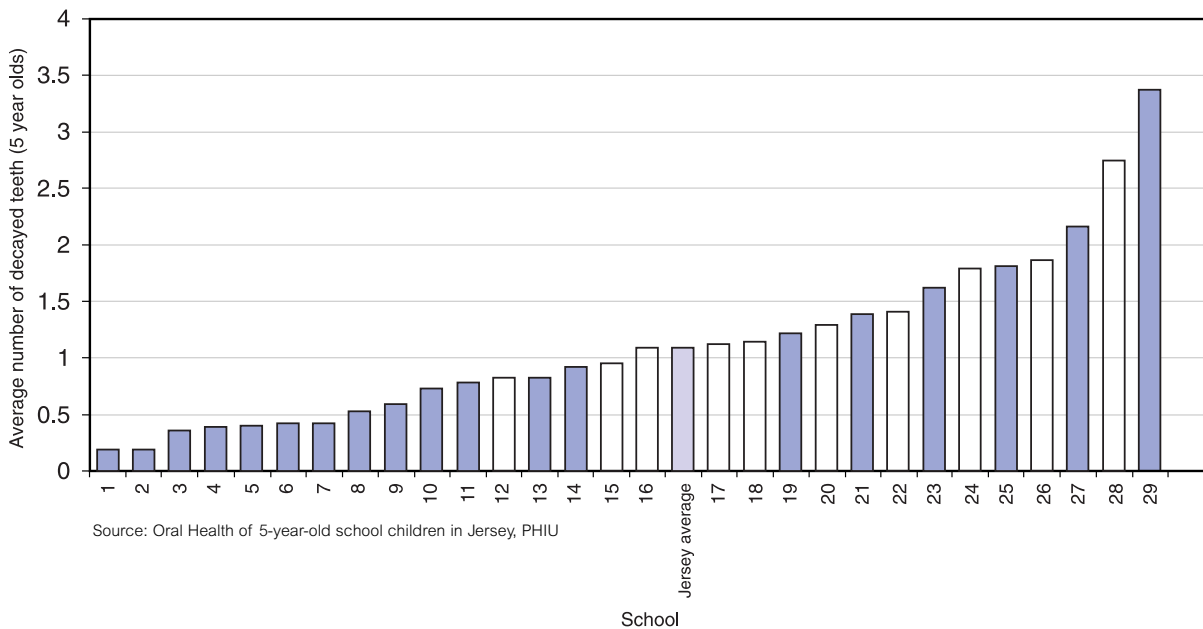
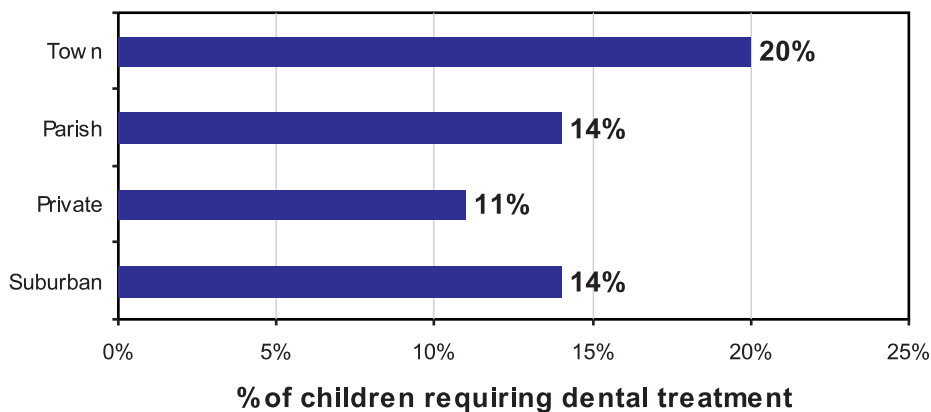
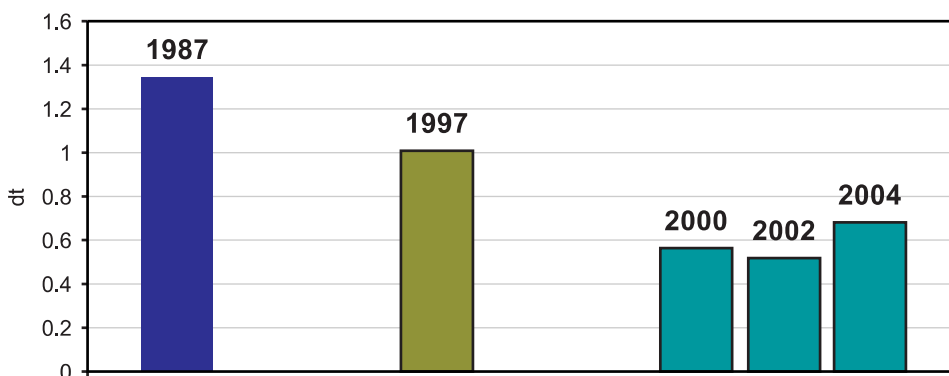


Figure 3 **Variations in dental health between town and country**



Source: Oral Health of 5-year-old school children in Jersey, PHIU

Figure 4 **Trends in active decay in five-year-olds**



Source: Oral Health of 5-year-old school children in Jersey, PHIU

### Social class and social deprivation

Many factors which affect health have a social gradient. Research has shown that social disadvantage and poor health tend to go together. In the UK researchers have studied socially deprived populations and discovered that they have higher death rates and that many health problems are worse in manual workers (e.g. heart disease, stroke, lung cancer, accidents). People from poorer social classes usually have more risk factors and greater exposure to health hazards than the middle/upper social classes. These differences can often explain geographical differences in health.

The term social deprivation summarises factors about people and their social setting which might make them more vulnerable.

There are several ways of measuring social deprivation. We have studied social deprivation using the 'Carstairs Index' and Jersey census data.

The Carstairs Index includes:

- low social class (manual workers)
- lack of car ownership
- overcrowding
- male unemployment.

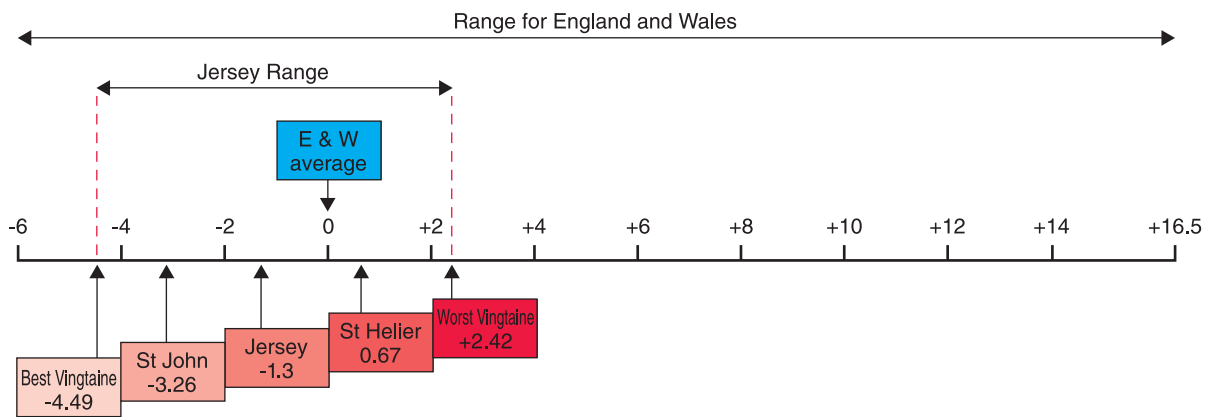
For social deprivation, Jersey overall is more affluent than England and Wales (*figure 5*).

There is also a wider gap between the 'haves' and 'have nots' in England and Wales, compared to Jersey.

There are, however, differences in social deprivation within the Island. The Public Health Intelligence Unit has calculated a 'Carstairs score' for each of the local vingtaines and compared it with the average for the Island as a whole. Social deprivation is closely linked with health, which gives some indication of where health problems

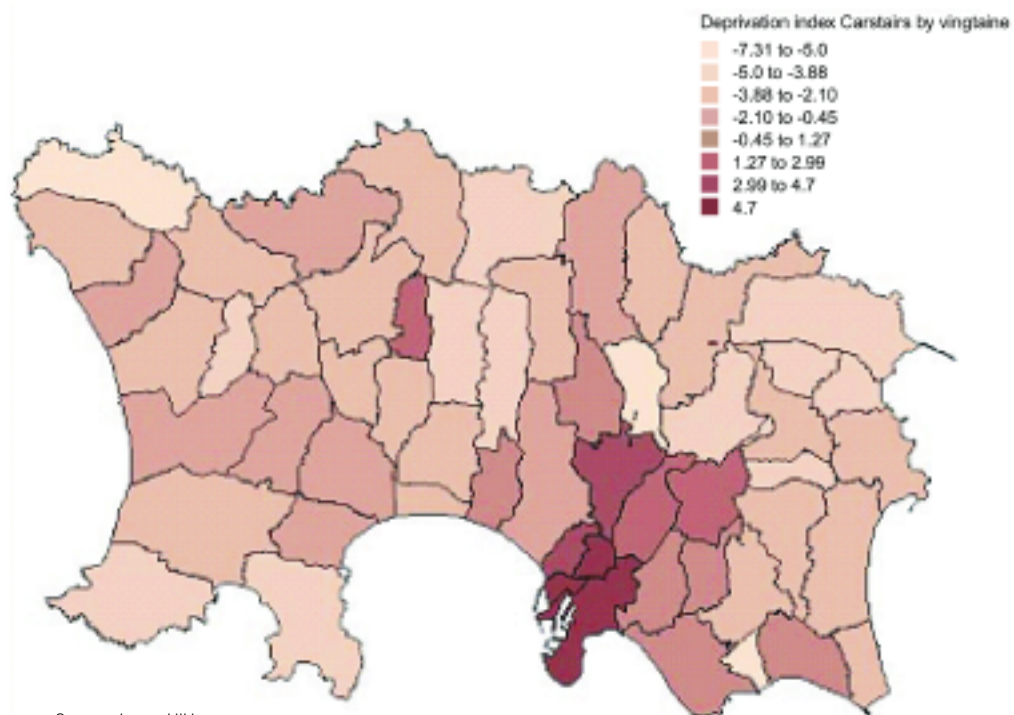
are likely to be worse. St Helier town has the worst social deprivation score, and so is likely to have the worst health problems and potentially a greater need of health care services (figure 6). St Helier town is slightly more deprived than the UK average and the worst vingtaine is deprived with a score of 2.42.

**Figure 5 Comparing social deprivation in Jersey with national benchmarks (Carstairs Index)**



Source: UK Office for National Statistics and Jersey HIU

**Figure 6 Hot spots for socially deprived communities in Jersey**



Source: Jersey HIU



There is a complex relationship between social disadvantage and poor health and simple solutions would almost certainly fall short of the mark. The findings of the Black Report 'Inequalities in health' in 1980 and the Acheson Report 'An independent inquiry into inequalities in

England in 1998' remain relevant today. Their recommendations are wide-ranging and multifaceted addressing the economic, social, lifestyle and environmental determinants in health.

**Health inequalities will never disappear but the gap could be narrowed by:**

**ECONOMIC**

- promoting independence through high employment rates and economic prosperity for all
- targeting benefits to the most needy, focussing on young women and families with young children.



**ENVIRONMENTAL**

- making Jersey a place which is conducive to good health e.g. the smoking ban, promoting walking and cycling within the town plan and access to good food
- targeting improvement for communities with poor housing and environment e.g. reducing overcrowding, petty crime and accidents.



**EDUCATION**

- ensure that every Islander has the opportunity to reach their full educational potential
- roll out the 'Healthy Schools' programme focussing on schools with poorer catchment areas, improving nutrition and cooking skills in particular.



**HEALTH CARE**

- addressing the 'inverse care law' whereby poorer people get relatively less health care.



### Ethnic origin and culture

The Public Health Department is often asked whether there are particular health problems faced by Islanders who have come to Jersey from other countries such as Portugal/Madeira or Poland. This question could only be accurately answered if health data differentiated between cultural communities. No data is currently available. This is an issue we would like to address in the future.

### Age

#### Children and young adults

Children are more likely to suffer from infections. The main causes of death for young adults are different from those for older people and are predominantly due to external causes. Those in the 15-24 age group have higher death rates from transport accidents than older Islanders. Thankfully these accidents are relatively rare locally. Young men are more likely to commit suicide. Sexually transmitted infections continue to increase.

#### Older people

As people get older they are more likely to suffer from heart disease (*figure 7*), stroke, cancer and arthritis. Many other common, and less common, conditions are also more prevalent in older

people. Older people are more likely to live with a chronic disease and to use health services more than younger adults. Around 28% of Islanders over 75 have long-term health problems that cause them serious difficulties with daily activities.

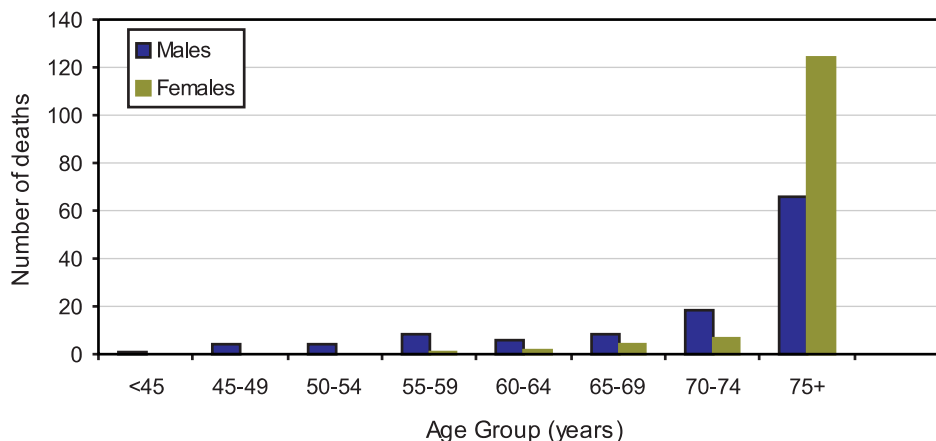
### Gender

Women live longer than men because they suffer less from the big killers, heart disease and stroke, which tend to occur at a later age for women. Jersey women live on average six years longer than men and this life-expectancy advantage has increased by two years over the last hundred years. Women, however, are more likely to spend more years in poor health.

There are clear differences in the main causes of death for men and women. Breast cancer is the most common malignant cancer for women in Jersey and accounts for 21% of all female deaths (*figure 8*). Women also suffer from cervical, ovarian and womb cancer.

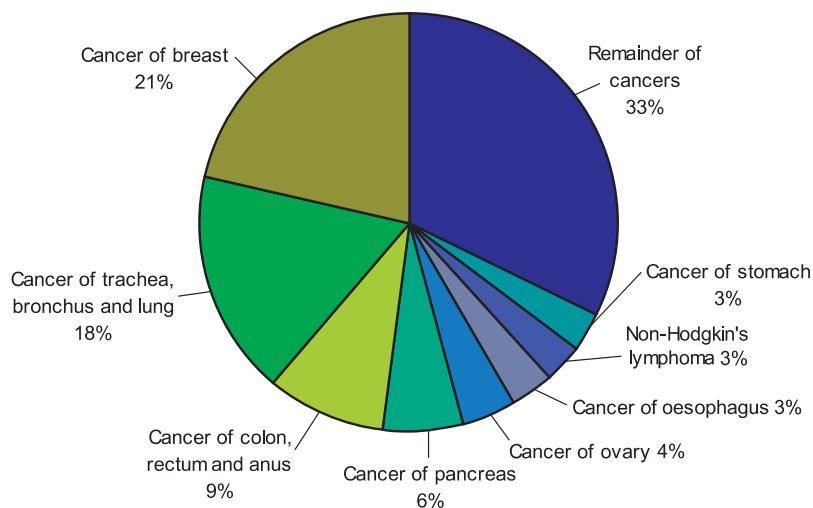
Men are more likely than women to die prematurely from lung cancer (*figure 9*), although women are now catching up as their smoking prevalence had increased. Young men are more likely to have a fatal accident or commit suicide than young women.

*Figure 7* Heart disease mortality increases with age



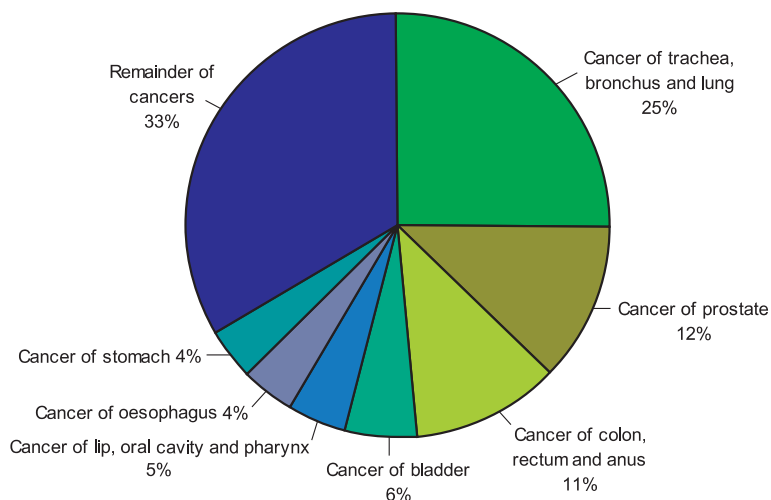
Source: Jersey Deaths Database, PHIU

Figure 8 **Main causes of death from cancer in women**



Source: Jersey Deaths Database, PHIU

Figure 9 **Main causes of death from cancer in men**



Source: Jersey Deaths Database, PHIU

### The hereditary basis for disease

There are some diseases that run in families for example haemophilia and muscular dystrophy. Because we inherit the genes we are born with, there is not much we can do to change this. In recent years, however, much progress has been made looking at the genetic components to many common diseases. Knowing more about an individual's genetic predisposition to disease opens up new avenues:

- for prenatal and antenatal screening
- for disease prevention, screening and early,

more effective treatment

- to target treatment
- to have fewer side effects from treatment
- to use limited healthcare resources more effectively.

Genetic research is shedding further light on the common causes of disease, for example breast and colon cancer, hypertension, asthma, heart disease, Alzheimer's and deep vein thrombosis. This has implications for the type of treatment people might receive in the future and could have a major effect on healthcare resources.

### Lifestyles

People’s lifestyle and behaviours are known to affect their health in many ways. Recent surveys indicate that there are lifestyle differences between groups of people on the Island.

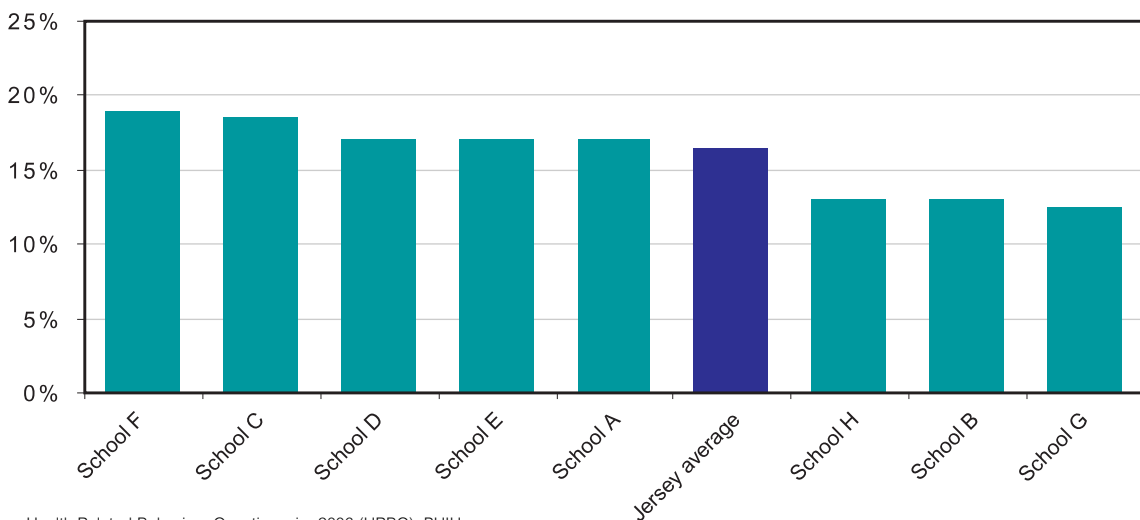
skip breakfast, smoke, drink more alcohol than they should and worry more than boys. They are also less likely to take regular exercise. Boys on the other hand are more likely to be satisfied with their life, smoke heavily and keep bullying problems to themselves.

### Young People

The recent lifestyle survey of Jersey secondary school children demonstrated that there were differences in lifestyle behaviours between girls and boys. As they get older girls are more likely to

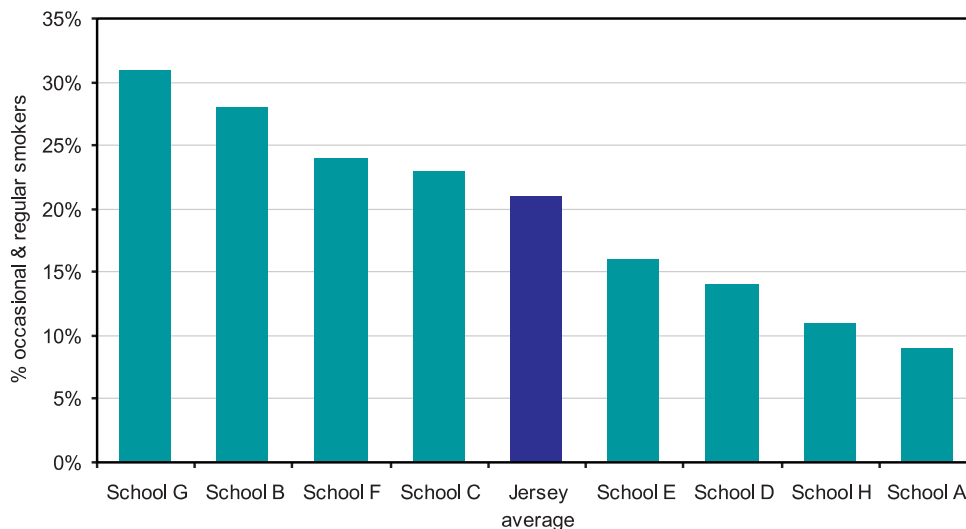
There were also differences between schools. Interestingly while some lifestyle behaviours were similar for all schools, for example drinking alcohol (*figure 10*), others, like smoking (*figure 11*), were quite different in schools across the Island.

**Figure 10 Prevalence of 14-15 year-olds drinking alcohol by school**



Source: Health Related Behaviour Questionnaire 2006 (HRBQ), PHIU

**Figure 11 Prevalence of 14-15 year-olds smoking regularly by school**



Source: Health Related Behaviour Questionnaire 2006 (HRBQ), PHIU

Young people today are smoking and drinking less than their peers of ten years ago, so it will be interesting to see if that follows through into their early 20s. Currently those in their early 20s are the heaviest smokers and drinkers in Jersey; they were the school generation of 1996 and 1998 when we measured higher levels of drinking and smoking in past surveys.

### Adults

The Jersey Annual Social Surveys have allowed us to look at adult lifestyles in Jersey. Comparisons between communities, however, are hard to ascertain. This is another issue that we will address in future reports.

### The health challenge

Comparing Jersey with similar communities reveals that the health and wellbeing of Islanders is generally good.

We have limited data available to reveal health variations between people and communities in the Island. We do know, however, that urban schools have more tooth decay and that children in urban schools have poorer lifestyles on average.

Social disadvantage is generally linked to poorer health. There is more social deprivation in St Helier which should concentrate our attention on communities here.

*The challenge is to:*

- improve lifestyles, education and physical and social environments
- target services to those most at risk.

*To do this we need:*

- accurate, timely local data
- an understanding of the determinants of health
- a willingness to change.

### Recommendations

*I recommend:*

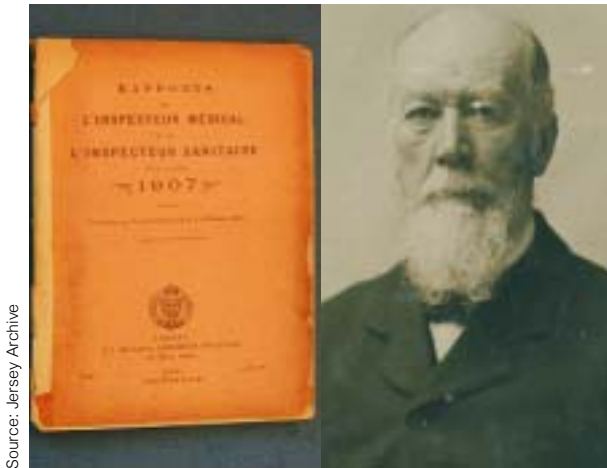
- that the States' Statistics Department and the Public Health Intelligence Unit devise and collect an expanded data set to describe better health variations in Jersey.
- that the States address the economic, social, lifestyle and environmental determinants of health to narrow the gap between the 'haves' and the 'have-nots' focusing particularly on St Helier communities.

### References

1. Black Report 'Health inequalities; the health divide', 1980.
2. Acheson Report 'An independent inquiry into inequalities in health in England', 1998.



## Health 1907 – the good old days?



Source: Jersey Archive

Dr Paul Chappuis 1853 - 1928

When, 100 years ago in 1907, L'Inspecteur Médical, Dr Paul Chappuis, presented his Annual Report, the challenges facing Public Health were very different from those of today. This report, traditionally written in French, as with all official documents of the time, gives us a fascinating picture of Islanders' health and lives during that year when the Island population was just over half (52,000) of that in 2007.

Dr Chappuis, originally from France, was well known on the Island. Aside from his medical role,

it seems he played an active part in Island life, involving himself in archaeology at La Cotte cave in St Brelade which was used by Neanderthal man 250,000 years ago and where the bones of woolly mammoth and rhino were discovered.



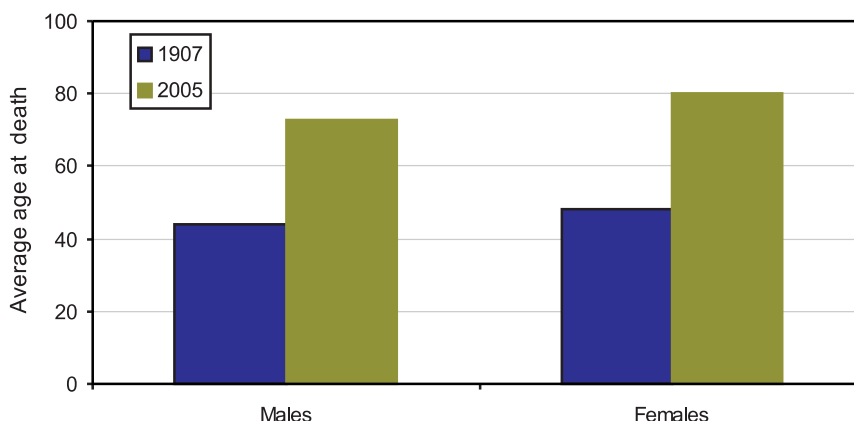
Source: Société Jerseyaise

Dr Paul Chappuis at La Cotte cave

### Early death and infectious disease

In 1907 life was short: men died at an average age of 44 and women 48 (figure 12). Most of us today regard this decade of our lives as a time when we are in our prime. The latest figures for 2005 show the average age of death as 74 for a man and 80 for a woman.

Figure 12 Life expectancy comparisons 1907 and 2005



Source: Jersey Deaths Database, PHIU and MOH Report 1907

The causes of death in 1907 were different too, with infectious disease being the main cause of death (figure 13). There were outbreaks of measles, typhoid, diphtheria, scarlet fever, tuberculosis and whooping cough. A smallpox epidemic reached the adjacent French coast but it did not reach Jersey.

*“For the seventh consecutive time the report can confirm smallpox has not occurred in Jersey. This is, however, not a reason to forget about precautions as the Island was literally surrounded by the disease. During this year epidemics have prevailed in Dunkerque, Paris, Rennes, St Brieuc and Brest and of course it could have arrived at any time by the steamer services.”*

Nowadays, vaccines prevent most deaths from infectious diseases. 364 people died from infectious diseases in 1907 and of these 356 could have been saved by our modern immunisation programme.

The other big killers, like today (figure 13), were diseases of the heart and circulation. Unlike today, however, there was no mention of obesity.

**Diseases highlighted in the 1907 report**

**Measles**

There was an outbreak of measles with about 30 cases in the months of November and December

1906. It spread successively through each parish, reaching a peak in May 1907, then tailing off slowly. The country parishes of the Island recorded 557 cases and St Helier 575 cases, totalling 1,132 which included six deaths. Five out of six of these deaths were in St Helier. In some families there were notifications of four, five, six or even seven children taken ill at the same time. Measles was also no respecter of age: 30 patients were over 40 years old and one patient was 81.

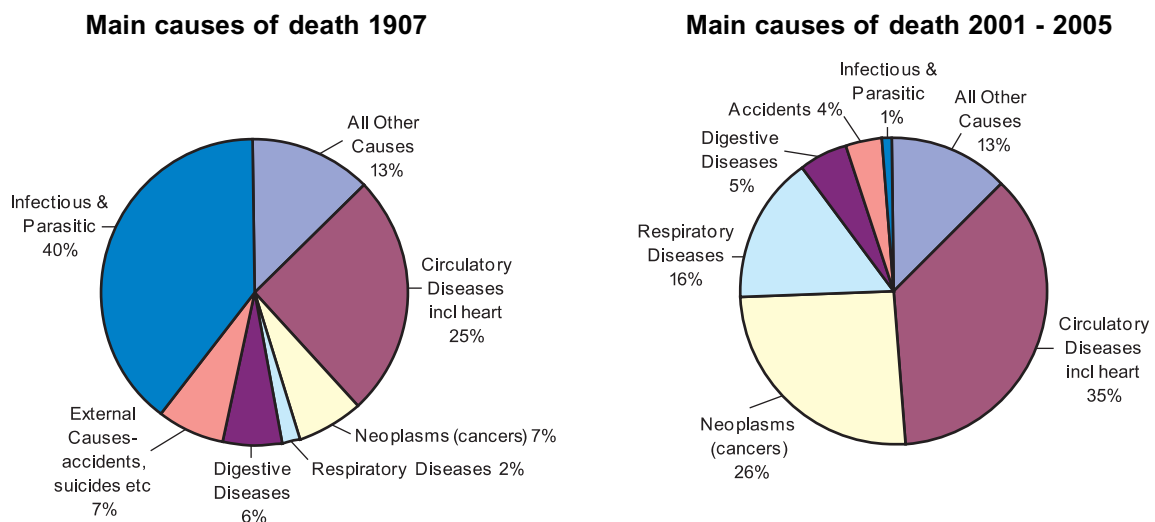
*“The special character of the 1907 epidemic was its extreme contagiousness.”*

Dr Chappuis closed schools in all parishes as soon as the disease made its appearance with the aim of reducing spread. Unfortunately the report doesn't tell us how many patients suffered permanent damage to their health. We might have expected 75 patients to have suffered significant complications from measles including deafness, diarrhoea, pneumonia, convulsions, meningitis, encephalitis and conjunctivitis.

**Typhoid**

Dr Chappuis described typhoid as endemic rather than epidemic, with little variance from year to year. In 1907 typhoid killed 8, with 45 cases in total. Typhoid also appeared indifferent to the seasons of the year.

Figure 13 The ‘big killers’ comparing 1907 and 2005



Source: MoH report 1907

Source: Jersey Deaths Database, PHIU

Some cases were imported into the Island. One person visited Cancale just before Easter, bringing oysters back to Jersey, at the same time sending some to friends in England. An Islander who ate some died of a violent typhoid attack; but in England, where the oysters were not as fresh when they arrived; there were four linked cases of typhoid including two deaths.

### Diphtheria

Diphtheria was another problematic disease. There were 70 cases reported and of these 7 patients died. This was fewer than in the three preceding years. Mortality attaining 10% was regarded as 'too high'. There were 52 cases in the Parish of St Helier and 18 cases in the countryside.

### Scarlet fever

Scarlet fever had been present throughout 1906 and gradually decreased during the first five months of 1907. Subsequently, after several months of silence, the disease made a new appearance and 8 cases occurred in St Helier.

### Other Diseases in 1907

Other major killers were tuberculosis (83), bronchitis (66), meningitis (20), cerebral diseases (117), diseases of the heart and circulation (129), diseases of the liver and digestive system (56), paralysis and other disorders of the nervous system. The good news was, however, that some people did reach old age, with 64 deaths being reported simply as 'vieillesse' (old age).

Infant mortality was high in 1907. 25 infants died from infantile diarrhoea, with 14 deaths in St Helier and 11 in the countryside. The mothers of these infants suffered too, with six cases of puerperal fever including three deaths; a disease suffered as a result of infections following child birth. In the UK 2,000 women died as a result of this infection in 1901: in the year 2000 only two women died.

Whooping cough took its toll on the younger generation claiming 12 lives, mainly in St Helier. It was mostly the older generation of the community who suffered badly from influenza - seven died. Cancers and tumours were much less prevalent in our Island in 1907 than they are today causing 67 deaths. Unfortunately we don't have a break down of types of cancers.

### The Sanitary Inspector

Dr Chappuis reported jointly with his colleague Mr G Goold Walker, L'Inspecteur Sanitaire. Mr Goold Walker inspected premises on notification of an infectious disease and was usually able to trace the source. This was sometimes impure water, infected milk or the existence of insanitary conditions. In 18 cases, wells or cisterns were condemned, the water supply being impure.

One farmer was ordered to discontinue the supply of milk to the Convent of St Andrew, "*there being infectious disease in his family.*" Indeed two of the recipients of the farmer's milk contracted typhoid. The farmer himself was fined the full penalty of £20 plus costs.

In respect of typhoid, Mr Goold Walker's attention was drawn to the oyster beds at Gorey. Two pits, used for storage of oysters, were found to be too near the sewer outfall and had been reported as "*unfit for use owing to danger of pollution.*" The owner attempted to prove the run of the tide would carry the sewage away from the pits. He was wrong and the pits were condemned.



Grouville Bay in 1907

Source: Société Jersiaise

Smoke-testing the drainage systems of 29 dwelling houses was carried out mainly because of the presence of an infectious disease. In nine of these houses the whole system was renewed and the remainder had less serious defects.

369 milk shops and dairy farms were visited and, despite general conditions improving, the condition of the majority of the milk shops was

not as it should have been. It was considered that the only remedy for this state of affairs was compulsory registration of milk shops, and granting of licences to sell milk once the premises conformed to the required standard of fitness.

53 bakehouses were visited, almost all of which were in a satisfactory condition; however in one a “*water closet of modern pattern with flushing cistern*” had been substituted for the “*foul hopper closet*” formerly in use.



Source: Société Jerseyaise

Grocer and Bakehouse in 1907

## Conclusions

In 2007 health concerns for the Island were very different from those in 1907. Back then, running water and indoor sanitation were for the rich. Infectious diseases were a major problem and immunisation programmes were to be a thing of the future.

Vaccination, better sanitation and nutrition and modern health services have given our generation longer and healthier lives than our forebears. When tackling the new health challenges of the 21st century, it is good to look at earlier times and take stock to see how much the Island has accomplished.

## Recommendation

*I recommend:*

- that the annual reports of the L'Inspecteur Médical, L'Inspecteur Sanitaire and the Medical Officer of Health should be archived with the Jersey Heritage Trust for safekeeping and future reference.

## Tracking terminations in Jersey

Despite worries at the time, the change to the Jersey termination of pregnancy law has not resulted in increasing numbers of terminations. In 1997 the local law was changed to allow terminations to be legally carried out at the Jersey General Hospital (up to twelfth week of pregnancy). Prior to that, any women wanting a termination had to go to a clinic in the UK.

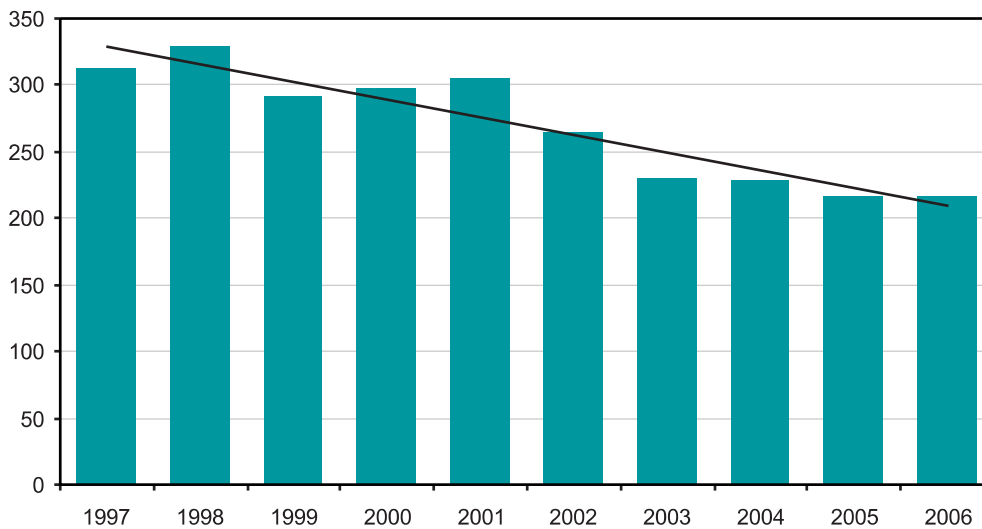
### Numbers of terminations

Over the past five years an average of 232 terminations have been carried out annually in Jersey. Of these, over 90% have been for women who are resident in the Island.

The number of terminations carried out on the Island has declined from over 300 per annum, when the law was first introduced, to plateau at just over 200 a year (*figure 14*). The reasons for this downward trend are probably a combination of good health education and contraceptive services, the introduction of emergency contraception (morning-after pill) in 1991 and improved definitions.

Jersey termination rates are lower than those in England and Wales for all age groups (*figure 15*). They are particularly low for teenagers.

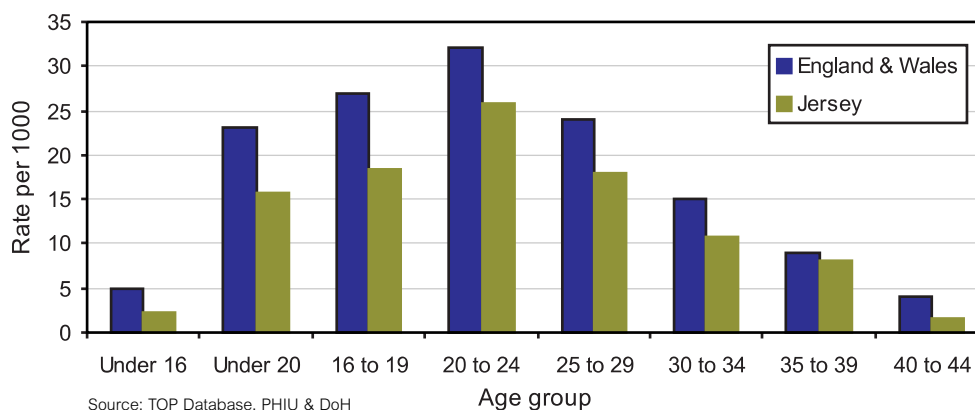
Figure 14 Number of terminations carried out in Jersey



Source: TOP Database, PHIU



Figure 15 Termination rates comparing Jersey with the UK



### Terminations for girls under 16 years

The majority of women who have terminations are aged between 20-39 (figure 16). Only 17% of local terminations are performed on teenagers and only a very small number (an average of 4 per annum) are for girls under 16. Most women who have terminations in Jersey are single (74%) and for about half of women the termination is the result of their first pregnancy.

### Legal terminations before 13th week of pregnancy

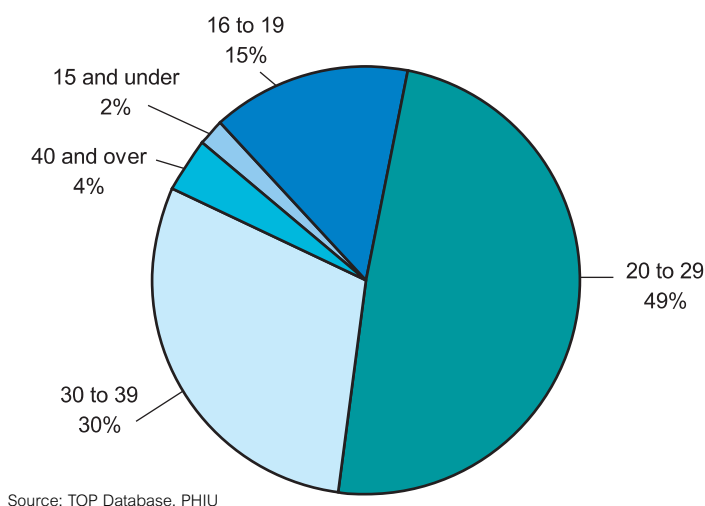
98% of all terminations are carried out within the Jersey legal limit, before the 13th week of gestation. This compares with 89% in the UK.

The very small proportion carried out after that (an average of 5 per year) have been due to exceptional circumstances or emergencies, such as fetal abnormalities or to save the life of the mother.

### Women having more than one termination

For nearly three quarters of women, the termination is their first (figure 17). In comparison with the UK, fewer local women had had previous terminations - 32% of women in the UK in 2003-2005 compared with an average of 26% in Jersey over the past five years. In Jersey, the service sees only 9-10 women each year who have had two or more previous terminations.

Figure 16 Age of women having terminations (2002-2006)



### Teenage pregnancies

Conception rates for the under 20s in Jersey have decreased slightly over the past two years and are much lower than for the UK (figure 18).

Local termination data is combined with birth data to give an overall conception rate for the Island which can then be compared with other areas.

### Conclusions

Through monitoring termination data we can paint a positive picture of Jersey in comparison with the UK. There are fewer terminations being performed and, of those which are, very few are carried out late in pregnancy. Only a minority of women have more than one termination. Teenage pregnancy is also low and falling.

Figure 17 Number of previous terminations

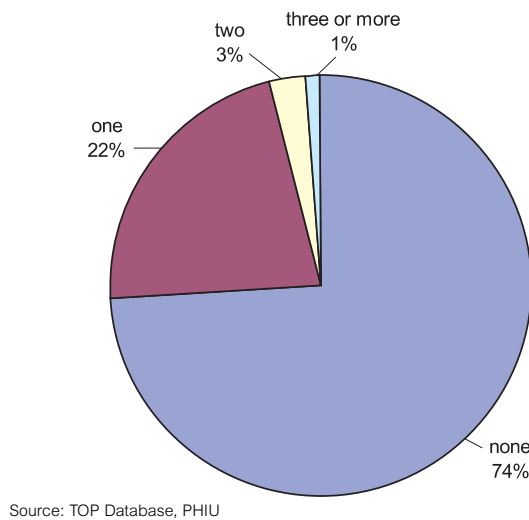
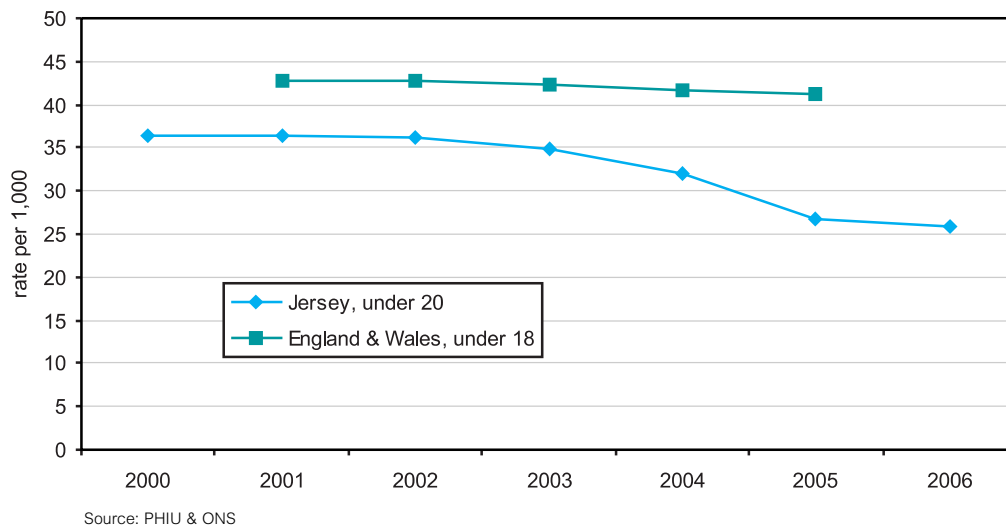


Figure 18 Teenage pregnancy - Jersey compared with England and Wales



## Chapter 2 Health Improvement

**“We were gradually winning the fight against alcohol misuse but ‘binge-drinking’ is a new challenge.”**



## Suicide – a family tragedy

Suicide is devastating. Each suicide is a loss to the wider community as well as an individual tragedy, felt intensely by loved ones left behind.

On average 9 Islanders take their own lives each year. Conservative estimates of current numbers bereaved by suicide in Jersey suggest that approximately 65 people per year experience both the short and long-term physical and mental effects of losing someone close to them through a suicide. It is generally accepted that the impact of this lasts a lifetime. Health and Social Services have made preventing suicide a priority.

### The global picture

Suicide is a serious global public health challenge. It is the thirteenth leading cause of death worldwide, and the seventh leading cause of death in the European Region. According to the World Health Organisation, from 1950-1995 the global rates of suicide have increased by 60%.

In 2000, suicide claimed the lives of an estimated 815,000 lives worldwide with an overall, age-adjusted rate of 14.5 per 100,000 per population. The same rate in Europe is slightly higher at 19.1 per 100,000 per population.

### The national picture

In England the suicide rate is decreasing. In the last thirty years of the 20th century, suicide rates in older men and women fell. The suicide rate, however, is not evenly spread across age groups. Suicide has risen in young men in the 25-34 age group. In this group there are four male suicides to every female suicide.

Continued targeted efforts to prevent suicides have been successful, with a sustained fall in suicide among young men in England in recent years, although the rate still remains high in comparison to the general population.

### The local picture

Suicide is an important public health problem here in Jersey. It was first raised as an issue in the Medical Officer of Health Report (2001). Jersey has a suicide rate almost double that in England and Wales - 11 per 100,000 per year in Jersey compared with 6 per 100,000. It is the fourth most frequent cause of death here, after circulatory disease, cancer and road traffic accidents.

Locally we can show an overall reduction in suicide rates, (*figure 19*), comparable to that reported in the English Suicide Prevention Strategy Annual Report (2004).

As in England, suicides in Jersey are unevenly spread across the age groups, and between men and women. In Jersey, young men are particularly at risk of suicides (*figure 20*).

### Preventing suicide

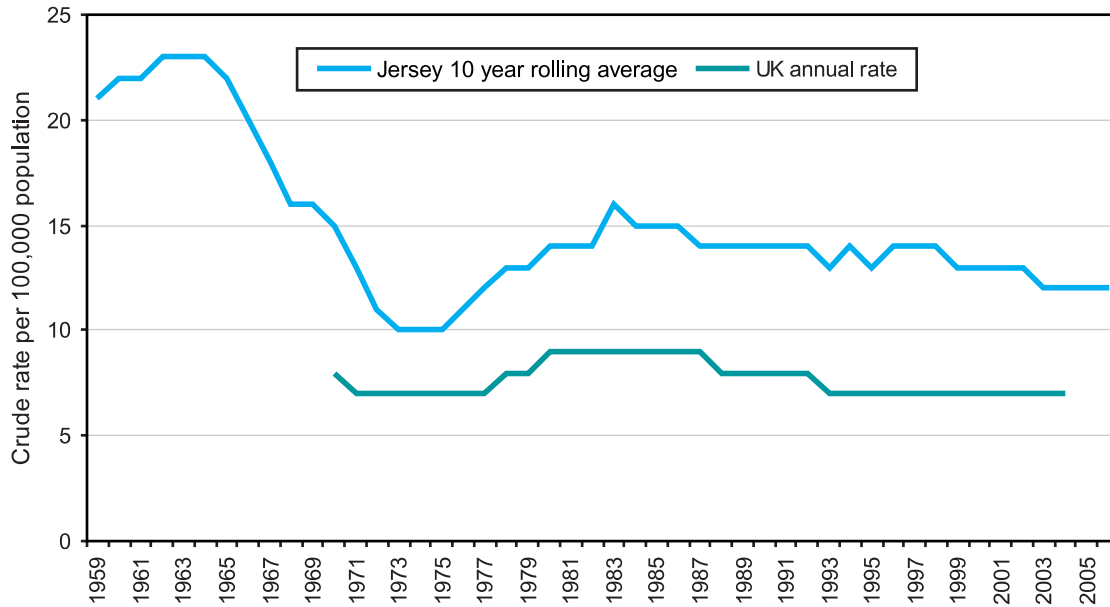
#### National Consensus

No one single action will reduce suicide rates across a population. A wide variety of organisations have a role to play. A broad strategic approach which co-ordinates the contributions of different agencies is necessary. Research into the area of suicide prevention shows key risk factors for suicide:

- mental illness
- social isolation
- a previous suicide attempt
- physical illness
- substance abuse
- family violence
- access to means of suicide.

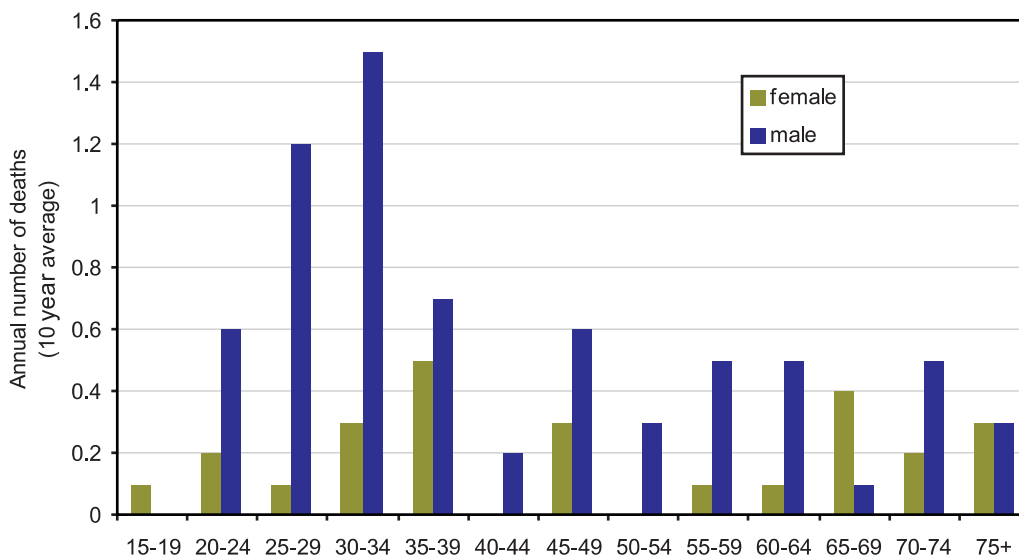
Suicide prevention strategies were launched in England and Scotland in 2002. A recent review recommended that preventative activity should focus on '*a broad array of preventative interventions addressing different risk factors at various different levels*' (WHO 2004).

Figure 19 **A downward trend in suicides**



Source: PHIU

Figure 20 **Suicide risk varies with age**



Source: PHIU

### Local action

The Health Promotion team and Mental Health Services, working with representatives from the statutory and voluntary sector, produced the Suicide Prevention Strategy (2002-07), to reduce the number of suicides in Jersey.

This focuses on maximising opportunities for intervention wherever possible to reduce both attempted and fatal suicide. The strategy has four key areas of action:

- primary prevention (using whole population approaches)
- early interventions (targeted approaches for at-risk groups)
- crisis intervention (for those in immediate need and at high suicide risk)
- post-event support (for those bereaved by suicide).

Good progress has been made with the strategy, with a number of key actions completed:

- Samaritan-sponsored signage in car park hotspot areas
- Accident and Emergency Department liaison nurses to support those at risk
- protocol with the police for working with those at risk
- mental health resource directory describing all helping agencies
- improved collection of local information on suicide
- better post-suicide support for bereaved families
- initial training to improve risk assessment skills of professionals
- audit of overdose activity in the Accident and Emergency Department.

### Recommendation

*I recommend:*

- carrying out a suicide audit to determine the key reasons for, and methods of, suicide in Jersey.

### References

1. NIMHE: 2004: National Suicide Prevention Strategy for England, Annual Report on progress 2004.
2. Scottish Executive: Choose Life, A National Strategy & Action Plan to Prevent Suicide in Scotland: 2002.
3. Health Evidence Network; (2004) For which strategies of suicide prevention is there evidence of effectiveness; World Health Organisation Europe.
4. World Health Organisation.



## Alcohol – too much of a good thing?

### So what's the problem?

For many, alcohol is an enjoyable part of everyday life. Regular modest consumption of alcohol can help prevent heart disease. It is important commercially - every year around £111,000,000 is spent on alcohol in Jersey. The government enjoys revenue of approximately £11,000,000 from alcohol impôts duty. The alcohol industry provides employment opportunities. So why are we concerned?

### Too much of a good thing

As a population we drink too much alcohol. Even though alcohol consumption reduced in the 1990s, in Jersey we consume more alcohol per capita than our UK and French neighbours (*figure 21*).

Islanders drink more often, but the proportion who exceed recommended weekly amounts is comparable to the UK (*figure 22*).

### Binge drinking

The new public health challenge posed by alcohol is 'binge drinking' among young adults. This has

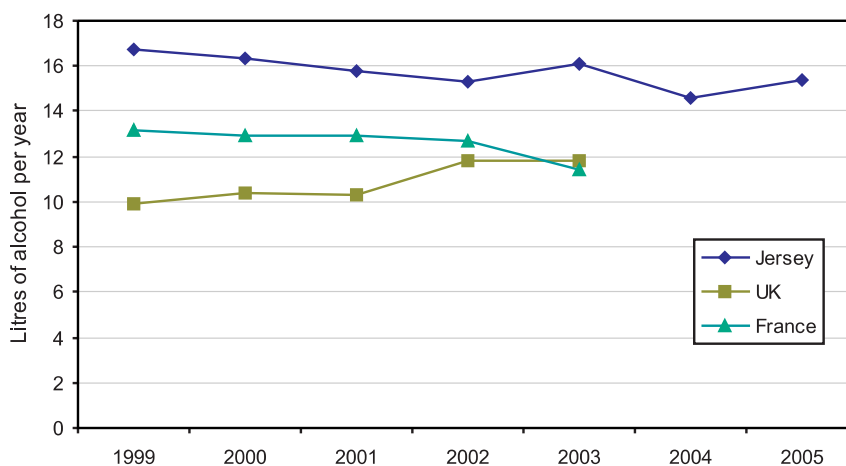
been the subject of considerable recent media attention. 'Binge drinking' is drinking large quantities of alcoholic drinks in one session (eight or more units on the heaviest drinking day in the last week for men and six or more units for women).

Over a third of young Jersey adults binge drink. In England young men are the main binge drinkers, whilst Jersey young women are keeping pace with their male peers (*figure 23*). This is particularly worrying as the female metabolism is less able to cope with alcohol poisoning, leading more readily to liver cirrhosis.

### Alcohol dependency

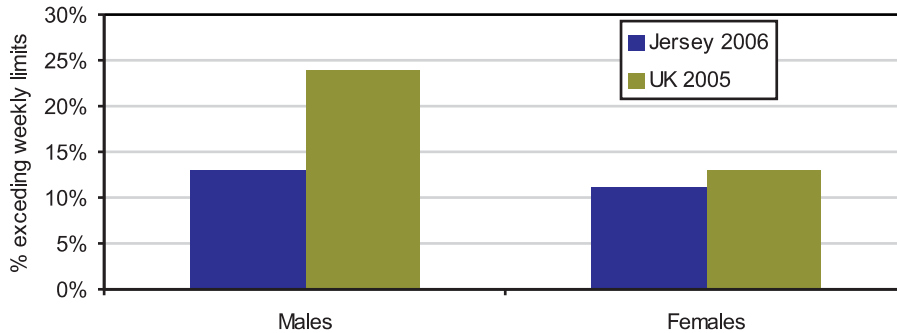
Alcohol addiction is a problem which can wreck lives, both for the individual with the addiction and their families and friends. 3% of adults in Jersey have a serious drinking problem which is likely to damage their health. Since 1999, however, the proportion of Islanders dependent on alcohol has dropped from 7%. Numbers are very small, so this may not be a true representation of what is actually happening, although it resonates with decreasing levels of alcohol dependency in the UK.

*Figure 21* **Alcohol consumption per capita**



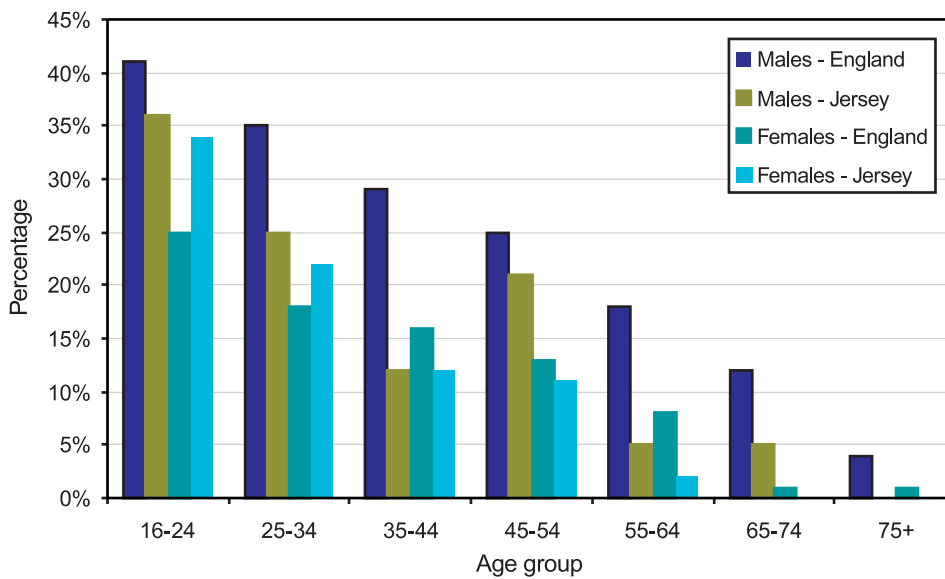
Source: States of Jersey Statistics Unit and WHO Statistical Information System

Figure 22 Islanders exceeding sensible alcohol limits



Source: States of Jersey Statistics Unit and WHO Statistical Information System

Figure 23 Binge drinking in Jersey and England (2006)



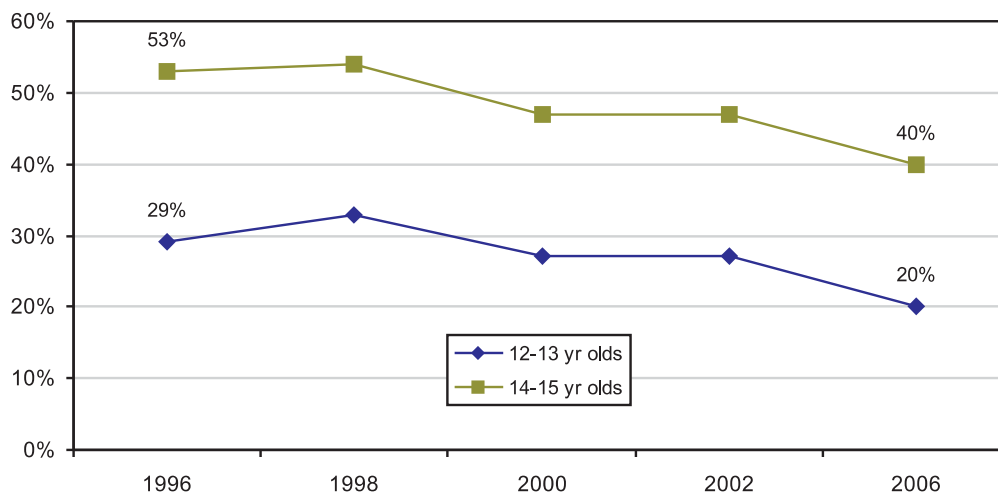
Source: Jersey Annual Social Survey 2006, States of Jersey Statistics Unit, General Household Survey 2005 and ONS

### Children’s drinking patterns

Children are particularly vulnerable when they drink alcohol. Their smaller size and inexperience makes them much more susceptible to the intoxicating effects of alcohol. Even small amounts can impair their judgement and lead them to take undue risks, which can compromise their personal safety. There are recommended safe daily limits for adult alcohol consumption, but no guidelines for children and young people. Childhood drinking is decreasing in Jersey.

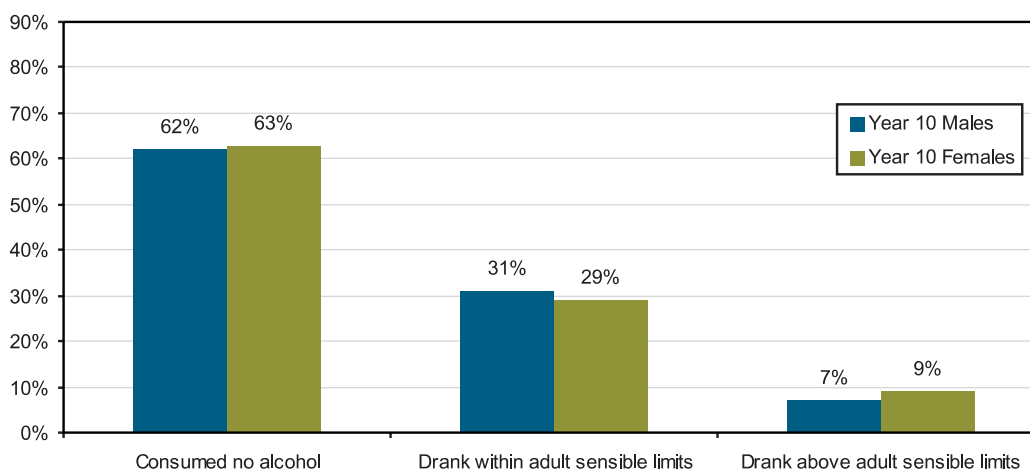
When surveyed, fewer school children reported drinking, in the week prior to the survey, than 10 years ago (figure 24). 40% of 14-15 year-olds have never, or only occasionally, drunk alcohol and are less likely to drink than their UK counterparts. Although the majority of Jersey 14-15 year-olds don't drink, around one in twelve 14-15 year-olds drink above levels which we consider safe limits for adults (figure 25); a similar proportion to the UK. Teenage girls are overindulging more than boys, a pattern that we see them taking into adulthood.

Figure 24 Young people drinking at least one alcoholic drink in the last week



Source: HRBQ 2006, PHIU

Figure 25 Alcohol consumption of 14-15 year-olds in previous week



Source: HRBQ 2006, PHIU

### Excessive alcohol wrecks lives

We understand a great deal about the harm that can be caused by regularly exceeding the recommended safe levels of alcohol consumption. Recent figures showed that last year a tenth of Jersey people ‘failed to do what was expected of them because of their drinking’. Over a fifth felt guilt or regret after drinking and a similar proportion were unable to remember what they had done the night before. About a tenth had been injured, or injured someone else, as a result of their drinking.

### Health risks from excessive alcohol

The risks of drinking above the sensible limits include:

- liver damage - fatty liver, alcoholic hepatitis and cirrhosis - which can lead to liver failure and death
- cancer - of the mouth, larynx, pharynx and oesophagus, liver, stomach, colon and rectum and possibly breast
- high blood pressure - which increases the risk of heart attacks and strokes
- disease of the heart muscle (cardiomyopathy)

- inflammation of the stomach lining (gastritis), ulcers and damage to the pancreas
- psychiatric disorders - heavy drinking is closely linked with mental health problems, including depression, and with an estimated 65% of suicides
- reproductive problems - in men, temporary erectile impotence and longer-term loss of potency, shrinking testes and penis and reduced sperm count. In women the menstrual cycle can be disrupted, it may increase the risk of miscarriage and can result in low birth-weight babies, birth defects and fetal alcohol syndrome.

### **Reducing alcohol consumption to prevent harm**

Key elements of any meaningful public health approach to reducing population consumption of alcohol are:

- reducing availability
- increasing price
- educating and promoting safe drinking.

Health and Social Services are also necessary for people with alcohol dependency to help them withdraw and recover their lives.

### **The availability of alcohol**

Licensing is one of the central mechanisms used to regulate the availability and sale of alcohol in Jersey. Locally, licensing comprises three elements:

- age of purchaser and consumption
- hours of sale
- conditions of trading.

A review of the Jersey Licensing Law (1974) is scheduled for 2008. This will provide an opportunity to review existing licence categories. It will also define mandatory actions for licensees, to assist in the regulation and control of alcohol.

Other areas already addressed through the Jersey Alcohol Strategy include establishment of a 'proof of age' scheme and a 'pub watch' scheme. Self regulation by industry representatives has also been established with structured and validated training schemes for both door and bar staff.

### **The cost of a pint**

The price of alcohol influences the level of population consumption. A 10% rise in the price of alcoholic beverages has been estimated to reduce mortality from alcohol-related conditions by up to 37%. Increasing price is particularly effective in reducing underage drinking.

In Jersey, changes in alcohol duty have been made annually since 1996. The forthcoming Goods and Services Tax will apply to alcohol, increasing its purchase price further. Currently, prices of alcohol vary, with pubs tending to be more expensive than off-licences and supermarkets, but cheaper than most restaurants.

### **Advertising versus education**

The promotion and advertising of alcohol influences what and how we drink. Addressing the way alcohol is promoted is a key part of any public health approach.

In Jersey, the Bailiff responded directly to irresponsible promotion of alcohol by imposing an Island-wide ban on 'happy hours'. Alcohol continues to be regularly used as a 'loss-leader' in supermarkets. This is likely to increase consumption.

Generous personal allowances for alcohol purchase to travellers also encourages bulk buying. Many of the brands sold to travellers are considerably stronger than similar brands available to the consumer at home. From a public health perspective, plans to extend duty-free shops at the harbour and the airports would be a step in the wrong direction.

Commercial promotional activity can be powerful in influencing vulnerable groups, including children. Making sure that young people are educated about the effects of alcohol is a priority. In Australia, new targeted approaches to alcohol education in schools have been successful.

Pilot sites in the UK are currently using similar approaches to improve the knowledge and skills of young people with regard to alcohol.

Table 2 **Advertising versus education**

| Key features                             |   |
|--|---|
| Alcohol education taught in three phases | <ul style="list-style-type: none"> <li>✓ Uses local data to define each educational phase</li> <li>✓ First phase to be taught immediately prior to use of alcohol</li> <li>✓ Second phase linked to common situations involving alcohol</li> <li>✓ Third phase is linked to drink-driving</li> <li>✓ Alcohol taught alongside other health issues</li> <li>✓ Booster sessions to re-enforce knowledge gaps</li> </ul> |
| Content and teaching                     | <ul style="list-style-type: none"> <li>✓ Based on young people's experience</li> <li>✓ Provides accurate normative information</li> <li>✓ Harm-minimisation approach</li> <li>✓ Skills and activity based</li> <li>✓ Taught within the English, social studies, health and PE curricula</li> </ul>  |
| Teacher training                         | <ul style="list-style-type: none"> <li>✓ Teachers receive intensive training in drug education</li> </ul>   |

Source: The National Drug Research Institute

### Community solutions

Jersey is unique. The geography and population characteristics influence alcohol consumption. The majority of the Jersey population live and work in St Helier. The same parish hosts many licensed premises: 77 of the 121 public houses are located in St Helier (64%) as well as 10 of the Island's night clubs.

St Helier residents experience the social side effects of the current levels of alcohol consumption. These include anti-social behaviour on a Friday, Saturday and Sunday night, and an increase in disturbance because of noise. St Helier residents can make an important contribution: the Safer St Helier project is working with residents to identify what needs to be done and help make it happen.

### Health services for alcoholics

The Alcohol and Drug Department, led by Mike Gafoor, Director, Alcohol and Drug Service, is a community-based service which has been in existence since 1988. Clinicians receive over 700 referrals a year, of which 230 are alcohol related. The services provided for people dependent on alcohol include alcohol detoxification, individual counselling and group therapy, as well as information and advice. The overall aim of the service is to reduce the harm caused by dependency.

### Recommendations

*I recommend:*

- that the forthcoming licensing law includes measures to reduce alcohol consumption
- the new 'Healthy Schools' programme includes an alcohol education component.

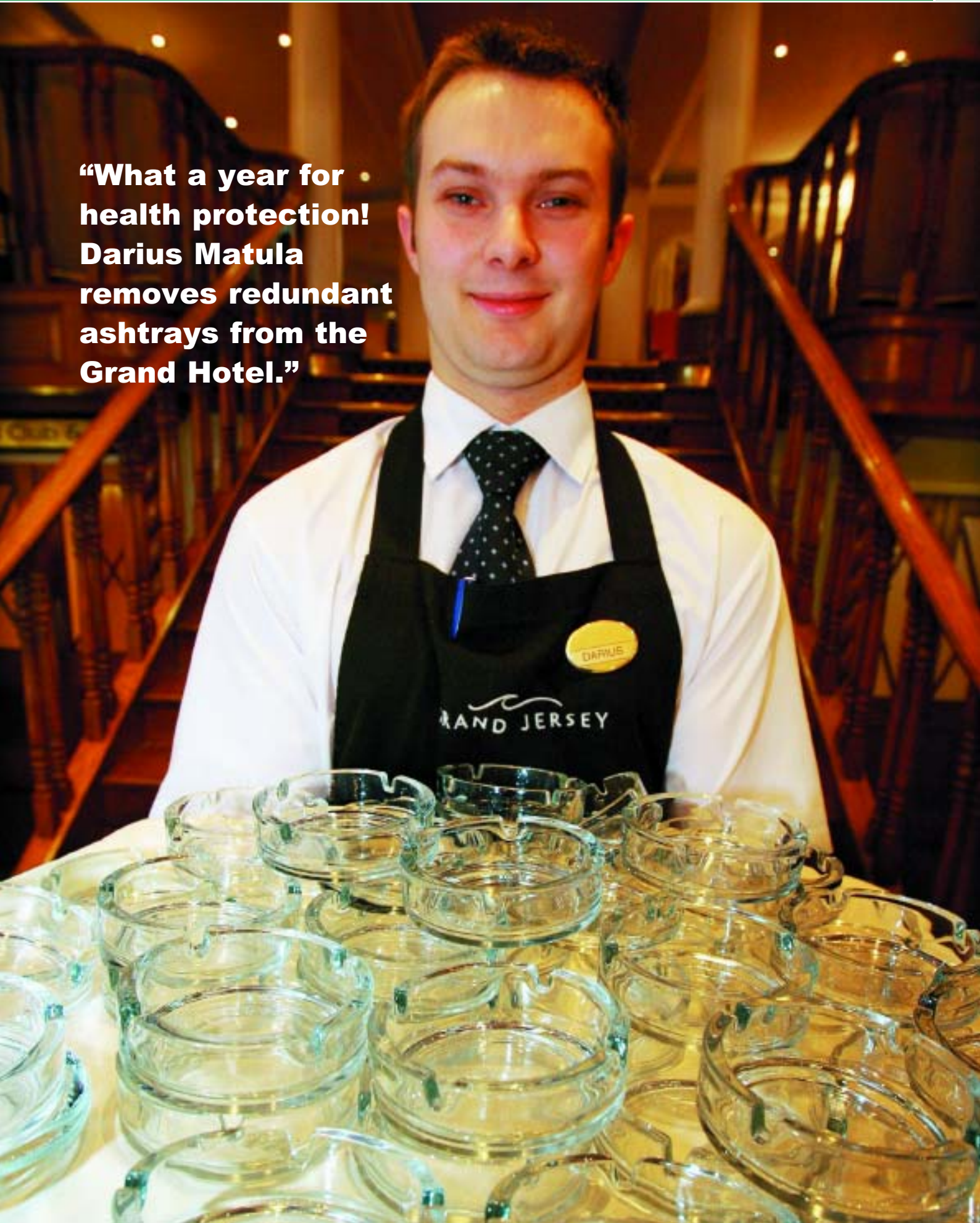
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## Chapter 3 Health Protection

**“What a year for health protection! Darius Matula removes redundant ashtrays from the Grand Hotel.”**





## Safe as houses?

Our home is central to life, it provides for our fundamental need for shelter, but is also many other things besides. Our home gives us comfort, security, privacy, independence and personal identity. Poor housing on the other hand can cause ill health and accidents.

Recognition of the impact of poor housing on health is not new. The first reports can be traced back to the 1840s. Edwin Chadwick, the pioneer of environmental health, produced his Report on The Sanitary Condition of the Labouring Population of Great Britain in 1842. Chadwick established a link between the appalling living conditions of the poor and disease.

### Health problems from poor housing

It is difficult to establish conclusively the link between poor housing and health, given that people who live in poor housing often suffer from

many deprivations that can lead to ill health in their own right. Research findings, however, are generally consistent, linking poor housing and ill health (*table 3*). Health problems can be physical or mental in nature. An increasing length of exposure to poor housing is associated with increasing ill health and housing conditions in childhood have a long-term health effect.

### Housing in Jersey

In 1999 the Public Health Department undertook a Jersey Health Survey covering many aspects of Island life and health. We included questions about housing and its perceived impact on Islanders' health. In 2006 we used the same questions about housing again as part of the Jersey Annual Social Survey (JASS). We were subsequently able to compare the results between the two surveys and look for changes in housing concerns.

Table 3 **The health problems associated with poor housing**

| Housing problem                     | Health impact   |
|-------------------------------------|---|
| cold                                | chest infections  |
|                                     | hypothermia   |
|                                     | heart attacks   |
|                                     | stroke  |
| damp and cold                       | asthma  |
|                                     | eczema  |
|                                     | rhinitis  |
|                                     | depression  |
| indoor air pollutants & infestation | asthma  |
|                                     | lung cancer   |
| overcrowding                        | increased infections                                      |
|                                     | emotional problems  |
|                                     | social impairment   |
|                                     | child development delay and poorer educational attainment |
|                                     | mental ill health   |
| flats                               | increased GP consultations                                |
|                                     | social isolation  |
|                                     | psychiatric disturbance                                   |

Source: see references

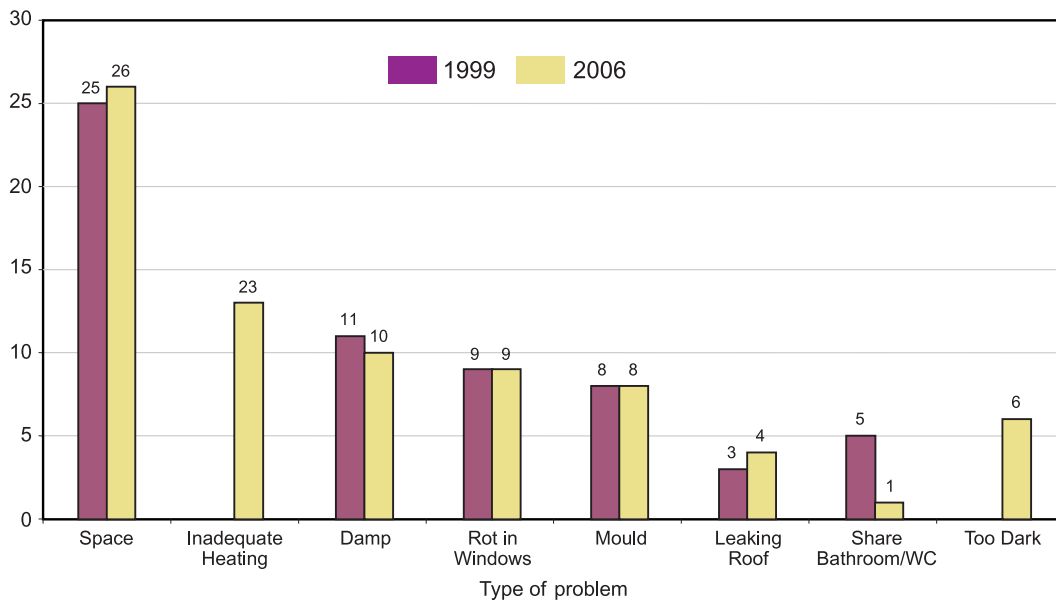
In 1999 45% had at least one problem with the quality of their accommodation, rising to 50% in 2006. Lack of space was the biggest concern (figure 26), with lack of light and heating growing in importance. Fewer people were, however, sharing bathrooms. In 1999 4% considered that their housing conditions had made their health worse, increasing to 7% in 2006.

Young adults (18-29) were the most likely to feel that their housing situation caused or exacerbated health problems (figure 27). This probably reflects a group who are either living in tied accommodation, such as in hospitality or

agriculture settings, or are transient and therefore living in lodging accommodation. The housing licence system in Jersey could be contributing to poor living conditions for this vulnerable group.

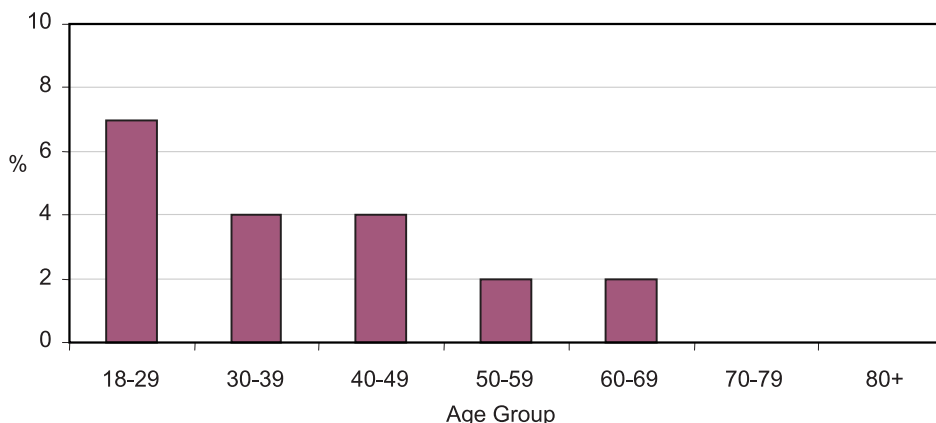
The 2006 survey also highlighted the link between housing and mental health issues. Mental health complaints almost doubled when comparing those who reported living in satisfactory accommodation with those who lived in unsatisfactory accommodation. (16% were suffering moderate anxiety/depression with 2% extremely anxious: 29% being moderately anxious /depressed and 4% extremely anxious respectively).

**Figure 26 Housing problems compared 1999 and 2006**



Source: Jersey Health Survey 1999, PHIU and Jersey Annual Social Survey 2006, States of Jersey Statistics Unit

**Figure 27 Poor health reported linked to housing conditions**



Source: Jersey Annual Social Survey 2006, States of Jersey Statistics Unit

## A focus on key housing issues

### Overcrowding

Census data from 1996 sheds more light on Islanders' number one housing complaint - shortage of space. At that time there were 29,956 occupied dwellings on the Island but the actual number of private households amounted to 33,702. 3,746 households were sharing accommodation, possibly compromising their security, privacy and independence. In comparison with UK census data, however, Jersey has less overcrowding (5.28%) than the UK (9.02%).

Lack of space and overcrowded conditions have been linked to a number of health problems, including psychological distress and mental disorders, especially those associated with a lack of privacy. Overcrowding has also been linked with increased hygiene risks, an increased risk of accidents and spread of contagious diseases. Overcrowding is often linked with a low income. In these circumstances children's health suffers, particularly as they tend to have poorer educational attainment and development.



Source: Health Protection, Housing Photographic Album

### Cold houses and fuel poverty

People living in cold homes are twice as likely to have chest problems compared to the rest of the general population. Cold is also associated with an increased risk of death from cardiovascular problems and an increased risk of injury. Cold, damp housing may also delay recovery following

discharge from hospital. Those who need to heat their home for the longest periods are often least able to do so because of low income, thermally inefficient housing and fuel poverty.

Fuel poverty is most commonly defined as a need for a household to spend over 10% of its income to achieve temperatures needed for health and comfort. An estimated 22% of all households in England (4.3 million) suffer from fuel poverty. Fuel poverty tends to go together with:

- low household income
- poor quality housing
- inefficient and expensive heating systems
- increased demand for warmth because of age, ill health or disability.

Health effects are disproportionately severe because fuel poverty is most common among those at particular risk from cold housing. If a large proportion of income has to be spent on fuel, less is available for other things necessary for health and development, such as healthy food and recreation. The elderly living alone are at the greatest risk.



Source: Health Protection, Housing Photographic Album

### Indoor air quality

As people spend about 80% of their time indoors, the quality of air inside the home is important. Environmental tobacco smoke (passive smoking) in the home is a major health hazard. Exposed non-smokers have a 24% higher chance of contracting lung cancer than non-smokers who

are not so exposed. It is also a risk factor for heart attack. Parental smoking is associated with childhood asthma, meningitis and glue ear. Damp, dusty and humid indoor air makes asthma worse particularly for children. Radon gas is considered later in this chapter.

Indoor air must be replaced regularly with incoming air to reduce humidity and airborne pollutants. Adequate ventilation prevents pollutants building up and affecting health. Over the years building design has changed; natural ventilation in older homes is reduced with sash windows being replaced by double glazed units; open fireplaces, a good source of ventilation, are closed or removed; and air bricks are removed or sealed to prevent draughts and heat loss. New building regulations are addressing this issue for newly built homes.

### **Radiation in the home**

People are exposed to radiation through two main routes: externally from the environment and internally through inhalation and food and drink. Radiation is further sub-divided into ionising and non-ionising. We are all exposed to radiation in one form or another throughout our lives from medical x-rays, radon gas, air travel, TV broadcasts and mobile phones.

### **Non-ionising radiation (external)**

Non-ionising radiation has been topical recently with fears about possible health effects from mobile phone masts. The Public Health Department has made a thorough assessment, through national and international experts, to investigate this fear. We have concluded that masts are unlikely to affect health.

Exposure in the home is increasing with the introduction of new technology which relies on radio-frequency transmission such as wireless systems for home computers. Overall levels, however, remain at a fraction of the European standards that are set to ensure there are no adverse impacts on health. We will continue to keep abreast of research into this issue.

### **Ionising radiation (internal/airborne)**

Radon is a gas which comes from the ground and particularly from granite rock. Radon can become concentrated in houses without sufficient ventilation. Exposure to concentrated radon gas for long periods of time can cause lung cancer, a risk which is doubled for smokers.

Jersey is an area of high radon levels because of the granite sub-strata of the Island. Two surveys of properties have taken place on the Island in conjunction with the then National Radiological Protection Board of the UK (now the Radiation Division of the Health Protection Agency) and advice was provided to owners of properties found to have high levels. As a consequence of this work the Building Control Regulations require all new properties to have ventilation measures to prevent the build-up of radon gas.

### **Ionising radiation (internal/food)**

The UK Terrestrial Radioactivity Monitoring Programme (TRAMP) monitors the release of low-level radioactivity from major nuclear sites. The programme checks agricultural produce (milk, crops and meat). Jersey participates in this programme because of its close proximity to the French nuclear installations at Cap de la Hague and Flamanville. The levels for Jersey have always been low.

### **Poor housing design leads to accidents**

More than 4,000 people die every year in the UK following injury in the home, more than the number of people that die as a result of road traffic accidents. Nearly three million people attend accident and emergency departments as a result of domestic injury, and as many again are treated by general practitioners. Young children and older people are particularly likely to be injured while at home. Low-income households are also more at risk. For the over 60s, the most common accident at home is likely to be a fall associated with stairs, steps or baths/showers.

There are a number of effective ways to reduce accidents at home. Advice from professionals,

coupled with access to low-cost home safety equipment, leads to improvements e.g. window guards for those living in high-rise buildings and smoke detectors to give early warning of a fire. Changes in building regulations are making newly built homes much safer. In the UK, home inspection and regulation for landlords led to a 50% decrease in falls and a 35% decrease in child deaths in two years. This is an approach we would like to adopt in Jersey.

### Noise

Noise is the commonest source of complaints to Environment Health Officers (131 in 2006). Noise can cause impaired concentration, irritability and sleep deprivation. Chronic exposure can cause emotional problems including depression and increased feelings of helplessness. The World Health Organisation (WHO) studied noise impact on health in the LARES project in 2004 (large analysis and review of European housing and health status). WHO reported a significant link between noise annoyance and stress-related disease. Furthermore, the report showed that a person who lives in a noisy home is twice as likely to have an accident as somebody who lives in a quiet home.

### Improving housing through legislation

Tackling problems of poor housing has been a priority for Environmental Health Practitioners for over a century. UK housing started to improve after 1875 with the UK Public Health Act legislative framework. Jersey doesn't have specific legislation to deal with poor housing, currently relying on the minor provisions of the Statutory Nuisances (Jersey) Law 1999 'to effect improvement where there is a nuisance or conditions prejudicial to health.'

The Jersey Health Protection Service is formulating new legislation. Historically, UK and Jersey environmental health officers have used a 10-point fitness standard for the assessment of poor housing conditions, based on the structural condition of the property. The new legislation would see a departure from this approach to one of a health and safety system where the onus is

on the impact of the property on the health and wellbeing of the individual, the household type and the immediate environment. A property could impact differently on an individual depending on their age and health status. The legislation would also, for the first time, introduce the ability to deal with matters that may not strictly be structural in nature or related to missing amenities, for example asbestos material, radiation, noise or volatile organic compounds.

### Conclusions

While housing problems today are less damaging than in the last century, the link between poor housing and ill health is still important. For many, Jersey is a prosperous island and housing is considered in much the same vein. For some Islanders, however, home is not a source of comfort and good health. During the last five years, there has been an increase in the level of discontent of householders with their standard of accommodation. Lack of space continues to be the leading concern. The increase in new housing stock, therefore, appears to fall short of expectations.

Improving housing conditions should improve health and should in turn reduce the burden on the healthcare system; for example there would be fewer falls, fewer chest problems and improvements with regard to space and noise should improve mental health.

### Recommendations

*I recommend:*

- introducing a new housing law to address shortfalls in Island housing
- carrying out a survey of a sample of houses to assess condition, air quality and accident risk
- to consult with key stakeholders responsible for development, and regulation of development, to ensure the provision of appropriate space standards in new houses being built/planned.

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## Life after the smoking ban

The 'Restriction on Smoking (Workplaces) (Jersey) Regulations 2006' became Law at 4.00am on the 2nd January 2007 and, since then, virtually all enclosed spaces and workplaces in Jersey have become smoke free. Everyone at work, shopping or eating or drinking in a restaurant or pub will find Jersey smoke free.

***"The States' decision to ban smoking in all public places and workplaces marks a landmark in social policy. In my opinion the smoking ban law is the most significant legal advance to benefit public health this century and certainly in my living memory."***

**Dr Rosemary J Geller, Medical Officer of Health, 2nd January 2007**

This new law will save lives and prevent chronic illness and disability which is associated with smoking. We are measuring this effect and in time we hope to report that: smoking prevalence has dropped, fewer children are smoking and there are fewer heart attacks.

### Introducing the smoking ban

During the first two weeks of the ban, Bob Wareing-Jones, supported by environmental health colleagues, visited over 200 premises to assist businesses, from the smallest cafés to multinational companies. They gave help and advice to proprietors to introduce the ban swiftly and smoothly including advice on signs, the design of smoking shelters, locating outdoor heaters and ashtrays, installing awnings and additional al fresco seating.

### Fears proved unfounded

Fears that smokers, proprietors and employers might not comply with the law have been unfounded. Compliance, and the attitude to compliance, as far as we have been able to monitor, has been excellent. Happily, there has been no need for enforcement action due to the

positive response by business and the general public, making the regulations largely self policed.

Representatives of the hospitality trade feared a fall off in business and takings following the ban. This has not materialised so far. Publicans, who feared loss of business most, have commented that the majority have seen little change to business since the enforcement began.



Source: Jersey Evening Post (JEP)

Noel Flood and Sean Murphy at The Blue Note

Sean Murphy from the Lamplighter said *"We're very busy on the rugby and that's when we've noticed how clear it is and it's fantastic we don't have to open doors to let the smoke out and the food sales have gone up."*

Sean had thought the pub was going to be hard-hit but said trade had improved. *"We are getting more young office-type ladies coming in and it has improved the pub."*

### Teething problems

For some premises, covered passageways between buildings and entrance porches have become smoking areas. Enclosed areas such as these are covered by the law. Responsible companies have responded immediately to the

need to comply with the new regulations and have quickly adopted measures to protect themselves and their staff.

Most places required to display a non-smoking sign now do so. At first some businesses didn't have signs. For convenience the Public Health Department provided self-adhesive signs free of charge which fitted neatly to doors or windows at the entrance of premises. To our knowledge there has been only one case of refusal to display a sign. This matter has now been resolved and the sign displayed.

It is disappointing that discarded cigarette butts on our streets are clearly evident. Flower planters have become large ashtrays spoiling the ambience of our town. Smokers who no longer have access to ashtrays in pubs, clubs and eating establishments need replacements.

The Connétable of St Helier, Simon Crowcroft has provided pouches for cigarette butts in return for a donation to charity. We are encouraging landlords to provide unobtrusive outdoor smoking litter bins for their customers.



St Helier planter with cigarette butts

### Have your say

We have received positive feedback from Jersey residents and visitors alike about smoke-free

buildings and smoke-free clothes at the end of an evening out. Of the 400 or so premises we have visited since the ban came into force, the predominant views from employees have been how much more pleasant their work environment has become. The lingering smell of smoke on their clothes and in their hair has disappeared. Many report feeling better at the end of a working day.

Not everyone has been happy, of course with some negative feedback from Islanders mixed in with the overall positive response. People have commented via BBC Radio Jersey's writing and blogs pages (*figure 28*).

### A smoke-free world

Jersey has joined an ever increasing list of countries that have smoking-ban legislation in force (*figure 29*).

New York City implemented their 'Smokefree Air Act' in March 2003. Twelve months later they found that:

- tests showed that air quality in bars and restaurants had improved dramatically
- business tax receipts in restaurants and bars had gone up by 8.7%
- employment in restaurants and bars had increased by 10,600 jobs.

In an Irish survey, one year on, 98% of the Irish said that the law banning smoking in public places had been a success.

### Jersey advice sought

Officers from English Local Authorities have contacted the Jersey Public Health Department for advice, as they geared up for the English smoking ban which came into force in July 2007.

York, Market Harborough and Bromley, amongst others, have sought our experiences and taken the opportunity to air their misgivings as they prepare. We expect to continue this liaison along with our ongoing relationships with Scotland, England and Guernsey.

Figure 28 Islanders have their say



Figure 29 Smoking bans in place across the world





### 'Help 2 Quit' - the new service to help smokers quit

The new 'Help 2 Quit' stop-smoking service started on 29th January 2007. The service is available free to any Islander who wants to give up smoking.

Miriam Prior and her team offer an intensive, tailor-made smoking cessation programme for each individual, using advice, motivational techniques and prescribed drugs.

The 'Help 2 Quit' team have been inundated with clients wanting to give up smoking, 468 callers during the first two months.

More and more people are realising their dream of becoming a non-smoker. By the end of April, 78 Islanders (74% of 'Help 2 Quit' clients) had quit.

### 'Help 2 Quit' clients

Mr Maurice Brochand is a 69-year-old resident of Grouville who had smoked 20 cigarettes per day over 15 years. He reduced this amount to five per day after the smoking ban on 2nd January 2007 and until he joined the 'Help 2 Quit' eight-week programme on the 22nd January. Since that time he has not smoked and has seen 'Help 2 Quit' staff on a weekly basis.

At the end of April Mr Brochand was able to report he finds food and drinks smell and taste better and his family are pleased he has stopped smoking. Mr Brochand said: *"I am pleased with myself for not smoking for this length of time."*



Source: Public Health

Mr Maurice Brochand with 'Help 2 Quit' adviser Sharon Dundon



Source: Public Health

'Help 2 Quit' team - Sharon Dundon, adviser, Rhona Reardon, adviser, Chris Edes, adviser, Lin Tarrant, Administrator and Mirium Prior, co-ordinator



Source: Public Health

Mr Jose and Mrs Sonia Nunes

Mr Jose and Mrs Sonia Nunes started smoking when they were children. They are now non-smokers.

*"Since stopping smoking my health has improved, I have more energy and don't get out of breath anymore when I am walking"* says Mrs Nunes.

*"We also stopped for the sake of our children's health and now no one smokes in our home"* added Mr Nunes.

Mr and Mrs Nunes saw 'Help 2 Quit' adviser Sharon Dundon on a weekly basis and used nicotine patches.

## Immunisation – our children, our future

Immunisation is a simple, safe and effective way to protect Island children against harmful diseases that can kill or cause serious illness. Immunisation is thought to be the most cost-effective of all health prevention strategies world-wide, resulting in many lives saved and benefits accrued to society as a whole.

More than two centuries ago Edward Jenner proved to the world that there was a simple way to prevent infectious diseases. He developed a vaccine to prevent smallpox. It took 175 years (1805-1980) to rid the world of that disease.

Over the last 40 years the childhood immunisation programme has been considerably extended to protect children against a wide range of diseases. The incidence of, and number of deaths from, vaccine-preventable diseases such as measles, whooping cough, meningitis, polio and tetanus have been greatly reduced where these vaccines have been introduced.

Immunisation not only protects children, it also gives protection to the community as a whole. The success of immunisation programmes is dependent upon maximising the uptake and coverage across the appropriate age groups. To ensure community protection (herd immunity), a coverage of 95% is required. This is the target we should be aiming for in Jersey. 'Herd immunity' is particularly important to protect the small minority of children who cannot be vaccinated for medical reasons.

### Childhood immunisation in Jersey

There are approximately 1000 children born each year in Jersey. All these children are offered vaccination throughout childhood as per the UK routine immunisation schedule (*table 4*).

Children are vaccinated either by the Public Health Department at community health clinics in parish locations across the Island (68%) or at GPs' surgeries (32%). The Child Health Team of Family Nursing and Home Care assist at the community health clinics and also assess other aspects of children's wellbeing and development. Health visitors have vaccinated at the Communicare health centre at St Brelade.



Claire Stacey vaccinates Charlotte Boyle

Source: Public Health

**“The two public health interventions that have had the greatest impact on the world’s health are clean water and vaccines.”**

**World Health Organisation**

Table 4 Children’s routine immunisation schedule

| Age of child                | Diseases protected against:  | Number of injections |
|-----------------------------|--|----------------------|
| 2 months                    | <ul style="list-style-type: none"> <li>• Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenza (Five in one injection)</li> <li>• Pneumococcal infection</li> </ul>                         | 1<br>1               |
| 3 months                    | <ul style="list-style-type: none"> <li>• Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenza (Five in one injection)</li> <li>• Meningitis C</li> </ul>                                   | 1<br>1               |
| 4 months                    | <ul style="list-style-type: none"> <li>• Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenza (Five in one injection)</li> <li>• Meningitis C</li> <li>• Pneumococcal infection</li> </ul> | 1<br>1<br>1          |
| 12 months                   | • Combined Haemophilus Influenza and Meningitis C  | 1                    |
| Around 13 months            | <ul style="list-style-type: none"> <li>• Measles, Mumps and Rubella</li> <li>• Pneumococcal infection</li> </ul>   | 1<br>1               |
| 3 years 4 months to 5 years | <ul style="list-style-type: none"> <li>• Diphtheria, Tetanus, Pertussis, Polio</li> <li>• Measles, Mumps and Rubella</li> </ul>  | 1<br>1               |
| 15 years                    | • Tetanus, Diphtheria and Polio  | 1                    |

Source: Public Health

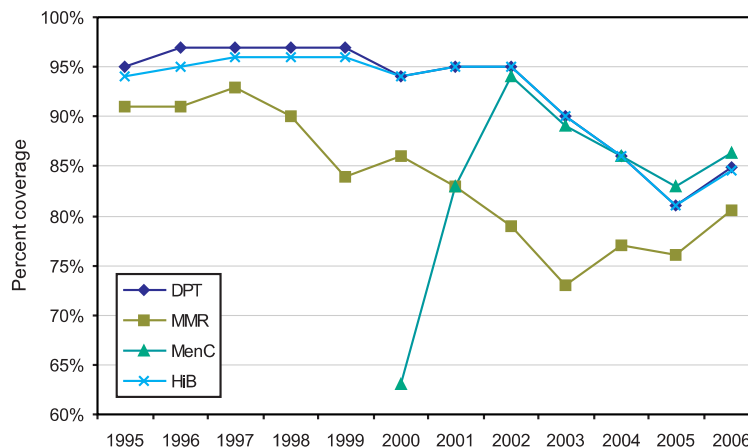
### A need for improvement

Despite incontrovertible evidence that vaccination is an efficient and cost-effective means of reducing morbidity and mortality, coverage is suboptimal for Jersey pre-school children. Worse still, Jersey’s coverage appears to have been decreasing, particularly over the last three years (*figure 30*). Jersey’s coverage is poorer than in the UK which means a greater number of Jersey children are left unprotected against potential death and disease (*figure 31*). There are several reasons why our coverage figures may not be as high as we would wish. One may be that parents

are not convinced by the evidence given by healthcare professionals and scientists for the need for vaccination. Another may be the lack of integration between the two immunisation services in Jersey and an incomplete database. Finally, in primary care vaccination may incur a fee, which may reduce uptake.

The scientific and health communities have a responsibility to ensure that our information is accessible, consistent and understandable so that people can make an informed choice regarding vaccinations, as with other medical interventions.

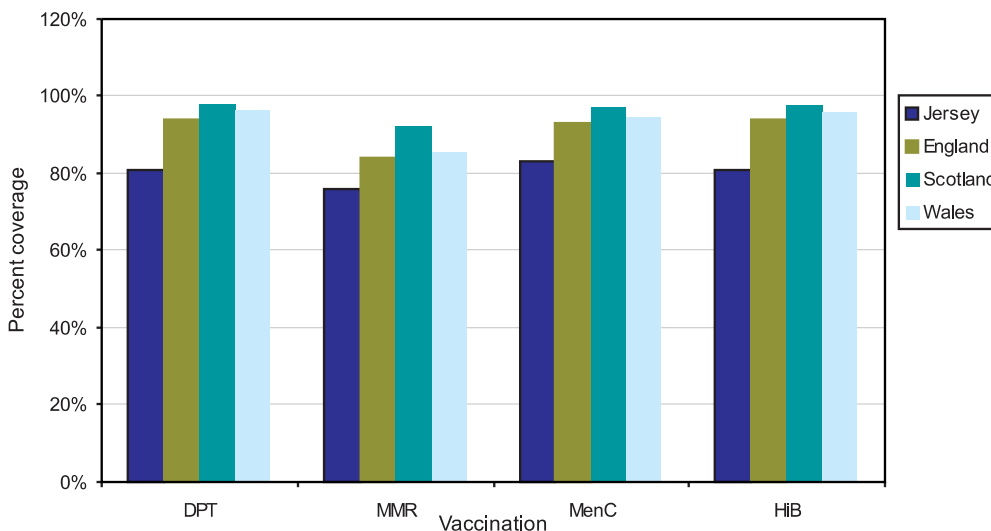
Figure 30 Vaccination coverage: Jersey 1995 - 2006



Source: Child Health System, PHIU



Figure 31 Comparison of vaccination coverage: Jersey and UK 2005



Source: Child Health System, PHIU, HPA, www.nphs.wales.nhs.uk, www.hpa.org.uk and www.isdscotland.org

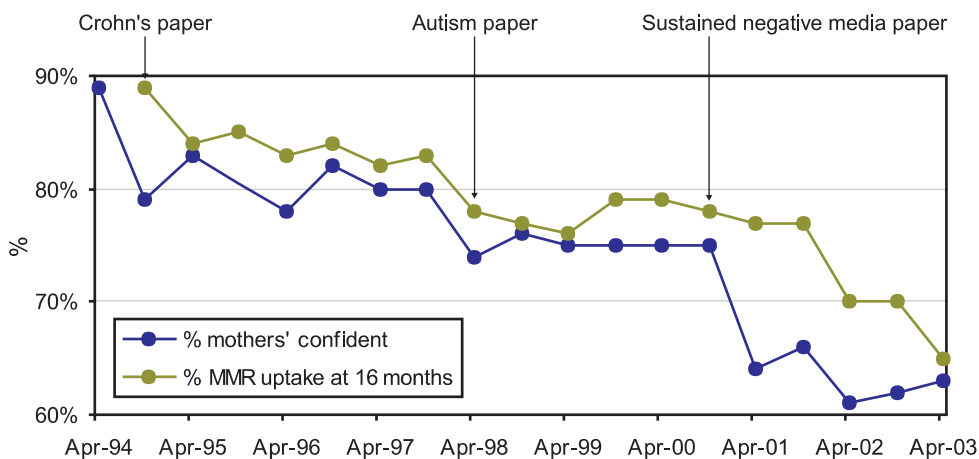
### Measles outbreaks in the UK

Despite the availability of safe effective vaccines, measles is not fully under control. The coverage in some areas of the UK has been so low that it has led to outbreaks, the largest of which have been in Surrey, Sussex and South Yorkshire. The damaging media coverage, which made a false link between MMR vaccine and autism and bowel disease, reduced the uptake of MMR and

eroded parents' confidence (figure 32).

MMR coverage in Jersey hit a low of 73% which is well below the target of 95% to ensure the 'herd immunity' required to prevent epidemics and protect individuals who cannot be immunised for medical reasons. A decline in vaccination uptake leads to increasingly large outbreaks of measles and, finally, the reappearance of measles as an endemic disease.

Figure 32 Adverse publicity and MMR uptake in the UK



Source: Child Health System, PHIU

### Childhood infections: surveillance in Jersey

We run a system of notification for all vaccine-preventable childhood infections in Jersey. GPs, on diagnosing a disease such as measles, would report the case to the Public Health Department. In 2006 we were notified of two cases of suspected measles. We think it is likely that more childhood infections are occurring which are not being notified.

### A successful service in Jersey for the future

Dr Mark Jones, Consultant Community Paediatrician, will provide the clinical and strategic leadership for the immunisation service and will be supported by an immunisation nurse specialist. We plan to transfer all immunisation services into General Practice in the future, once essential primary care infrastructure is in place.

The aims of the service will be to:

- provide a high quality, cost-effective service, free at the point of delivery
- increase coverage to 95% for DTP and 90%+ for MMR and other vaccinations
- ensure all 'hard to reach' groups have good access to vaccination
- improve clinical governance arrangements, especially within primary care
- improve the reliability of coverage data through better integration of Health & Social Services Department and primary care IT systems.

### What the future could hold for childhood immunisation

There are new developments in vaccine production occurring all the time. New vaccines, with major potential for improving health, are in the research and development pipeline. They include vaccines to protect against:

- Rotavirus diarrhoea - Rotatec has recently been introduced in the USA
- Human Papillomavirus (HPV), a leading cause of cervical cancer - Gardasil is being considered for introduction in the UK

- Group A and W135 meningococcal disease - vaccine trials are underway
- Hepatitis A and B - vaccines have been available for these diseases for many years
- Chickenpox - MMRV is a combined attenuated measles, mumps, rubella and varicella vaccine for use in children aged 12 months to 12 years.

None of these vaccines has as yet been added to the UK childhood immunisation schedule but some are included in immunisation schedules in other countries. In Jersey, we will assess each development and consider whether to change our current immunisation programme based on the best research evidence.

### Conclusions

A successful strategy must deliver an immunisation service of high quality which is readily accessible, efficient and delivered free at the point of delivery. We have already made progress, but in order to have optimal impact we need to increase population coverage. This will require commitment and partnership working with all health professionals in primary and secondary care settings. Following considerable efforts by all those involved in immunisation services last year, we have reversed the downward trend in Jersey.

### Recommendations

*I recommend:*

- improving the system to report and monitor infectious diseases
- improving vaccination coverage rates and information technology systems
- transferring immunisation services into primary care, once infrastructure and governance arrangements are in place.

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## Chapter 4 Health Care

**“Excellent primary care services are a prerequisite for public health.”**





### Primary care – public health in action

Source: Queen's Road Medical Centre



#### 'New Directions'

Excellent primary care will be the cornerstone of the Jersey Health Strategy 'New Directions'. Without expanded and excellent primary care, many opportunities for improving Islanders' health are being missed. While GPs' services in Jersey are generally of a high standard, primary care in Jersey must keep moving forward.

Medical care from family doctors or general practitioners (GPs) forms the major part of primary care in Jersey. Other professionals such as health visitors, community pharmacists and social workers are also prominent primary care practitioners.

There are a number of areas on which primary care can build. Parts of the present infrastructure of primary care are poorly developed - such as patient safety systems, computer systems and buildings. The role of nurses within primary care teams is particularly underdeveloped. The Jersey Law, which sets out how GPs will be paid, is out of date and is getting in the way of developing modern primary care.

Primary care services will need to do more in Jersey. The proportion of older and very old people in our population is growing - paralleled by an increase in numbers of people with diabetes and other chronic conditions that become more common with increasing age. The expectations of patients as consumers continues to increase.

In optimising health in the Island, we shall be looking to GPs to lead on three initiatives:

- improving patient safety through clinical governance
- systematic prevention and care for people with chronic disease
- preventing illness and keeping people well.

#### Safe primary care

Above all primary care must be safe and effective for every patient, every time and in every Jersey practice. Following a number of high profile failures in patient safety in the UK, including the appalling crimes of Harold Shipman, Professor Sir Liam Donaldson, the Chief Medical Officer for England, is insisting on a new patient safety regime based on 'clinical governance'. In response, the UK Government will take a new approach to safety for UK doctors, nurses and other health professionals.



Source: CMC Annual Report 2006

Professor Sir Liam Donaldson,  
Chief Medical Officer for England

To make sure that primary care in Jersey keeps pace with English safety standards, we will need to act on Sir Liam's recommendations in Jersey - now incorporated in a new UK White Paper, [Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century - February 2007]. To maintain their registration with the General Medical Council, and in turn with our Royal Court, essential to being able to continue to practice medicine, Jersey doctors will need to

keep up to date with their medical knowledge, be able to demonstrate this, and have their competency in medical practice checked on a regular basis.

### **Systematic prevention and care for people with chronic disease**

Many people are living their lives with a long-term chronic condition such as diabetes, heart disease, asthma, arthritis or a mental illness. Some of these illnesses are becoming more common. People live with their illness for many years. While they can't be cured, their symptoms can be controlled.

Although disease prevention is the first weapon in our armoury, good management of chronic diseases is essential. The goal is to help patients live with their illness, and keep as well as possible. Systematic, patient-centred and integrated primary care for chronic disease is well advanced in some parts of the world and in pockets across the UK. As a result, patients feel better, more satisfied with their care and are less likely to deteriorate and go into hospital or a nursing home.

We propose a new system where there will be advice and support to primary care teams from specialist nurses attached to the hospital. As part of a clinical pathway approach, doctors and nurses would use clinical decision protocols. These would have checklists of the laboratory tests and advice or treatments which a patient might need at any one time. The 'New Directions' Primary Care Group has produced four examples of this approach for diabetes, osteoporosis, depression and asthma. These examples show how patients can be cared for, depending on the severity of their disease, through:

- preventing illness or complications
- making a timely first diagnosis and subsequently diagnosing complications
- regular assessment of the condition
- treatment based on the best evidence.

People with a chronic condition would have a primary-care-based 'case manager' who would be able to provide intensive help when needed.

A small proportion of patients may have more than one chronic condition, or be at high risk of sudden deterioration. Such patients are regularly admitted to hospital and would prefer to stay well at home. An intensive approach for these individuals could improve their quality of life and reduce the burden on the hospital.

### **The 'expert patient'**

*"My patients understand their diseases better than I do."*

Patients as experts in their own care are a rich resource - largely untapped. Many patients can become key decision makers in their treatment and gain greater control over their lives. The development of 'expert patients' programmes is an important component of good chronic-disease management with potential to maximise good health, lengthen life and reduce the need for emergency medical treatment. This topic is covered in more depth in the next section of this report.

### **Preventing illness**

Primary care has a central role in providing services to prevent illness and keep people well. Detecting health problems early can prevent an illness starting in the first place. Patients need to know what symptoms should alert them to seek medical advice. In turn, doctors and nurses need to be able to use their skills to make prompt diagnoses - without which illness can go untreated, and complications develop.



Source: Public Health

Dr Philippa Venn with Claire Boleat and baby Frances

Primary care services would provide health advice and coaching, prescriptions when needed, screening and immunisation. Such services need to be provided consistently and comprehensively, on a large scale, to particular groups of the population. In the future, Jersey GPs and primary care teams are likely to offer comprehensive Islandwide services for:

- smoking cessation
- weight reduction
- influenza vaccination
- contraception
- screening (cervical, Chlamydia and bowel)
- childhood immunisation
- child health surveillance.

### Conclusions

Islanders deserve a world-class primary care service. Jersey GP services have many strengths such as responsiveness and good doctor-patient relationships. We want to preserve these strengths whilst building new and better services for the future.

### Recommendations

*I recommend:*

- the 1967 Health Insurance Law needs to be rewritten to promote multi-professional primary care teams to prevent illness and keep patients with chronic disease well and living independently
- safety (governance) arrangements in primary care are brought into the 21st century, taking account of English recommendations and linking to the General Medical Council
- more systematic services for chronic conditions are needed, including the necessary computer systems and information flows
- primary care services for preventing illness need to be expanded, offering patients help and advice before they become ill
- the Island develops processes to facilitate patient and public involvement within healthcare in Jersey.



## Patients as experts



Source: NHS Photographic Library

A group of expert patients

### Chronic disease

The increased prevalence of chronic diseases presents a huge challenge, not just to our local health service but worldwide. We are, as a population, living longer. As we grow older more of us will be living with a range of conditions which can be managed, but not cured. Growing problems with obesity and binge drinking will also add to the chronic disease burden in the future. Chronic diseases include:

- heart disease
- stroke
- cancer
- arthritis
- diabetes mellitus
- mental health problems
- asthma
- multiple sclerosis.

### Living with a chronic disease

Chronic diseases vary in the effects which they can have. They can cause disability, pain, embarrassment or stigma. At any one time a person with a chronic disease may have to cope with many potential stressors, such as:

- managing acute attacks or flare-ups
- accessing health services
- making the most of current treatments
- coping with fatigue
- balancing work/family demands
- developing strategies for dealing with the psychological consequences of their condition.

People living with a chronic disease can also experience a range of losses such as employment, status, income, identity and their role in the family and community. These factors add to the overall strain of coping with the condition itself.

Living with a chronic disease not only has a significant impact on a person's quality of life but also on that of their family, as everyone struggles to adapt and to cope.

People with chronic conditions often report that they do not feel involved enough in decisions about their care, and believe that not enough information is given to them and their families about their illness. People also feel that tests or treatments are not clearly explained to them, and that there is often no one to talk to about their anxieties and concerns.

### The expert patient

The concept of the expert patient puts the person at the very centre of management of their chronic disease. It recognises that such people are often in the best position to know what is needed to manage their own condition. For too long, the knowledge and experience of patients has been an untapped resource. We are beginning to recognise now how powerful this can be.

People can, and should, be key decision-makers in the treatment process. In this way, feeling empowered, they can take some responsibility for management of their own condition and work in partnership with their health and other care professionals.

The whole ethos is to allow individuals to gain greater control over their lives. In doing so, confidence can improve as can wellbeing. The end result is a person better able to cope with the daily challenges of living with their chronic disease.

### Introducing expert patients programmes (EPP)



Source: NHS Photographic Library

Expert patients programme in the UK

Expert patient programmes (EPPs) are user-led self-management programmes. They are not simply about educating patients - they aim to help develop confidence and motivation. They are run by trained 'lay' tutors, experienced in making life changes because of their own chronic condition. We do not as yet offer EPPs in Jersey.

EPPs have been running in the UK for several years. The courses are free - six sessions lasting 2½ hours, on a weekly basis. Groups of participants learn general skills relevant to most conditions. Groups usually include people with a range of different conditions.

EPPs offer a toolkit of fundamental techniques designed to focus on five core self-management skills:

- problem solving
- decision making
- resource utilisation
- developing effective partnerships with health care providers
- taking action.

Topics covered include goal setting, healthy eating, exercise, how to talk to health professionals and dealing with feelings of depression and isolation.

There is a strong emphasis on participants setting practical, achievable goals which are monitored each week.

### Do EPPs work?

Evidence gathered by the UK Expert Patient Task Force 2000 indicated that, when given the necessary skills, a person with a chronic illness can moderate the impact of their disease and improve the quality of their life in a number of important ways, including:

- reduced severity of symptoms
- significant decrease in pain
- improved life control and activity
- improved resourcefulness and life satisfaction.

Self-reported data, gathered from thousands of participants, indicates that the programme has been successful:

- almost everyone (94%) who took part in the evaluation felt satisfied with the course
- 45% of patients felt more confident that they would not let common symptoms (pain, tiredness, depression and breathlessness) interfere with their lives.
- 38% of patients felt that such symptoms were less severe four to six months after completing the course.
- 33% of patients felt better prepared for consultations with health professionals.

In addition many participants reported a reduction in their use of health services, in particular GP consultations, outpatient visits, Accident and Emergency attendances and physiotherapy.

Thus, there is the potential to reduce the burden on health services, although further research is needed to be conclusive.

### Recommendation

*I recommend:*

- introducing an EPP in Jersey, on a small scale, with full evaluation, expanding the service subsequently should it prove to be successful.

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## Disability from back pain

Back pain has always been around - but people's attitudes to it have changed in the developed world. In the past, the need to keep functioning despite suffering pain meant that people kept mobile, stayed at work and subsequently were less disabled.

### The cost of back pain

#### Human cost

Back pain leads to considerable human misery and suffering. People can become disabled and lose out on their usual social contact. Sufferers can have a shorter life expectancy, develop mental health problems, and, unfortunately, often end up with more back pain.

#### Cost to society

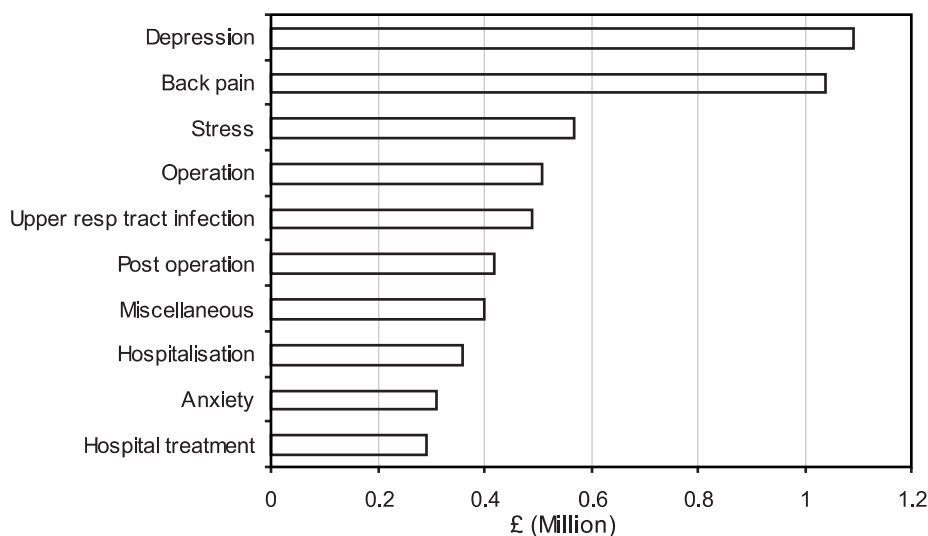
Back pain is a very costly issue for the governments across the developed world. The

statistics are impressive. In England, estimates include:

- an annual cost to the National Health Service £4.8 billion
- non-NHS costs (eg private treatment) £2.0 billion
- Social Security benefits £1.4 billion
- lost productivity £3.8 billion

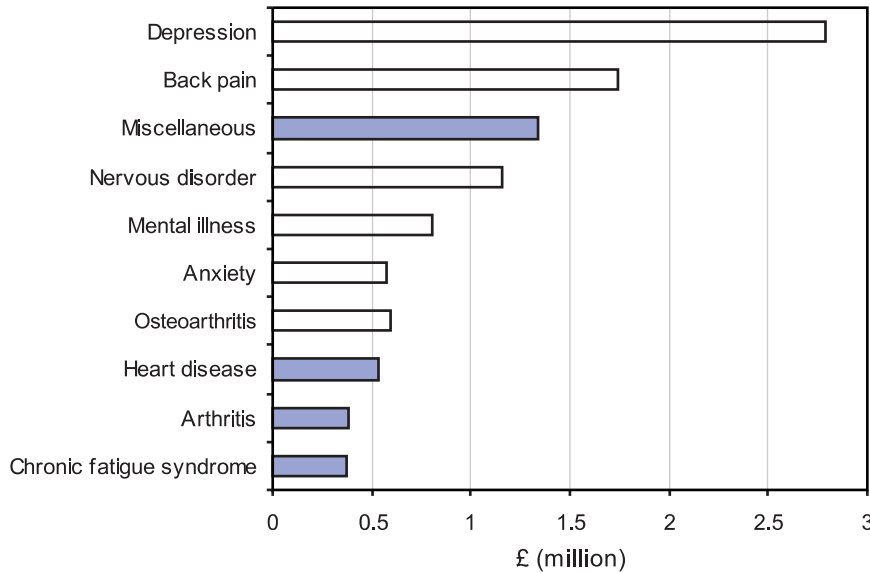
In Jersey, in 2006, back pain was the second commonest reason for claiming Short-term Incapacity Allowance (2,746 claims). It was also the second commonest reason for claiming Long-term Incapacity Allowance (190 claims). Short-term Incapacity Allowance in 2006 cost the Social Security Department £1,043,398 and for Long-term Incapacity Allowance, an additional £1,743,635 (figures 33 and 34).

Figure 33 Short-term Incapacity Allowance paid in 2006



Source: Jersey Employment and Social Security Department (E&SS)

Figure 34 Long-term Incapacity Allowance paid in 2006

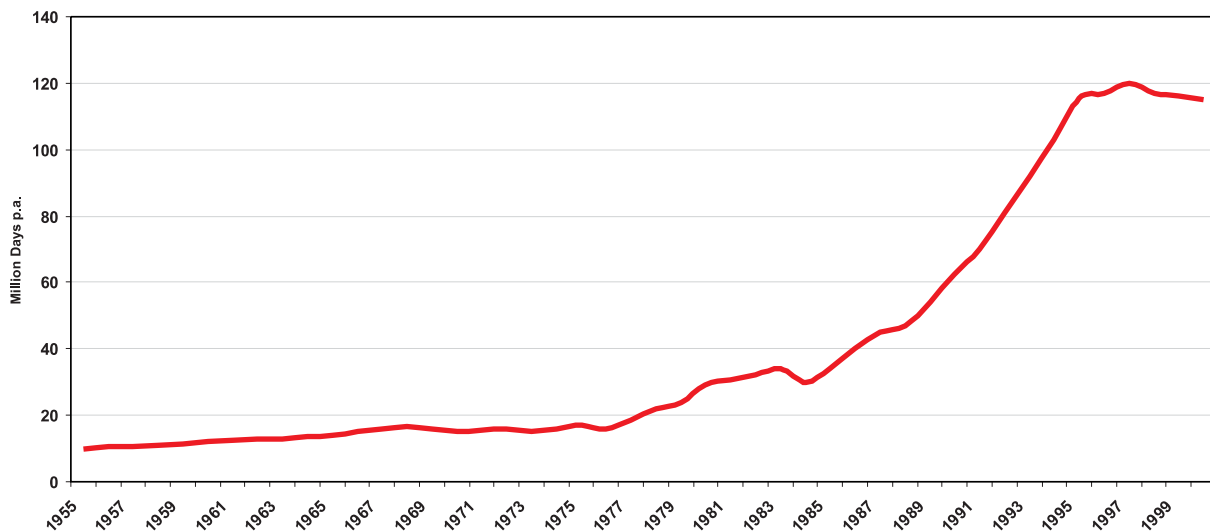


Source: Jersey Employment and Social Security Department (E&SS)

We are not able to calculate the total costs of health care, taking account of patient payments, Social Security Co-Payments, costs of medication and of care provided by the hospital. Despite this, based on what we do know, and what we can extrapolate from UK data, the costs of back pain to a society are considerable.

In developed countries claims for disability benefits as a result of back pain have been steadily increasing (figure 35). Recent trends confirm rising work loss, increased early retirement and growing levels of chronic disability, tending to suggest that the condition is poorly managed.

Figure 35 Trend in UK benefit costs paid for low back pain



Source: Disability Trends in the UK 1955-2000, based on annual statistics from the UK Department of Social Security

### **An epidemic of back pain?**

The incidence and prevalence of back pain has, perhaps surprisingly, remained the same for decades. The problem seems to be a rise in the levels of disability which people are experiencing, yet there is no medical explanation why this should be so. Instead, what we are observing is the consequence of an exponential rise in the amount of sickness certification for this condition.

The consequences of long periods out of work can be catastrophic - both for individuals, and for society. On the day a person stops work with back pain they have a 1-10% chance of still being off work a year later. Once off work for 4-6 weeks, they have a 20% risk of long-term disability (1 in 5 patients with back pain are signed off work for more than a month). Once someone has been off work because of back pain for 6 months, he or she has only a 50% chance of ever returning to their previous job. By 1-2 years, most people who are not working because of back pain become virtually unemployable.

### **What should we be doing to manage this better?**

The reality is that most patients who suffer from back pain recover rapidly and need minimal investigation and treatment. Guidelines produced in several countries by professional bodies all recommend that resources should be aimed at the more vulnerable patients.

All these guidelines recommend a specific pathway for patient treatment, which includes movement of patients on to more intensive assessment and treatment, if their symptoms are not resolving in 4-6 weeks. It also includes a psychosocial assessment of each patient in this category.

### **The Jersey Back Assessment Clinic**

We are setting up a new Back Assessment Clinic in Jersey, as a working collaboration between the Pain Medicine, Orthopaedics and Physiotherapy Departments. It will specifically target those back pain patients most at risk of developing chronic

pain and disability. The service aims to channel available resources more effectively and tailor treatment to prevent worsening disability in this vulnerable group.



Source: Public Health

Shane Perrier at the Jersey Back Assessment Clinic

A new treatment pathway will integrate primary and secondary care elements, providing support for primary care. We are also working with partners - Occupational Health colleagues and other States' departments to develop a seamless vocational rehabilitation service. This will involve Employment and Social Security and the Jersey Employment Trust in a 'Return to Work' initiative for chronic back pain sufferers. This partnership approach is consistent with the States of Jersey Strategic Plan objectives, with potential to improve efficiency and reduce unnecessary duplication between States' departments. Better interdepartmental and interagency working will provide a simpler, more streamlined service for individuals with back pain and occupational issues.

The Jersey Back Assessment Clinic will focus on patient self-management and client-centred care. The service is founded on a large body of evidence (including many similar schemes successfully implemented throughout the world) ensuring maximum benefit for patients in Jersey, and best use of resources.

We know that the present system of consultant-led back pain triage clinics will not be sustainable, given increasing rates of back pain disability. In



future, a physiotherapist will assess and may treat the patient, underpinned by medical support. This will allow us to use the resources we have available to maximum effect - for example, consultant time.

We know also that patients' beliefs about their back pain will influence the effectiveness of treatment and rehabilitation. These beliefs, along with each patient's degree of psychological distress, strongly influence their chances of recovery. The new system is designed to focus on these elements in the first critical period of back pain management.

We expect that rapid assessment and sound evidence-based management of back pain will result in:

- quicker recovery
- less pain and distress
- less time off work
- less chronic disability
- better use of resources.

UK equivalent, physiotherapy-led assessment services, supported by appropriate medical disciplines have achieved:

- significant reductions in waiting list times for orthopaedic and pain clinic consultant review
- more appropriate referrals to surgeons, when an operation needs to be considered
- lower re-referral rates - better management first time around
- lower 'patient non-attendance' rates for consultant review
- increased satisfaction - staff and patients.

### Next steps

Consultations between stakeholders (pain clinic, rheumatology, orthopaedics and GPs) have started and will continue until we are ready to provide an Islandwide service. Education, advice and support will be offered to GPs.

### Recommendation

*I recommend:*

- prevention of long-term disability from back pain through the Jersey Back Assessment Service.

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# Deaths from prescribed drugs

## Fentanyl misuse – a Jersey problem



A fentanyl patch

### Deaths caused by fentanyl

Towards the end of 2006, we learned from the Deputy Viscount that there had been a spate of deaths in Jersey. All were linked to the same unusual cause - abuse of the controlled drug, fentanyl. As this report is going to publication, five Jersey fentanyl deaths have been confirmed. A sixth is suspected. In a population of our size, this amounts to a serious public health problem. The Jersey fentanyl deaths (males, age range 25-45) were all linked to injecting a solution of fentanyl that had been extracted from fentanyl patches.

### What is fentanyl?

Fentanyl is a highly valued and effective drug for controlling severe pain. It can be used safely, for bona fide medical reasons, when it is used exactly as prescribed - and stored and disposed of safely. It generally comes in the form of a skin patch. The patch contains a high dose of fentanyl which, if used correctly, slowly releases the painkiller through the patient's skin. It is very useful for people who have trouble swallowing, or when strong painkilling medication, taken by mouth, is no longer effective.

### Why is fentanyl so dangerous?

Fentanyl is an opiate drug - similar to morphine and diamorphine (heroin). Contained within the

patch, however, the fentanyl dose is about 200 times more potent than a single dose of heroin. It is, therefore, about 200 times as risky when misused through intravenous injection. It is also particularly dangerous when combined with other illegal drugs.

### A review of fentanyl

Earlier this year, the Deputy MoH, Dr Susan Turnbull, led a review into the use and abuse of fentanyl in Jersey. She looked into the actions already taken in Jersey to reduce the risk associated with prescribed fentanyl patches and considered whether further action was needed.

She found that:

- fentanyl abuse has not been recognised as a problem in the UK, where 'street' Heroin is much more readily available. There is a black market in fentanyl patches on the Island for two main reasons:
  - customs and the police are so successful at keeping heroin and other illegal drugs off our streets
  - unlike the arrangement in many other countries, Islanders do not have to be registered with one GP. This means that people intent on obtaining fentanyl for their own misuse, or to sell, can shop around until they find a GP who agrees to prescribe, known as 'doctor shopping'; a fentanyl patch can fetch up to £80 on the street
- there were some disturbing reports of patients in genuine medical need of fentanyl who had had their patches stolen, or were harassed by people trying to buy them
- twice as much fentanyl was prescribed in Jersey in 2005 compared with 2002

- a number of steps had already been taken to address this problem:
  - Social Security's Prescribing Adviser and the Alcohol and Drug Service Director had written to all GPs alerting them to the dangers of fentanyl
  - we had already limited the type of fentanyl patch that could be prescribed in Jersey to a 'matrix' formulation, considered less easy to abuse
  - the Misuse of Drugs Advisory Council had recommended a change in the law to require notification of fentanyl addiction to the Medical Officer of Health, and to prevent prescription of fentanyl to people with a history of drug addiction - unless there is demonstrable physical disease, (this change came into force in March 2007).

### Public Health Alert

On 28th February, Dr Turnbull issued a Public Health Alert to all prescribing doctors in Jersey to:

- raise awareness of the cluster of recent deaths
- inform all doctors of the serious dangers associated with fentanyl
- urge all Jersey doctors to play their part in keeping the amount of fentanyl circulating in the Island to a minimum, prescribing only to people in bona fide need, and alerting us to people who may be 'shopping around' trying to obtain prescriptions by deception.

### Changes in the law

On 9th March 2007, a change to the Jersey Misuse of Drugs Law came into force. This placed fentanyl in the same legal group as other dangerous drugs, including cocaine and heroin, which a doctor:

*"shall not administer or supply to a person whom the doctor considers, or has reasonable grounds to suspect, is addicted to any drug, unless the person needs to be treated for 'organic disease or injury'."*

The law now requires doctors to notify the MOH about anyone with a history of drug misuse whom they are treating with fentanyl. This is one of the measures which helps alert us to people seeking controlled drugs from more than one doctor. Further measures are under consideration to detect, as well as deter, 'doctor shopping'.

### Recommendations

*I recommend:*

- that the Public Health team and the Social Security Department study and quantify the extent of 'doctor shopping'
- that a new system of patient registration with a general practice is introduced.



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