

The Case for Prevention

Annual Director of Public Health Report 2024

Foreword from Professor Peter Bradley, Director of Public Health

Good health is the foundation of Jersey's thriving society. It enables us to live fulfilling lives, participate in our communities, and contribute to the economy. Up to now, our approach to health in Jersey has focused on treating illness rather than preventing it. As this report highlights, investing in prevention is not only good for Islanders but is also one of the most effective ways to reduce pressure on healthcare services by creating a healthier population.

The evidence is clear: many of the most common and costly health conditions—such as heart disease, diabetes, and certain cancers—are largely preventable. Addressing risks to health, such as poor diet, smoking, harmful alcohol use and physical inactivity can significantly reduce the burden of disease. These behaviours are shaped in a deep way by the broader social, economic and environmental factors that affect physical and mental health in Jersey. These factors are the building blocks of good health: fair access to education, good work and housing, decent food, sufficient income, green spaces and so on—all of which play a crucial role in determining lifelong physical and mental health. When we talk about prevention or public health interventions in this report we are talking about these broader efforts of society, as well specific actions to improve health and not just actions from the public health directorate.

Prevention is not just about avoiding illness; it is about enabling people to live longer, healthier, and more productive lives. A strong focus on prevention benefits everyone: Islanders enjoy better health and wellbeing, employers have a healthier workforce, and healthcare systems can allocate resources more effectively to those in greatest need.

This report sets out a compelling case for prevention, backed by robust evidence. It calls for a shift in priorities—from reacting to ill health to proactively creating the conditions that support good health for all Islanders. Building on existing work, we can embed prevention at the heart of our policies, services, and communities, and build a healthier future for the Island, making sure it remains an attractive place to live, work and do business.



A handwritten signature in black ink, appearing to read 'Peter Bradley'. The signature is stylized and cursive.

Prof. Peter Bradley

Director of Public Health

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1 Executive summary

1.1 What is prevention?

Prevention aims to stop illness before it starts, or, in some cases, to slow its progress. Prevention is the core role of our public health team, as outlined in our strategy.¹

1.1.1 The building blocks of health

Although treating illness consumes more than £9 out of every £10 spent on health, healthcare services only account for about 30% of our health.²

Most of what makes us healthy comes down to the building blocks of health. As Figure 1 shows, these building blocks are money and resources, good housing, work, education and skills, access to good food, transport, the quality of our surroundings and our friends, family and communities.

Figure 1: Building Blocks of Health³



(Interestingly, our genes play only a relatively minor role in our health, roughly 10%).

These building blocks have a profound influence on how we behave, which in turn has a huge impact on how healthy we are.

For example, if we have a decent job that pays enough money, a comfortable home and we live in an area where we can easily find affordable healthy food, it is easier to be healthy. But if our housing is cramped, damp and expensive, our work insecure and poorly paid and our local shops sell mostly crisps, biscuits, cigarettes and alcohol, it is much harder to be healthy.

For this reason, almost all the work we do on prevention is collaborative, because these building blocks of health are the business of many different government departments, community organisations and businesses.

1.1.2 A summary of prevention activities

The aim of much of prevention work is to:

- Help create conditions where it is easier to be healthy, like making sure nutritious food is

widely available, wherever you live and regardless of how much money you earn.

- Support those who want to behave more healthily, for example by stopping smoking.
- Provide evidence-based interventions that we know prevent illness, like vaccination and screening programmes.

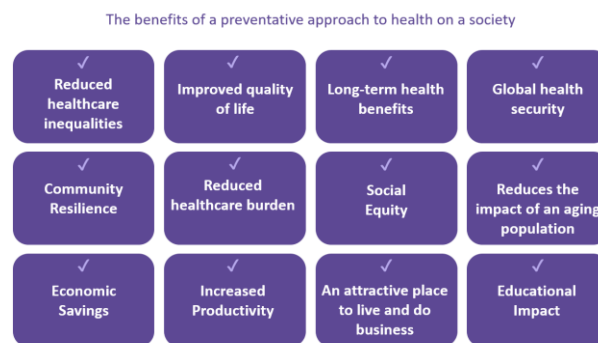
1.1.3 Differences in health

In all our work, we aim to reduce avoidable differences in health between different communities. As an Island community, we rely on each other every day. Good health enables us to work and contribute to our communities, so it is in all our interests to invest in prevention.

1.1.4 The benefits of prevention

Prevention is proven to have many benefits. These are summarised in Figure 2 below.

Figure 2: Benefits of Prevention



1.1.5 A summary of why prevention is important

Much of the poor health that afflicts our modern societies is not inevitable, especially the long-term illnesses that place such significant demands on hospitals and GPs. This illness is *preventable*.

There are several compelling arguments for investing in prevention:

- Preventing illness is cheaper than treating it. This preserves resources for other things.
- Enabling people to stay healthy for longer helps people continue to contribute to their work, families and communities. As an Island community, this benefits us all.

When we prevent illness, we reduce the suffering of our friends and families. By investing in prevention, we can keep each other healthy for longer, making Jersey a more enjoyable and attractive place to live, visit and do business, now and in the future.

1.2 An overall view of health

1.2.1 Life expectancy

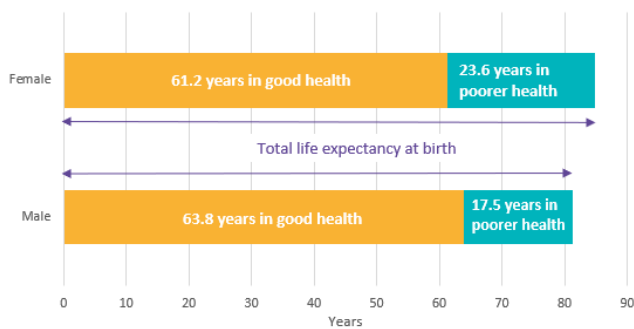
A child born in Jersey today can expect to live for 83 years, on average. This is roughly a year longer than in the UK and about two years less than the most long-lived countries like Japan. Women (85 years) generally live longer than men (just over 81 years), although the difference between the sexes has fallen in recent years.⁴

1.2.2 Healthy life expectancy

Healthy life expectancy refers to how many years we can expect to live in good health, not just how long we live. In other words, the age at which people, on average, become unwell.

As Figure 3 shows, women in Jersey tend to live longer than men, but spend a greater proportion of their lifetime in poor health. On the other hand, men have a shorter life span but become unwell at a slightly older age than women, meaning a smaller proportion of their total years is spent in poor health.⁴

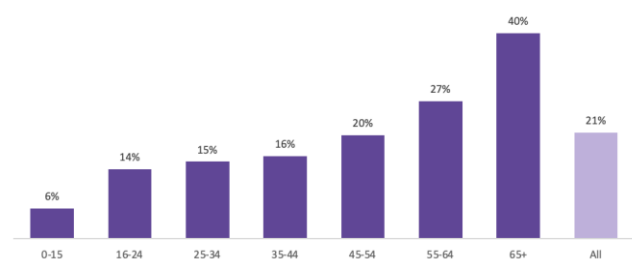
Figure 3: (Healthy) Life Expectancy⁴



1.2.3 Health and aging

Health generally declines with age. Figure 4 shows that although the average age people become unwell is over 60 years old, a significant percentage of people become unwell much younger; one in five people aged 45 and over report having a long-term physical or mental health condition.⁵ Data on self-reported health shows a similar pattern. 94% of Islanders aged 16-24 report having good or very good health, compared with 66% of Islanders aged 65 years or older.⁶

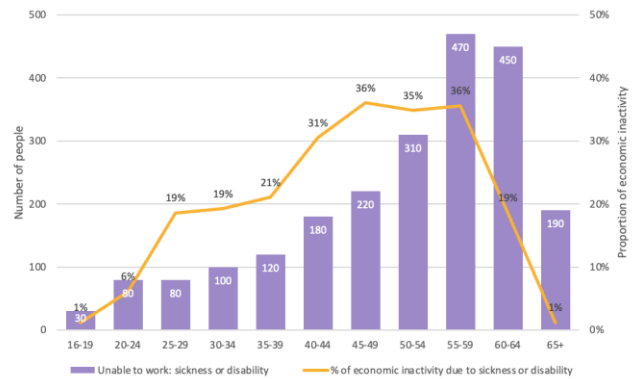
Figure 4: % of population with long-term conditions, by age⁶



1.2.4 Health and productivity

Figure 5 shows the effect this trend has on the workforce. Just 6% of economic inactivity for Islanders aged 20-24 is due to sickness or disability. Whereas, for people aged 45-59 more than a third of economic inactivity is due to sickness or disability.⁷

Figure 5: % of economic inactivity due to illness or disability, by age⁷



1.2.5 Health and prevention

Preventable deaths

Many of the conditions that cause illness and early death in Jersey are preventable. Data show that around 100 of the 800 deaths/year in Jersey could be prevented with better public health interventions.⁸

Preventable illness

Table 1.1 below shows what proportion of the most common long-term illnesses in Jersey could be prevented. Using this data, a significant amount of long-term illness on the Island could be prevented by helping people be more active, eat better, stop smoking and drink less.

Table 1.1: Preventable long-term illness^{5, 9, 10}

	Number of patients on GP disease register	Proportion considered preventable	Number considered preventable
Heart disease	2,925	80%	2,340
Stroke	2,015	80%	1,610
Type 2 diabetes*	4,600	80%	3,680
Cancer	4,720	40%	1,890
Dementia	820	45%	370

1.2.6 Summary

Although people in Jersey live slightly longer than in the UK, many people acquire serious, long-term illnesses in middle age, well before they retire. Much of this illness is preventable. If the Government of Jersey were able to successfully implement a systematic programme of prevention, the projected increase in demand for healthcare and social support related to poor health would reduce.

1.3 Why unequal health matters

Good average health in Jersey hides lots of variation in things like housing tenure, household composition, income and job type. But why does unequal health matter?

Our collective health is the shared resource on which our Island’s culture and prosperity depend. Avoidable poor health harms us all. It means fewer people can do the jobs - many of them not especially well paid - on which we all depend. It means more Islanders struggling to contribute fully to the lives of their friends, families and communities. It means more costs and less income for government.

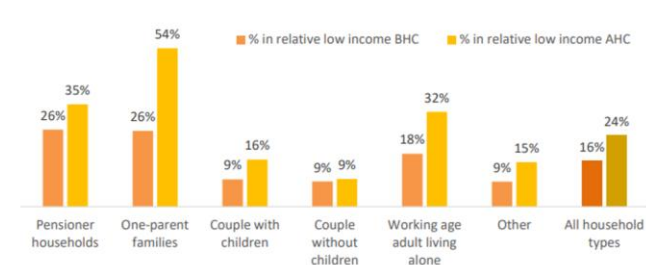
1.3.1 Unequal determinants of health

Unequal household income

Income is one of the most powerful determinants of health. If you have enough money for the essentials and a bit more, life is less stressful and it is easier to be healthy.¹¹

Jersey has significant and rising income inequality. One in four (24%) of all families in Jersey live in relative low income after housing costs. Household income varies a great deal by household composition and housing tenure. For example, more than one in two (54%) of one-parent families have low income after housing costs (Figure 6).¹²

Figure 6: Relative income and household type¹²



1.3.2 Unequal health risks

Physical activity

The more money you earn, the more likely you are to be physically active. Figure 7 shows this very clearly.¹³

Figure 7: Physical activity and household income¹³



Alcohol

Inequalities in risk from alcohol show an interesting pattern. Normally, risks are higher in people of lower socio-economic status. But for alcohol, the reverse is true: Figure 8 shows people with higher incomes are more likely to drink to dangerous levels. We also know Jersey is a “nation of drinkers”, consuming more alcohol per head than almost every other European nation.¹⁴

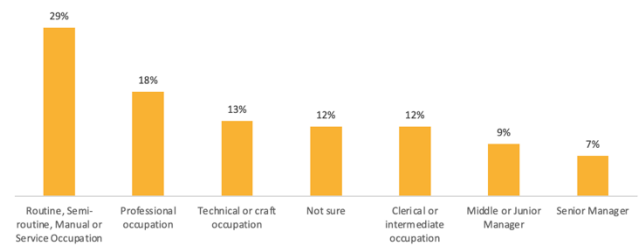
Figure 8: % population with high risk alcohol consumption and income¹⁴



Smoking

Risks for poor health from smoking are also unequally distributed in Jersey. Figure 9 shows that one in three (29%) of people working in routine, manual and service occupations smoke, compared to just one in 14 (7%) in senior manager roles.¹⁵

Figure 9: Smoking and occupation¹⁵



Obesity

Excess body weight raises the risk of long-term conditions like diabetes, cardiovascular disease, musculoskeletal conditions and some cancers. It is also linked to poor mental health. While there is limited data on inequalities related to obesity in adults, we know that children in urban areas or who attend non fee-paying schools are much more likely to be overweight or obese than their wealthier counterparts (Figure 10), although the differences may be reducing.¹⁶

Figure 10: Overweight and obesity in children by school type



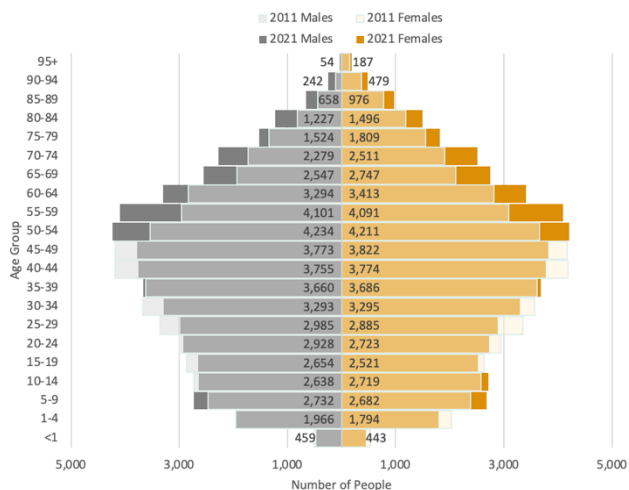
1.3.3 Summary

Good health is not enjoyed equally by all Islanders. This matters because, as a small Island community, we rely on each other. Much of the illness is caused by a set of common risks relating to the food we eat, physical activity levels, smoking and drinking. For a whole host of reasons – many of them outside of any individual’s control – people with fewer resources tend to be less healthy.

1.4 Demography

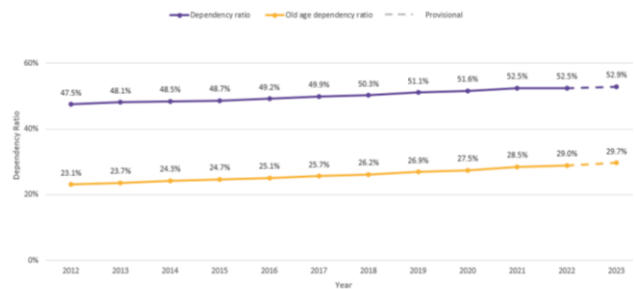
Jersey’s population has almost doubled since the 1950’s. Islanders are also, on average, seven years older than they were seven decades ago.⁷ Figure 11 shows the population in 2021. You can clearly see the biggest group is Islanders is their fifties.

Figure 11: Jersey's population pyramid, 2021⁷



This aging population will create a greater demand for healthcare and social support in the future. It will also mean there are fewer working-age people paying taxes to help government pay for those services. Figure 12 shows how the dependency ratio (the ratio of those outside working age to those of working age) has risen over time.¹⁷

Figure 12: Dependency ratio over time¹⁷



Living standards

The challenges to public finances of an aging population are exaggerated by falling productivity. Income is one way of measuring productivity. Figure 13 shows earnings have been roughly static (in real terms) for the last 10 years.¹²

Figure 13: Change to earnings over time¹⁸

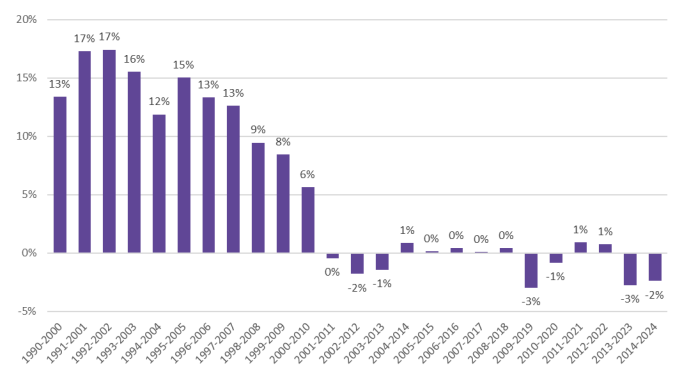
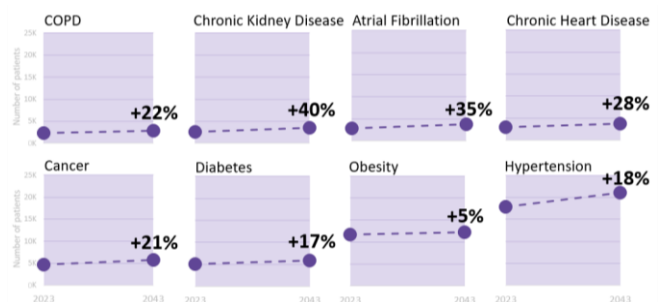


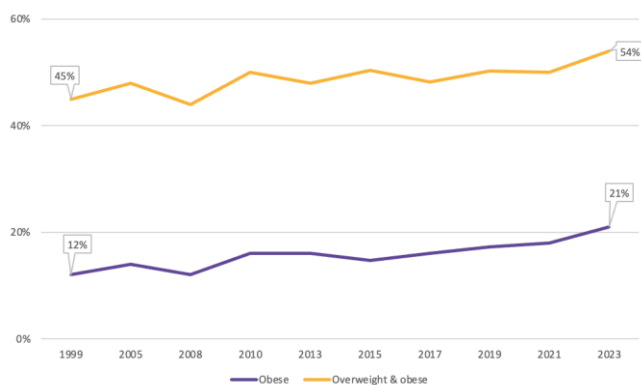
Figure 14 shows the expected impact of an aging population on the number of cases of eight long-term conditions.

Figure 14: Projected rise in long-term illness⁵



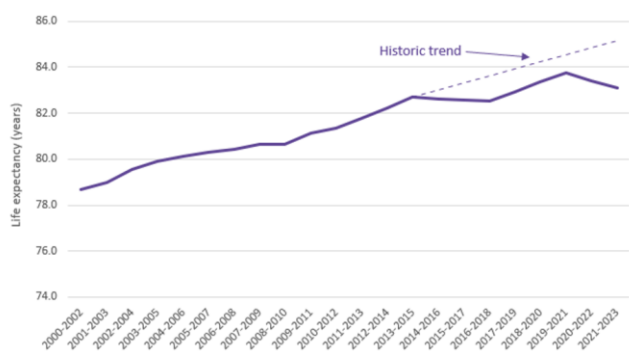
Even without the effects of an aging population, Islanders seem to be getting less healthy. Figure 15 shows that obesity rates have been steadily rising since 1999.¹³ Obesity increases the risk of a range of conditions including diabetes, heart disease, musculoskeletal disorders and some cancers.

Figure 15: Self-reported adult obesity over time ¹³



This might help to explain why improvements in life expectancy have begun to stall in recent years, even before the Covid-19 pandemic (Figure 16).⁴

Figure 16: Life expectancy over time



1.4.1 Summary

Jersey’s population is set to age in coming decades. This will increase demand for healthcare and social support. In addition, our existing population appears to be becoming less healthy, as evidenced by rising rates of obesity and a stalling in improvements in life expectancy. These demographic trends will put pressure on public finances. Improved prevention can help ease these pressures.

1.5 Future cost of (preventable) illness

We can estimate how much extra money an aging population might cost government through its use of healthcare services and health-related social support.

We’ve made the following assumptions:

- Assumed net inward migration of +325 people/year (government’s ‘central’ estimate)
- Rates of illness stay the same
- Use of healthcare and social support remains the same for each age group
- Current patterns of use will remain the same, i.e. if 50 year-olds see their GP once a year in

2023, we’ve assumed they will still see their GP once a year in 2053

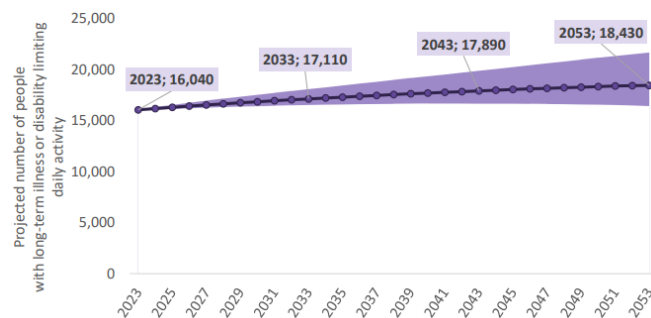
- Costs are based on the value of the pound today. They don’t take inflation into account.¹⁹

1.5.1 Modelling headlines

Multimorbidity

We estimate that by 2053 the aging population will mean there will be an extra 3,400 people with two or more long-term conditions in 2053, or an extra 2,390 people with an activity-limiting illness or disability (Figure 17).¹⁹

Figure 17: Projected increase in long-term illness ¹⁹



Increase in GP appointments and hospital bed days

We can use population estimates to work out how many additional GP appointments and bed days might be needed by a future, older population. Figure 18 and Figure 19 show we will need an estimated 43,520 extra GP appointments and an extra 23,670 hospital beds days by 2053.¹⁹

Figure 18: Projected increase in GP appointments ¹⁹

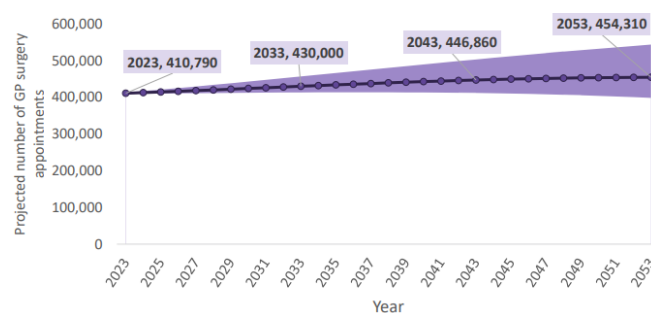
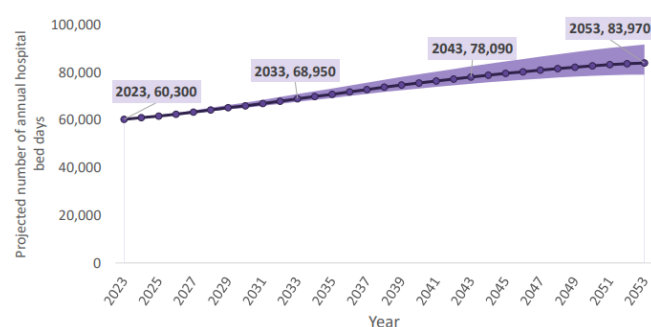


Figure 19: Projected increase in hospital bed days ¹⁹



Cost estimates

We can use these data to estimate how much the predicted need for extra healthcare and social support

might cost government. For example, an 11% increase in the number of GP visits would equate to an additional £1.4million (at 2023 prices).

The value of prevention

These data start to give a picture of the potential monetary value of prevention. Currently, Jersey spends at least £576 million on poor health, through health-related benefits and health care services. If the volume of illness on the Island was reduced by even 1%, there would be significant savings to be made.

Table 1.2: Costs and potential savings

Description	2023 Cost	1% reduction	5% reduction
Days lost due to illness (STIA)	£16,700,000	£167,000	£835,000
Prescriptions (cost of drugs & dispensing fees)	£26,500,000	£265,000	£1,325,000
Medical Benefits (payments to GPs, including medical benefit for GP consultations, pathology benefit, JQIF, Health Access Scheme, and various contracts with GP practices)	£12,900,000	£129,000	£645,000
Long-term Care	£76,000,000	£760,000	£3,800,000
Long-term Incapacity Allowance & Invalidity Benefit	£31,000,000	£310,000	£1,550,000
Carers allowance	£2,400,000	£24,000	£120,000
Medical products, appliances and equipment	£31,600,000	£316,000	£1,580,000
Hospital services	£282,500,000	£2,825,000	£14,125,000
Outpatient services	£96,800,000	£968,000	£4,840,000
Total	£576,400,000	£5,764,000	£28,820,000

1.5.2 Summary

As our population ages, we anticipate an increase in demand for health and care services, such as GP appointments and hospital bed days. Improved prevention would reduce this. Even a modest reduction in demand would achieve significant savings.

1.6 Appendix 1: The case for prevention

“Preventative health care can provide a [...] healthier population, a stronger economy [...] and an improved fiscal position”.²⁰

The previous governor of the Bank of England argues that health is a communal asset that we should support to make our society more resilient to the inevitable challenges it will face.²¹⁻²³ “A person who is in good enough health is likely to be happier, to keep in work, to pay taxes, not to require welfare or social care support, and to be able to support others.”²

We all have a stake in ensuring everyone can be as healthy as possible, and we will all benefit from it. This is especially true for a small island population like Jersey, where we rely on each other every day.

Prevention is fantastic value for money. Preventing illness is approximately four times cheaper than treating it.²⁴ The average return on investment for preventative interventions is £14 of value for every £1 spent.²⁵ Multiple academic papers and reports from governments and think tanks cite preventative

approaches as being effective, cheaper than treatment, with high average returns on investment. In many cases they are also cost-effective, i.e. they save more money than they cost.²⁵⁻³⁰

Interestingly, there is also considerable support for the economic case for prevention from business. Deloitte Consulting produced a series of reports making the case for prevention in the workplace, stating that every £1 spent by employers on employees’ mental health returns £5 of value.

Nonetheless, prevention is also context specific. Whether or not preventative interventions work, how well they work, and the size of the return on investment varies depending on the activity, the target group, the locality and the type of organisation delivering the programme.²⁵⁻³⁰ Because of this, thoughtful application - with careful reference to the needs and capabilities of the local population - is essential. Over time, skilful evaluation builds a local evidence base of effectiveness.

Some prevention activities are more reliably effective with better returns on investment. These include legislative approaches and evidence-based activities targeted at children.^{26, 28, 31}

There is a well-established link between physical and mental health and productivity. Poor health harms productivity, and vice-versa.^{20, 32-39}

While noting the inevitable challenges of a population with a greater number of older people, we shouldn’t lose sight of the huge potential of our older fellow citizens. “In countries that spend more on health, older people work, volunteer and spend more”. This activity has huge societal and economic value.⁴⁰

1.6.1 Summary

“Genetics, environment, and behaviours drive 70% or more of our health status. Treating sickness accounts for less than 30% but still consumes 90% of resources”.²

There is an overwhelming consensus from academia, governments, society and business that investing in prevention make sense. There are strong financial arguments - healthier people are more productive. There are compelling moral arguments - since many factors that influence health are outside of our individual control, it’s unfair that some people suffer worse health that could be prevented. As an Island nation, we depend on each other. Investing in our health is therefore an investment in all our lives.

Introduction

2 Introduction

Prevention is the core function of our public health directorate. Our strategy, *Seizing the opportunity: a population health prevention strategy for Jersey (2023-2027)*, set out our aims and objectives to achieve this.¹ Maintaining and improving the health of every Islander by working with other departments and in the private sector - through encouraging, influencing and leading policy and strategy - is the aim of the public health team.

Preventing illness and promoting good health is not something any government department can do on its own. Prevention almost always needs collaboration between government departments, and between government and businesses, communities and individuals. The value of this collaborative effort is increasingly recognised by government. For example, the Strategy for Sustainable Economic Development sets out how a “fair economy would support its elderly population to help them enjoy their retirement, in good health and with access to good care and treatment”.⁴¹ In addition, the recent Common Population Policy Annual Report 2024 highlights the aging demographic and lays out an Aging Well Roadmap which aims to reduce the risk of age-related diseases.⁴²

This year’s Director of Public Health Report considers the case for prevention in the Jersey context. The chapters that follow detail:

- What is prevention and why is it important
- The current burden of disease faced by Islanders
- How that burden is not equally spread across the Island
- How the Island’s population is aging and its likely impact on our future health
- An estimate of the costs of this aging population
- A summary of the evidence of the effectiveness of a preventative approach (appendix 1)

But first, it’s important to set out what we mean by prevention.

2.1 What is prevention and why is it important?

2.1.1 Traditional healthcare

We are all familiar with traditional healthcare services. We feel unwell, we visit our GP or the hospital and they advise a course of treatment. This might be medicine, surgery or some other procedure. If all goes well, once we’ve taken the pills or gone under the knife, we feel better and can return to living life to the full.

This was how modern healthcare services ran for decades and they were hugely successful. Antibiotics, chemotherapy, hip replacements, heart bypasses and the rest have turned events that used to kill or disable us into difficulties that can very often be treated, some as a matter of routine.

2.1.2 The need for prevention

So why do we need prevention?

1. There is a large international evidence base that shows that prevention works and is an efficient use of resources. This evidence is summarised in appendix 1.
2. It is always better to avoid illness than be treated for it. As anyone who has suffered the rigours of chemotherapy or gone through rehabilitation from major surgery knows, modern medicine may be hugely sophisticated, but it is also often painful, deeply unpleasant and expensive. Government spends a quarter of its income on healthcare; 94% of this is spent on treatment and only 6% on prevention.⁴³
3. Over the past decades, the numbers of people with long-term illnesses have risen, slowly and surely, to the point where hospitals and GPs are struggling to cope with demand. At the end of 2023, Jersey had 32,820 people with one of the 12 most common long-term illnesses, one in three Islanders.⁵ This demand is further increased because medical treatments for long-term conditions are more often about management than cure. This means that people need help for decades rather than weeks or months. We also often struggle to

give holistic, person-centred care to the more than 14,000 Islanders who have more than one long-term conditions.

4. Managing modern ailments is hugely expensive. A person with well-managed diabetes may still need regular foot care, weight loss drugs, eye screening, insulin injections, regular check-ups and so on. For the person who is unwell, this care is a vital kindness. But when we zoom out to look at the whole population, we can see it consumes a huge amount of resource. Type 2 diabetes is almost entirely preventable. If we organised life on our Island differently, far fewer people would suffer from it.
5. Much of what makes us healthy (or unhealthy) has nothing to do with healthcare services. The building blocks of health are decent housing, good food and work, education, having enough money, clean air and water, strong relationships with those around us. These building blocks in turn shape how we behave, which has a huge impact on health.

Our behaviour is profoundly influenced by our environment. For example, if our local shop sells lots of appealing fruit and vegetables at reasonable prices, we will find it easier to eat well. But if our local store sells mostly alcohol, cigarettes, crisps and biscuits it is much harder to be healthy, especially if we lack the time, money or transport to go elsewhere.

There are numerous other examples. If we live in a warm, comfortable and affordable house, it is much easier to care for ourselves and our loved ones than if our home is damp, cramped and expensive. If our work treats us with respect and pays us a decent wage, our mental health is likely to be much better than if we have to work for pay that doesn't cover the essentials and leaves us constantly worrying.

Figure 20: The building blocks of health ³



Source: The Health Foundation

2.1.3 What is prevention?

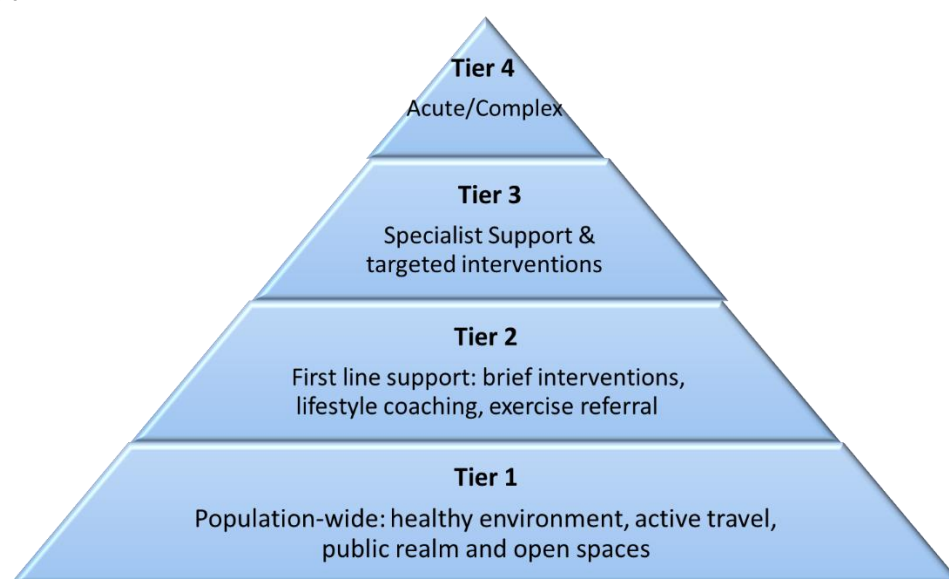
There are different kinds of prevention.

1. We can try to stop illness before it starts. There are many ways of doing this, for example:
 - a. We might focus on making sure as many people as possible have good homes, decent wages, clean air and water and access to good food. Government already has programmes in many of these areas.
 - b. We can vaccinate people against infectious diseases, like meningitis, flu and covid. Some immunisations (like HPV) even prevent cancer.

- c. We can pass legislation that makes it easier to behave in ways that support our health, for example by making active travel easier, or making it harder to buy cigarettes.
2. We can find people whose bodies are showing the early signs of disease but are not yet unwell. Treating illness early is more effective, cheaper and less intrusive. Cancer screening programmes work in this way.
3. We can support people who want to change their behaviours, for example by providing services to help people stop smoking, or by helping them eat better and be more physically active. These behaviour change programmes need to be supported by wider changes. For example, a stop smoking programme for individuals will be much more effective if it is supported by legislation that bans smoking in public places and ensures tobacco isn't cheap and widely available.
4. Finally, we can work with people who are already unwell to help slow down the progression of their disease (and, in some cases, reverse it). Diabetes prevention and remission programmes are good examples of this approach.

Figure 21 summaries the above into the tiers of prevention.

Figure 21: Types of prevention



Source: Public Health Directorate

2.1.4 The benefits of prevention

Preventing ill health can benefit Islanders, our communities and our economy, as detailed in Figure 22.

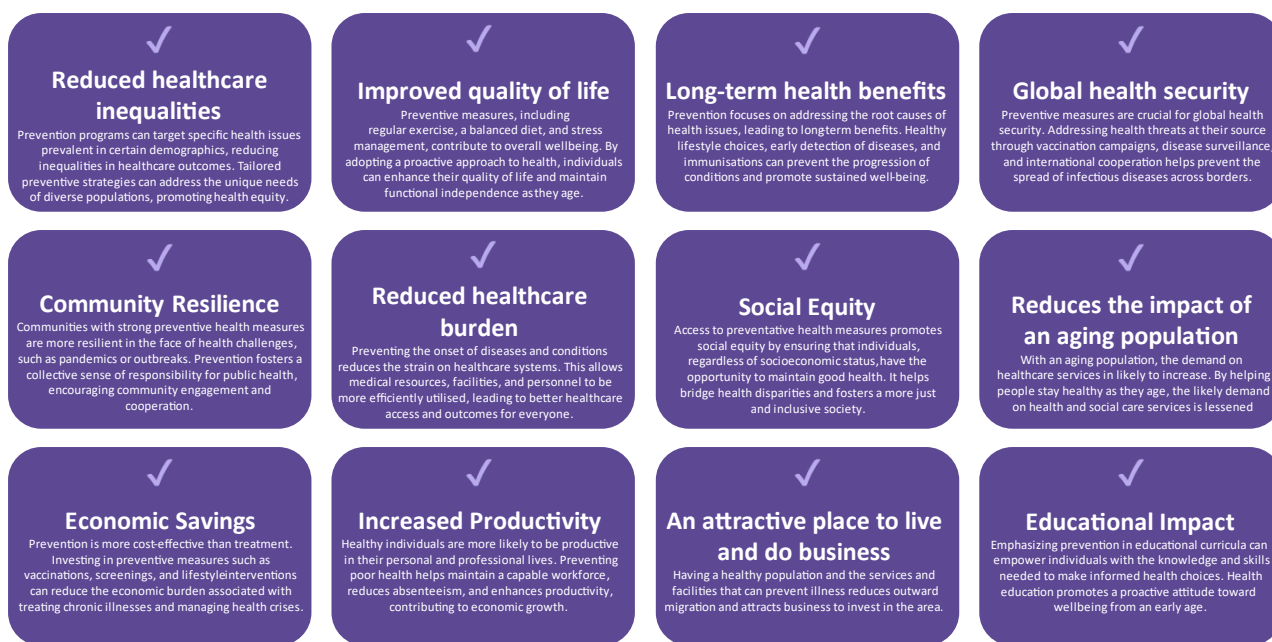
For example, if we make it easier for all Islanders to find and afford nutritious food, people will feel healthier and live longer in better health. This makes it easier for them to contribute to their communities by socialising, volunteering, working or running businesses. These activities create wellbeing and wealth, reduce demand for publicly funded services and increase government earnings, leaving more money to pay for things we all value like better schools or protecting our green spaces.

We put it like this in our strategy:

“It is in the interests of all Islanders for everyone who lives and works in Jersey to be enabled - through their own efforts and with the support of Government - to be healthy. As the pandemic showed, each of us relies every day on a multitude of people from all walks of life to produce our food, to care for our elderly and those who are unwell, to serve us in hotels, bars and restaurants, to educate our children, to deliver things we buy online, to empty our bins, to keep us safe. Health is the currency that allows us all to work, to socialise, to create, to care for friends and family, to explore life in all its richness.”¹

Figure 22: The benefits of preventative approach to health

The benefits of a preventative approach to health on a society



Source: Public Health Directorate

2.1.5 Summary

Prevention is about stopping illness before it starts or reducing the impact of existing illness.

Prevention is important because much of the poor health that afflicts modern societies is not inevitable. There are different ways to prevent illness or promote good health. One of the most powerful is to address the building blocks of health, like good food, education, work and housing. This needs the collaboration of different government departments, charities, businesses and communities. Other methods of prevention include vaccination and screening programmes as well as supporting people to behave in ways that improve their health, for example by stopping smoking.

Poor health is not shared equally by all Islanders. On average, those with fewer resources usually suffer worse health. This matters because, as an Island community, we all rely on each other in myriad ways, every day. In particular, those people on lower incomes, who are at risk of the worst health, often do the vital work that makes our Island function - planting crops, serving food, caring for children and the elderly, cleaning our offices, emptying our bins. It is in our best interests to invest in prevention so that *everyone* in Jersey is as healthy as possible.

As this report shows, prevention makes sense from an economic perspective. It is a more effective and efficient use of resources than treatment. Healthcare services are essential, but investing in prevention will, in the long term, help preserve a larger share of government resources for things we all value - like parks, schools, infrastructure, agriculture, youth clubs, arts and culture.

Finally, prevention is kindness. When we prevent illness, we reduce the suffering of our friends and families. By investing in prevention, we can keep each other healthy for longer, making Jersey a more enjoyable and attractive place to live, visit and do business, now and in the future.

Current burden of disease

3 Current burden of ill health

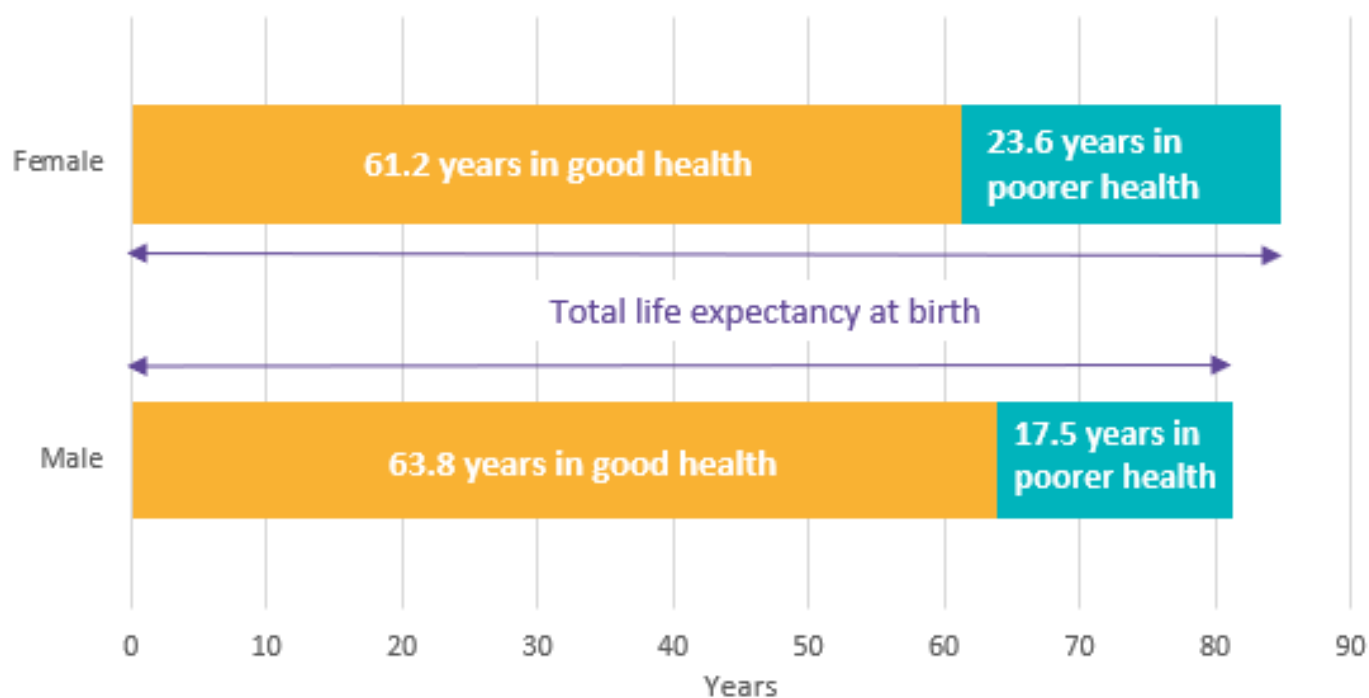
This chapter sets out the available evidence for how poor health is affecting Islanders at present. The data comes from published sources, such as the census, public health reports and data contained on the Government of Jersey open data site.^{7, 18, 44} Understanding the level of poor health in our community helps us to see how many people are currently affected locally, the severity of their ill health and how this changes their day-to-day life. We know which diseases and illness are preventable through good public health interventions, such as good quality diets, exercise and limiting exposure to harmful and hazardous substances, such as alcohol and tobacco.

3.1 Years spent in poor health

Using current data, we can calculate the average number of years Islanders will live. This is called life expectancy. Using information on self-reported health from the Jersey Opinions and Lifestyle Survey (JOLS), we can also estimate how many of these years will be lived in good health. This is called healthy life expectancy.

Jersey has a high life expectancy.⁴ This is cause for celebration – people are living longer than in the past. But we can also see from Figure 23, below, that a significant portion of those years will be lived in poor health. Much of this poor health is due to preventable long-term illness.^{9, 10}

Figure 23: Differences in life expectancy (2021-2023) and healthy life expectancy at birth for males and females (2022/2023)



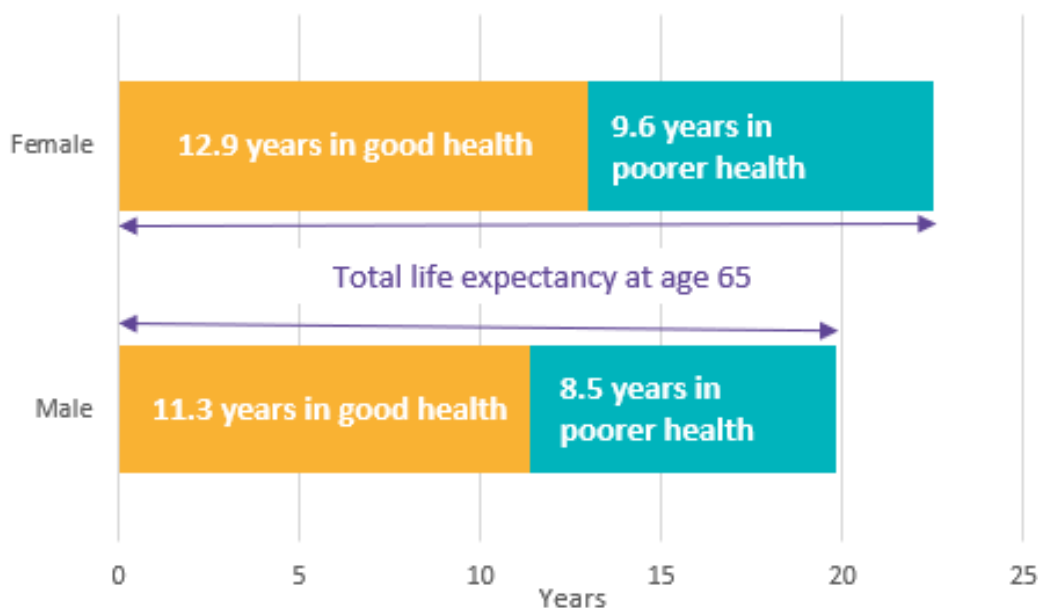
Source: Public Health Intelligence Unit

The latest healthy life expectancy report revealed a decline in healthy life expectancy for females at birth, from 69.7 years in 2016-2018 to 61.2 years for the latest period (2022-2023). This reduction was not seen for males, who have remained statistically similar over the same time span. The decline in healthy life expectancy for females, whilst life expectancy remains stable, means that, on average, females are spending more years in poorer health than previously.

Figure 24, below, shows life expectancy and healthy life expectancy for males and females at the age of 65 (for comparison, Figure 23, above, showed (healthy) life expectancy from birth).

At age 65, females can expect to live, on average, a further 22.5 years. However, 9.6 years of this is likely to be spent in poorer health. Males can expect to live a further 19.8 years once they reach age 65, with 8.5 years of these spent in poorer health. Despite females having an extra 2.7 years of life expectancy at age 65 compared to males, over half of this (1.6 years) is spent in poor health.⁴

Figure 24: Differences in life expectancy (2021-2023) and healthy life expectancy at age 65 for males and females (2022/2023)



Source: Public Health Intelligence Unit

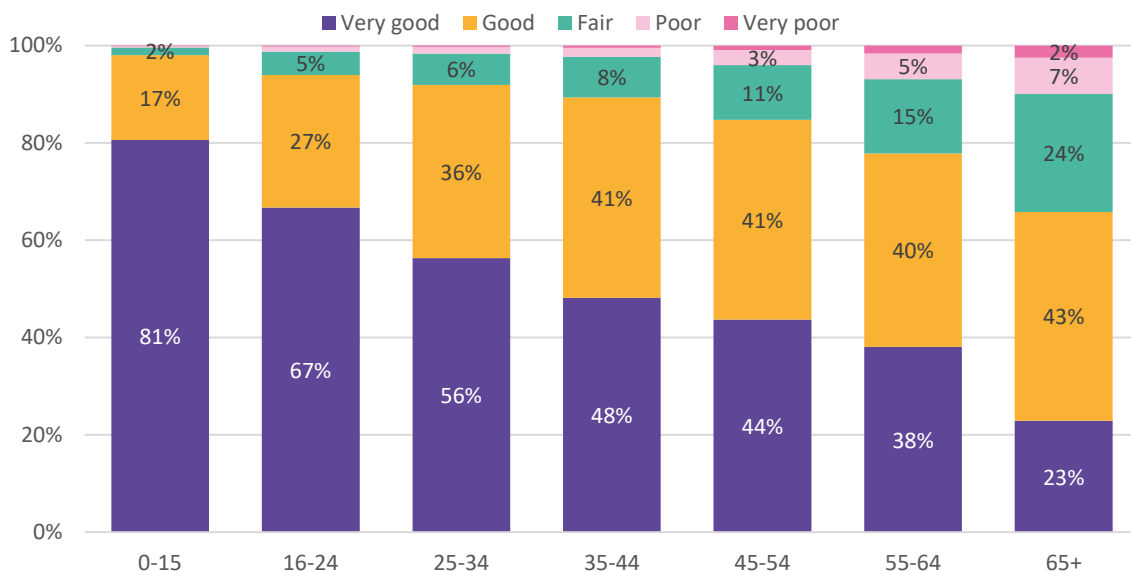
Data for the UK show that within the overall averages for life expectancy and healthy life expectancy, there are stark differences, depending on where you live. People living in poorer areas have shorter life expectancies and spend a greater proportion of their life living with poorer health.⁴⁵ Although this analysis is not currently possible for Jersey, it is very likely that similar patterns are playing out locally.

3.2 Number of people with poor health

For the first time, the 2021 census included questions on health status. This found that around half (49%) of Islanders reported their health as ‘very good’ and a further 35% reported having ‘good’ health. However, around one in ten (11%) had fair health and 4% had either ‘poor’ or ‘very poor’ health.

The number of people rating their health as ‘poor’ or ‘very poor’ increased with age, with around one in ten (10%) of residents aged 65+ rating their health as ‘poor’ or ‘very poor’.⁷

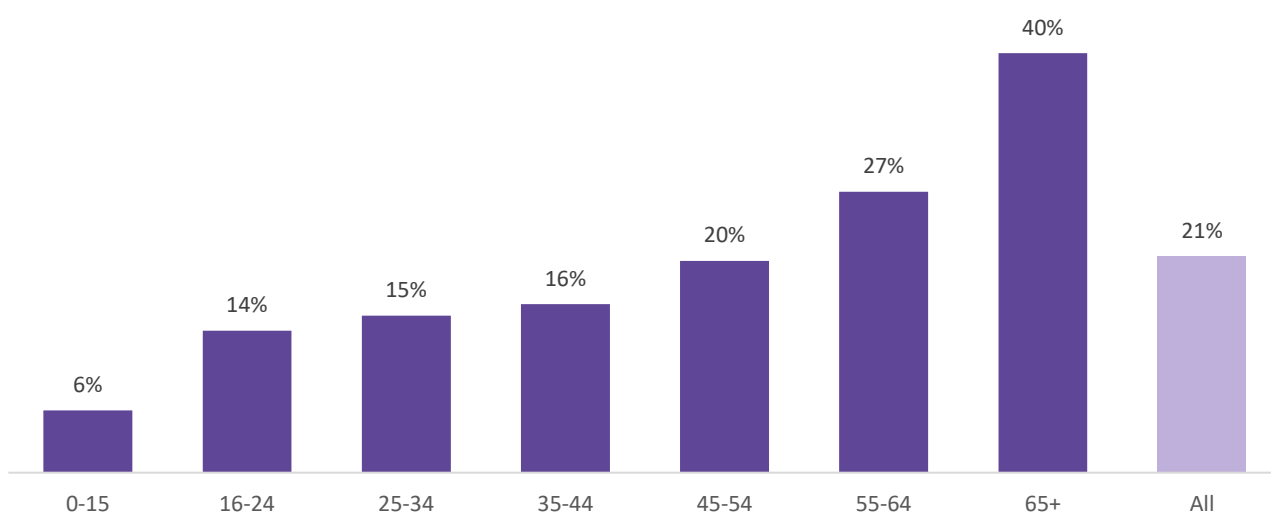
Figure 25: Self-assessed general health, by age, 2021



Source: Census 2021⁷

The census also found that 21,382 Islanders (21 per cent of the population) reported having a physical or mental health condition or illness, lasting or expected to last 12 months or more. The proportion of those with a longstanding illness in each age group increased with age.⁷

Figure 26: Proportion of population with a longstanding physical or mental condition or illness, by age, 2021



Source: Census 2021⁷

3.3 Multimorbidity

Diseases, long term conditions and disabilities become more common and accumulate with age, although this is far from inevitable. The latest multimorbidity report shows 32,820 individuals in Jersey had at least one of 12 long-term conditions at the end of 2023.⁵ These numbers differ in magnitude to those reporting having ‘poor’ or ‘very poor’ health or those reporting having a long-standing illness as part of the responses to the 2021 census.⁷ The disease registers held by GP surgeries used in the analysis for the multimorbidity report are defined as part of the Jersey Quality Improvement Framework (JQIF) and cover some of the more commonly occurring long-term conditions, such as hypertension (high blood pressure), cardiovascular disease and diabetes. Many of these conditions are preventable through evidence-based programmes. Other long-term conditions, such as cancer or learning difficulties,

are not currently part of the JQIF disease registers therefore the multimorbidity index represents an underestimate of the true burden of ill health in the Island.

Table 3.1: The number of patients on each long-term condition register as at year end 2023

“All patients” includes everyone who is on the register, regardless of what other conditions they may have, whilst “patients (single condition)” includes patients who have only that single condition. The number of patients on the register as a proportion of the total population is shown, as well as the average age of patients on the register.

Condition	All Patients	Proportion of Population	Average Age	Patients (Single condition)	Average Age (Single condition)
Hypertension (HYP)	17,800	17%	68	7,035	65
Obesity (OB)	11,635	11%	55	4,740	46
Asthma (AST)	5,965	6%	49	3,340	39
Diabetes (DIA)	5,055	5%	66	870	56
Coronary Heart Disease (CHD)	2,925	3%	73	505	66
Atrial Fibrillation (AF)	2,815	3%	75	445	67
Chronic Kidney Disease (CKD)	2,535	2%	78	275	70
Chronic Obstructive Pulmonary Disease (COPD)	2,325	2%	70	530	64
Stroke and Transient Ischemic Attack (STIA)	2,015	2%	74	350	64
Heart Failure (HF)	1,175	1%	79	50	69
Dementia (DEM)	820	1%	84	145	81
Mental Health Problems (MH)	780	1%	52	395	46

*Patient numbers rounded to the nearest 5

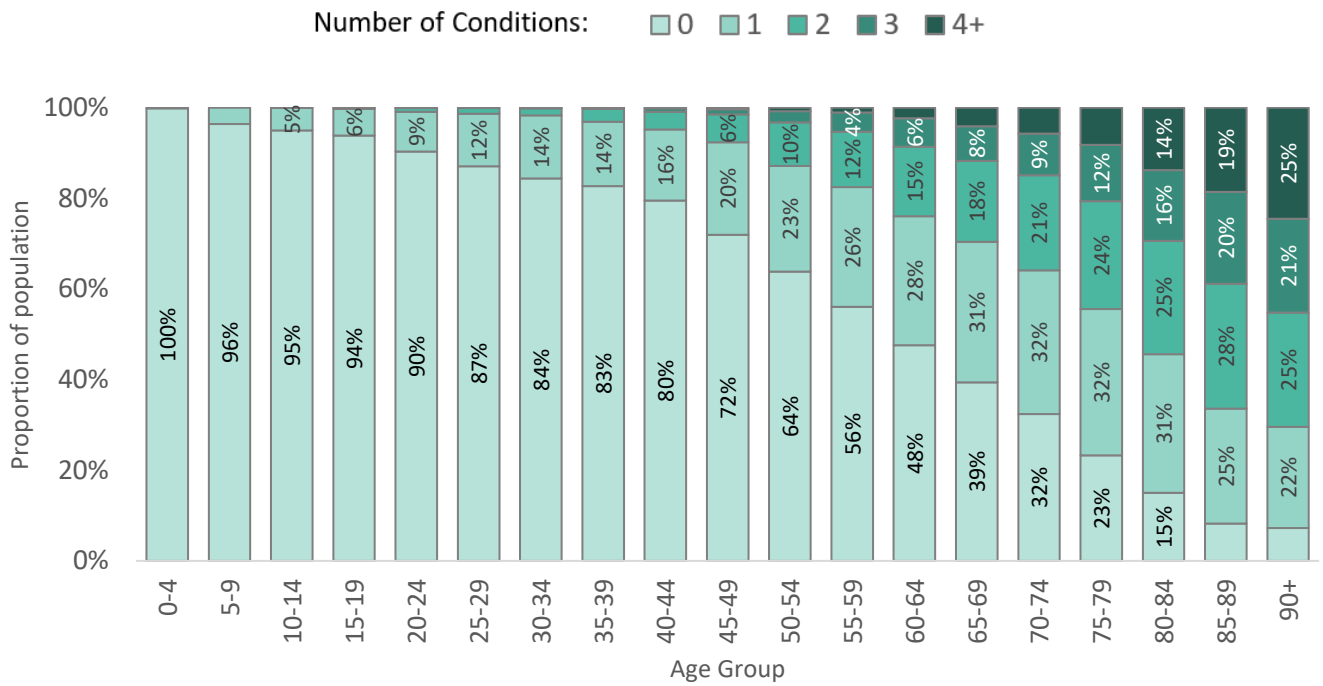
Source: Public Health Intelligence Unit, Multimorbidity Report 2023⁵

More than one in ten (14%) Islanders registered with GPs were found to have *two or more* long term conditions, meaning they are living with ‘multiple morbidities’. Of those individuals having two or more long-term conditions, progressively fewer had a higher number of long-term conditions:

- 8,450 individuals had two conditions, equivalent to 8% of the population
- 3,545 individuals had three conditions, equivalent to 3% of the population
- 2,145 individuals had four or more conditions, equivalent to 2% of the population

When considering the age pattern, it’s clear from the multi-morbidity data that the chance of having more than two long term conditions increases with age (Figure 27).⁵

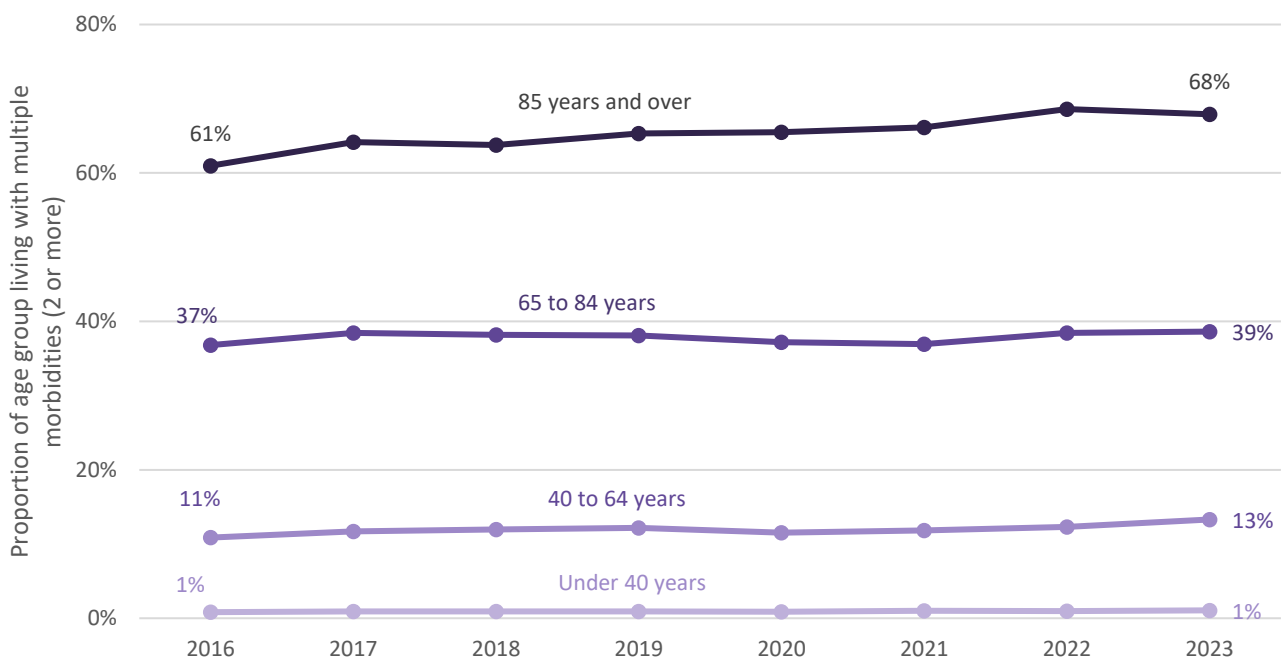
Figure 27: Number of long-term conditions by age at year end 2023; proportion of population



Source: Public Health Intelligence Unit, Multimorbidity Report 2023⁵

Life expectancy has increased over the past few decades, meaning that there are a greater number of older people living in the Island than ever before. However, the latest multi-morbidity report showed that there has been an increase in the proportion of those aged 85 and over who have multiple morbidities, rising from 61% in 2016 to 68% in 2023. This is likely because people with multi-morbidities are living for longer than ever before.⁵

Figure 28: Proportion of Jersey’s population in different age bands with multiple morbidities (2 or more long term conditions) between 2016 and 2023



Source: Public Health Intelligence Unit, Multimorbidity Report 2023⁵

Overall, there has been a slight increase in the estimated proportion of the population living with multi-morbidity, from 11% in 2016 to 14% in 2023.⁵

3.4 Preventable disease

It is estimated that up to 80% of new cases of heart disease, stroke and type 2 diabetes can be prevented through changes to how we live, as well as up to 40% of new cases of cancer.⁹ Recent research published in the Lancet Commission estimates that up to 45% of new cases of dementia are preventable.¹⁰ Applying these estimates to the current numbers of patients on GP disease registers for these conditions gives an indication of the current burden of illness that could be considered preventable.

Table 3.2: Preventable disease numbers, 2023

	<i>Number of patients on GP disease register</i>	<i>Proportion considered preventable</i>	<i>Number considered preventable</i>
<i>Heart disease</i>	2,925	80%	2,340
<i>Stroke</i>	2,015	80%	1,610
<i>Type 2 diabetes*</i>	4,600	80%	3,680
<i>Cancer</i>	4,720	40%	1,890
<i>Dementia</i>	820	45%	370

Source: Public health Intelligence Unit, Chief Medical Officer for England, Lancet Commission^{9, 10}

*Based on 91% of those on the diabetes register having type 2 diabetes

3.5 Health Service Usage

GPs conducted 271,994 in person appointments in 2022, with a further 50,671 remote appointments, an average of 3.1 GP appointments per Islander. There were an additional 13,914 consultations with other health care professionals in GP practices in 2022.¹⁸

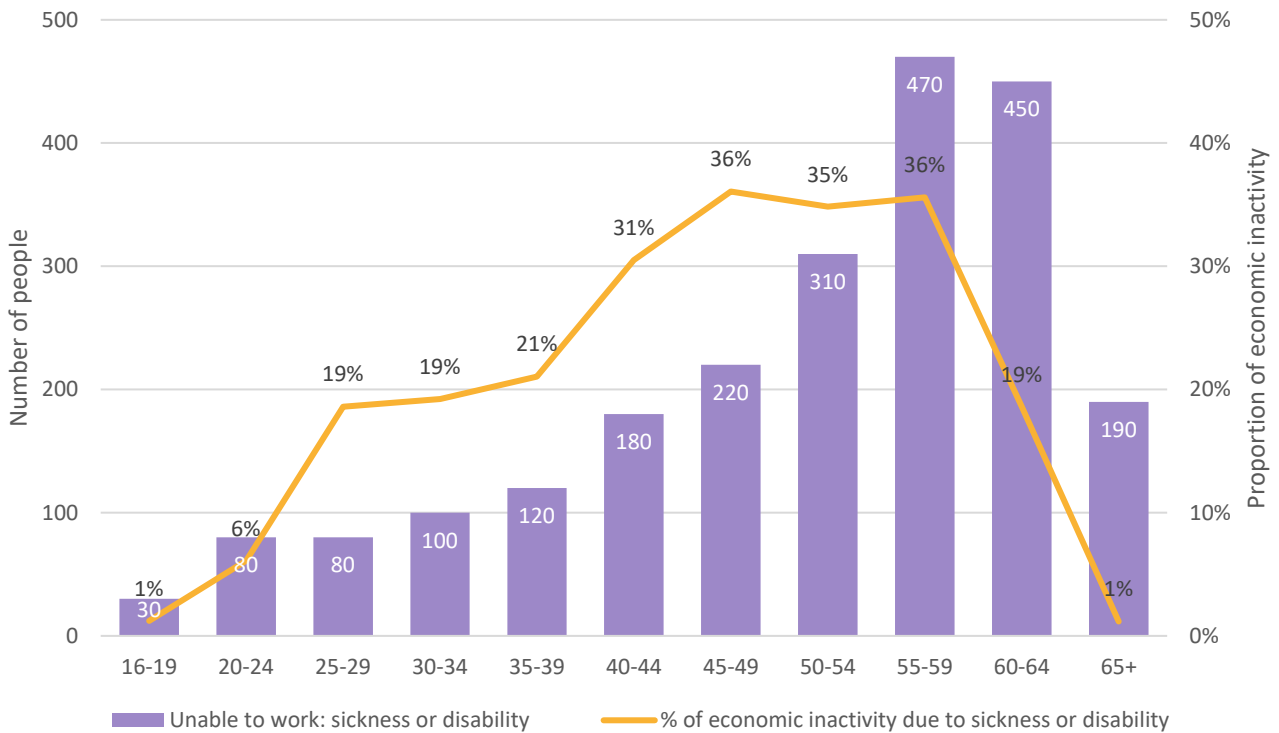
In 2023, there were 41,223 emergency department attendances, and 6,795 emergency admissions to Jersey General Hospital. Meanwhile, there were 47,656 outpatient referrals and 210,864 outpatient attendances. As at the end of December 2023, there was a waiting list of 13,640 outpatient appointments, 2,359 on the diagnostics waiting list and 2,812 on the elective waiting list.⁴⁶

In 2022, 2.28 million items were prescribed by GPs and Dentists, an increase of 28% over the last decade (1.78 million items dispensed in 2012). The total cost of prescribed items totalled £15.7 million in 2022, with an addition £7.8 million of pharmacy dispensing fees.¹⁸

3.6 Burden of ill-health on workforce

At the time of the 2021 Jersey Census, there were 2,220 adults (aged 16 and over) who were unable to work due to sickness or disability. This equates to around one in five (18%) of economically inactive working age adults being inactive due to their health, ranging from 1% of younger workers to over a third of older workers (Figure 29). Not all of these sickness or disability related absences will be preventable, but reducing the number of people affected by poor health will increase the number of people able to be economically active.⁷

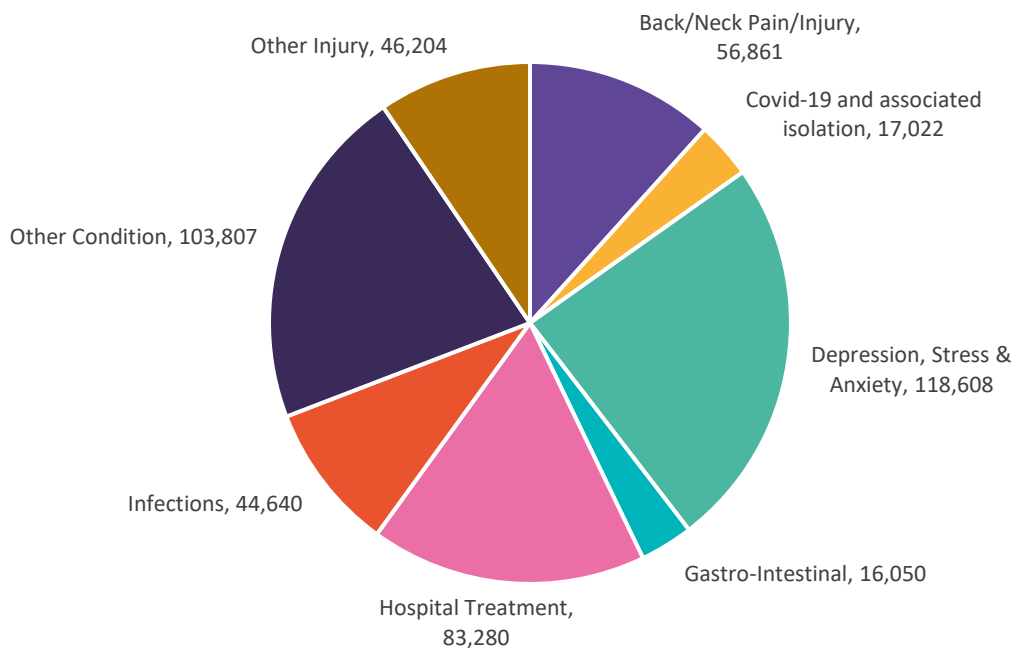
Figure 29: Number of adults unable to work due to sickness or disability and proportion of economic inactivity due to sickness/disability, by age group, 2021



Source: Census 2021⁷

In 2023, there were a total of 486,472 days lost due to sickness (as covered by short term incapacity allowance) for a total of 23,128 claims. The largest number of days was lost due to Depression, Stress and Anxiety (118,608 days), as shown in Figure 30.¹⁸

Figure 30: Number of days for which Short Term Incapacity Allowance was paid, by ailment type, 2023



Source: Customer and Local Services (Open Data)¹⁸

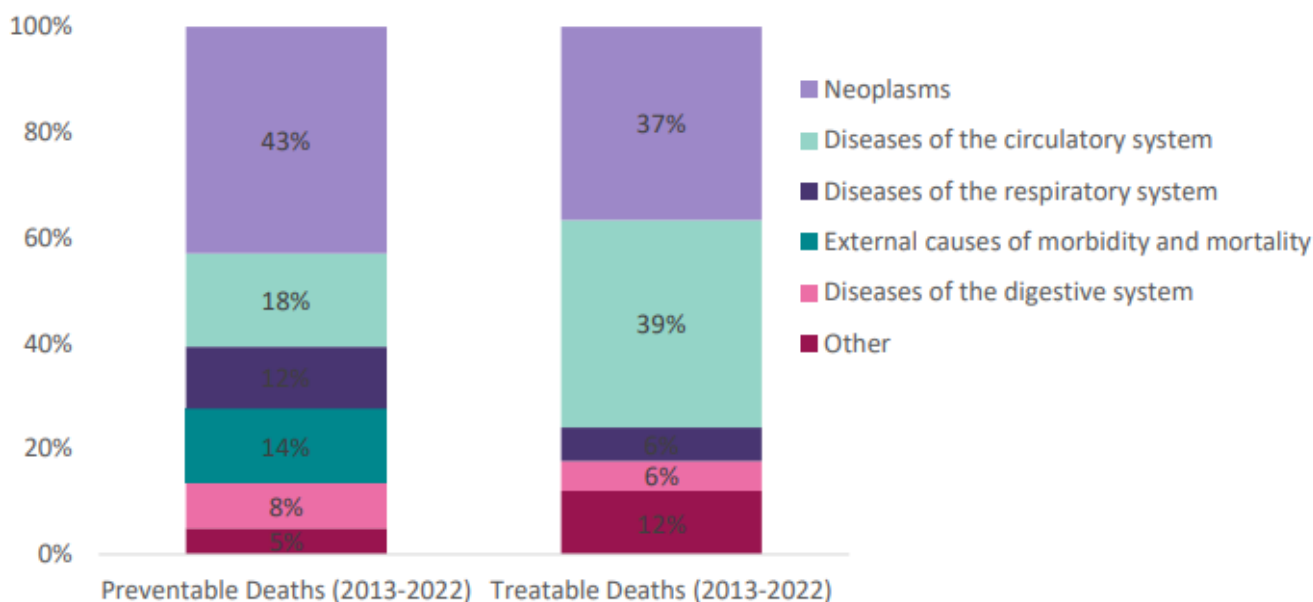
3.7 Preventable Deaths

There is a standard methodology which allows for the assessment of deaths which could be considered preventable. Preventable death include mortality from causes such as diabetes, infections for which there are routine vaccines available, cancers that can be prevented (like skin cancer and lung cancer), accidents and deaths related to substance misuse.

Using this definition, the Jersey data show that over 100 deaths per year would be considered preventable. Given that on average, there are around 800 deaths per year locally, around one in eight deaths could be prevented. Around two-fifths of preventable deaths are from cancer, with lung cancer being the largest individual cancer causing preventable deaths, followed by oesophageal and bladder cancers. Another fifth of preventable deaths are due to cardiovascular disease.⁴⁷

We can use similar methods to estimate what is known as treatable mortality. This describes deaths that could have been avoided through timely and effective healthcare. In 2022 there were 50 deaths from causes considered treatable to healthcare. Data for the last ten years shows that 39% of deaths falling under this definition were from diseases of the circulatory system, whilst cancers (neoplasms) account for another 37% (Figure 31).⁴⁷

Figure 31: Proportions of Preventable and Treatable deaths by cause (ICD-10 code chapter), over the last ten-year period (2013-2022)



Source: Public Health Intelligence Unit⁴⁷

3.8 Premature Deaths and Deaths of Working Age Individuals

One in three deaths (32% of all deaths in 2022) occur in those under the age of 75, this is deemed to be a ‘premature death’. With life expectancy at birth for Jersey residents now estimated to be well over 80 years of age, it’s easy to see how deaths before age 75 are premature. Cancer and heart disease are the leading causes of premature death in Jersey; much of which is preventable.⁴⁷

Another way to look at deaths data is to consider the number of deaths of people of working age (16-64 years). In 2022, there were 130 deaths among the working age population, 14% of the total number of deaths in that year. This means that one in seven deaths are of people who are likely to be economically active. Table 3.3 provides a breakdown of the causes of working age death in 2022.⁴⁷

Table 3.3: Main causes of working age deaths (aged 16-64 years), Jersey 2022

<i>Cause of death</i>	<i>Proportion</i>
<i>Neoplasms (cancers)</i>	44
<i>Diseases of the circulatory system</i>	18
<i>Diseases of the respiratory system</i>	9
<i>Diseases of the digestive system</i>	8
<i>External causes of morbidity and mortality</i>	7
<i>Other</i>	15

Source: Public Health Intelligence Unit⁴⁷

Over the last ten-year period (2013-2022), almost 1,300 deaths have occurred in those of working age. One way to assess the societal burden of these premature deaths – quite apart from the personal losses -, is to consider the number of years of working life (i.e. up to age 64) which have been lost because of that death. For the 130 deaths of working age individuals in 2022, around 1,590 years of working life were lost.⁴⁷

Over the last decade, deaths of working age
individuals have resulted in
15,200 years of lost working life.

3.9 Health burden of substance use

This section considers the impact of the use of substances such as tobacco, alcohol and drugs on the health of Islanders. Jersey has seen a dramatic change to the landscape of substance use over the last 50 or so years, but the legacy of duty-free tobacco and alcohol is still being seen in the health outcomes for Islanders.

In Jersey, alcohol use causes around 800 hospital admissions each year. A small number of these are for those aged under 18 (there were 51 admissions over the three years 2019-2021). Over a three-year period, around 30 to 35 deaths are caused by alcohol (depending on the measure considered) in Jersey.¹⁴

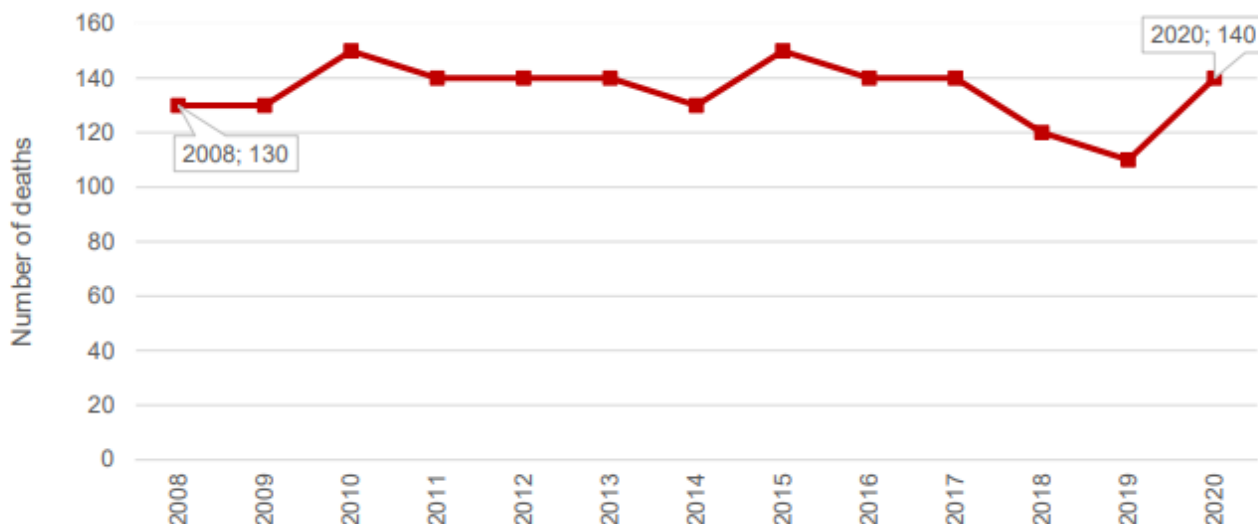
The Drug and Alcohol Service saw around 370 people referred for problems related to alcohol in 2022, with another 100 referrals for other substances.¹⁴ Other data related to drug related harm, shows that the total number of drug-related deaths in Jersey during the period 2019-2022 (rounded to the nearest 5) was 20.⁴⁸

By far the greatest impact from substance use is the impact of tobacco on the health of Islanders. The latest data shows that around 4% of hospital admissions (1,120 episodes) and one in five (19%) of all deaths in those aged 35 and over is related to smoking each year.¹⁵

In total, there were
1,760 deaths
due to smoking between 2008-2020

Despite a decrease in the prevalence of smoking, there is yet to be a significant and sustained reduction in the number of deaths due to smoking (Figure 32).¹⁵

Figure 32: Number of deaths among adults aged 35 and over in Jersey which were attributable to smoking, 2008 to 2020



Source: Public Health Intelligence Unit¹⁵

3.10 Summary

This section summarises the impact this poor health has on our Island, in terms of medical appointments, hospital admissions, sickness absence and loss of life. Much of this illness is preventable. The costs of this preventable illness are not only borne by the individuals and their close relatives and friends, but also in lost opportunities to contribute to society. The next section examines how this health burden is not shared equally among Islanders but tends to fall more heavily on those with fewer resources.

Unequal health

4 Unequal health

The burden of ill health is not felt equally by all Islanders. We know from elsewhere that people with fewer resources tend to have poorer health.⁴⁹ In this chapter, because of the link between wealth and health, we explore differences in income and wealth between different kinds of households and by ethnicity in Jersey. We also look at differences in health between communities, where we have the information to do this.

4.1 Income variation

An average (mean) Jersey household income was £930 per week after housing costs in 2021/2022.⁵⁰ Half (49%) of equivalised household incomeⁱ after housing costs went to households in the top 20% of the income distribution, compared to 5% going to households in the bottoms 20%.⁵⁰ This shows the variation in income distribution across households in Jersey.

The latest household income distribution survey found that one in five (21%) of individuals were living with relative low income (RLI), defined as household income below 60% of medium equivalised income (£520 per week before housing costs and £430 per week after housing costs). One in four (24%) of children were found to be living in relative low income households, whilst one in four pensioners (28%) were in relative low income.⁵⁰

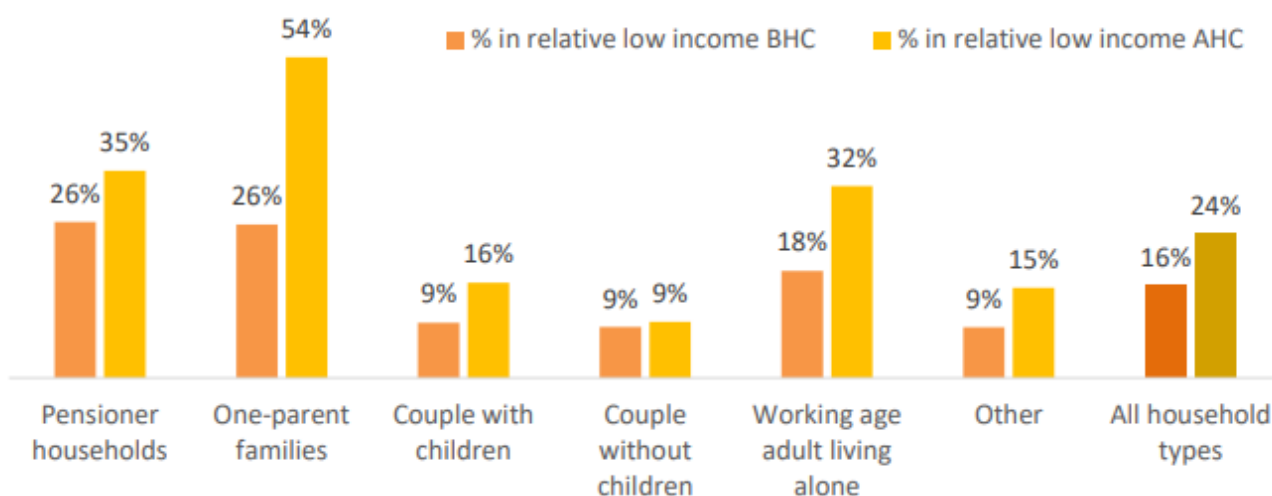
Table 4.1: Percent and count of individuals in relative low income before and after housing costs, 2021/2022

	Before housing costs		After housing costs	
	%	persons	%	persons
Children	15	2,500	24	4,000
Working-age adults	10	7,000	18	12,200
Pensioners	23	4,200	28	5,200
All individuals	14	14,000	21	21,600

Source: Statistics Jersey, Household income distribution survey 2021/2022⁵⁰

There is variation in the distribution of relative low income by household composition, with around 9% of couples without children meeting the definition after housing costs, compared to over half (54%) of one-parent households (Figure 33).⁵⁰

Figure 33: Proportion of each household type in relative low income before and after housing costs, 2021/2022

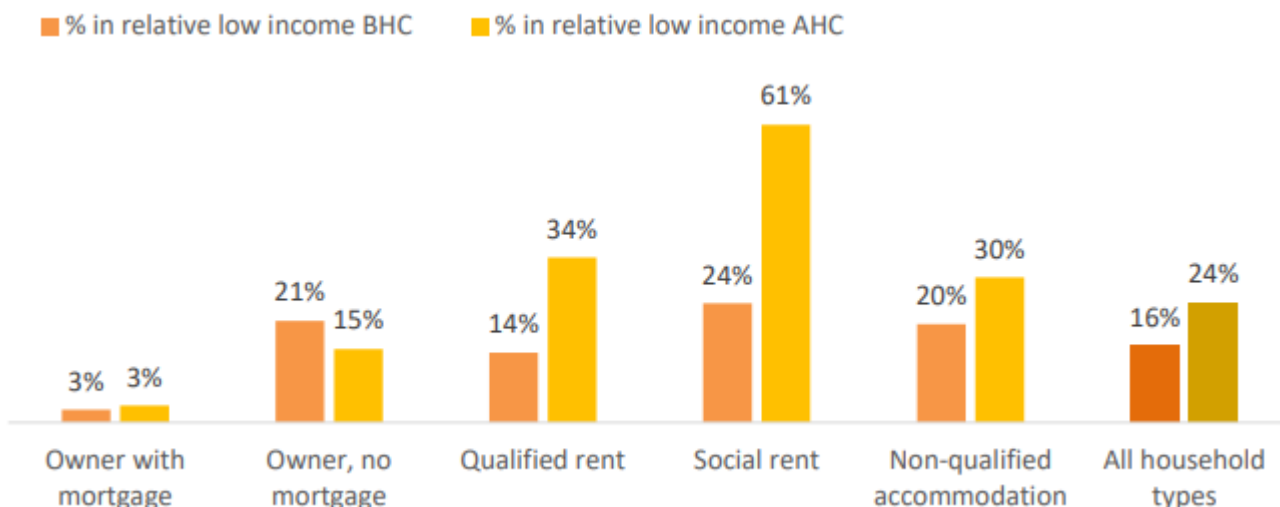


Source: Statistics Jersey, Household income distribution survey 2021/2022⁵⁰

ⁱ Equivalised income takes into account differences in the number of people living in a house, and their age. This means we can compare the household income of an elderly person living alone with the household income of a family of four with two young children, for example.

This variation was also seen for housing tenure, with around 3% of owners with a mortgage in relative low income after housing costs, compared to 61% of those in social rental housing (Figure 34).⁵⁰

Figure 34: Proportion of each household tenure in relative low income before and after housing costs, 2021/2022



Source: Statistics Jersey, Household income distribution survey 2021/2022⁵⁰

The report found that income inequality has increased over the last decade, that is the distribution of household income has become more unequal, particularly after housing costs are included.

- The 90-10 ratio of equivalised net income after housing costs, which measures the income of the 90th percentile over the income of the 10th percentile, has increased from 4.8 in 2009/2010, to 6.0 in 2014/2015, and to 6.6 in 2021/2022
- The Gini coefficientⁱⁱ for net income after housing costs, where 0 is complete equality and 1 is complete inequality, increased from 0.39 in 2009/2010, to 0.41 in 2014/2015, to 0.43 in 2021/2022. In other words, Jersey has become more unequal since 2009/10.

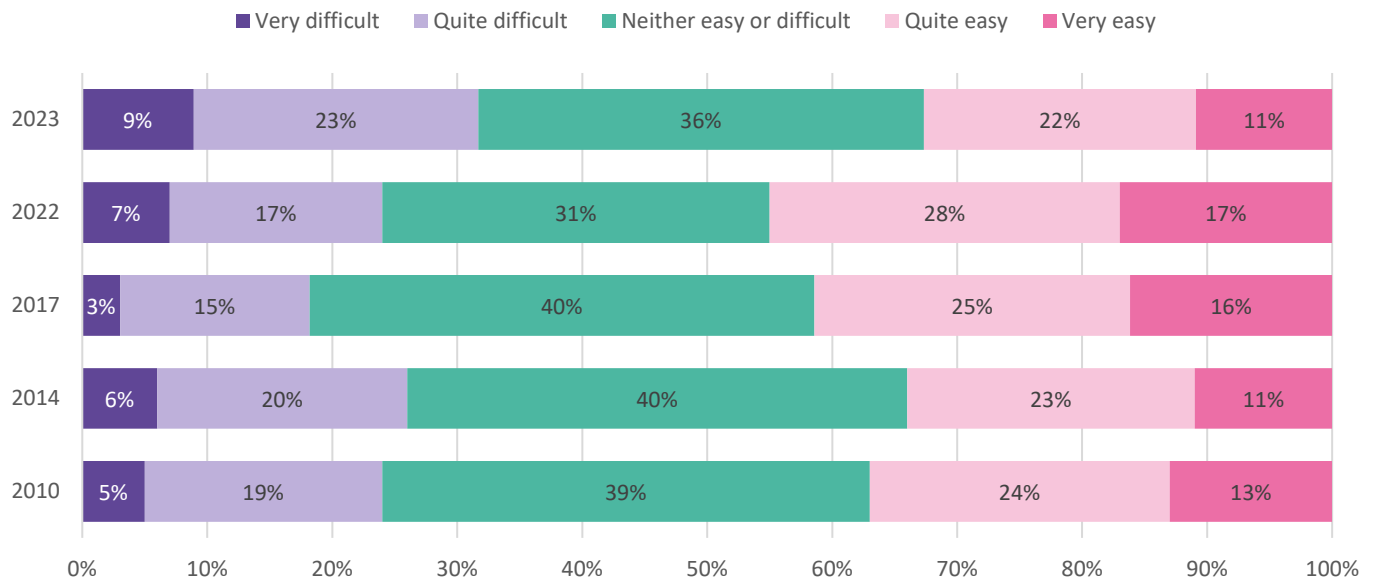
Jersey had higher income inequality than the UK, particularly after housing costs were accounted for, with a 90-10 ratio of 6.6 compared to 4.9 in the UK. The Gini coefficient was 5 percentage points higher for Jersey than the UK.⁵⁰

4.2 Money-matters

The variation in income can affect how easy or difficult Islanders find it to cope financially. A recent review showed “financial stress and precarity can negatively affect physical health by increasing stress levels and limiting health-supporting activities, including access to health services.¹¹ The Jersey Opinions and Lifestyle Survey (2023) found that almost a third (31%) of households reported having difficulty coping financially in 2023 (Figure 35), an increase from a quarter (24%) in 2022.⁵¹

ⁱⁱ The Gini Coefficient measures the relative difference in income between rich and poor. It is important because countries with a lower Gini Coefficient (i.e. less inequality) tend to have healthier populations.

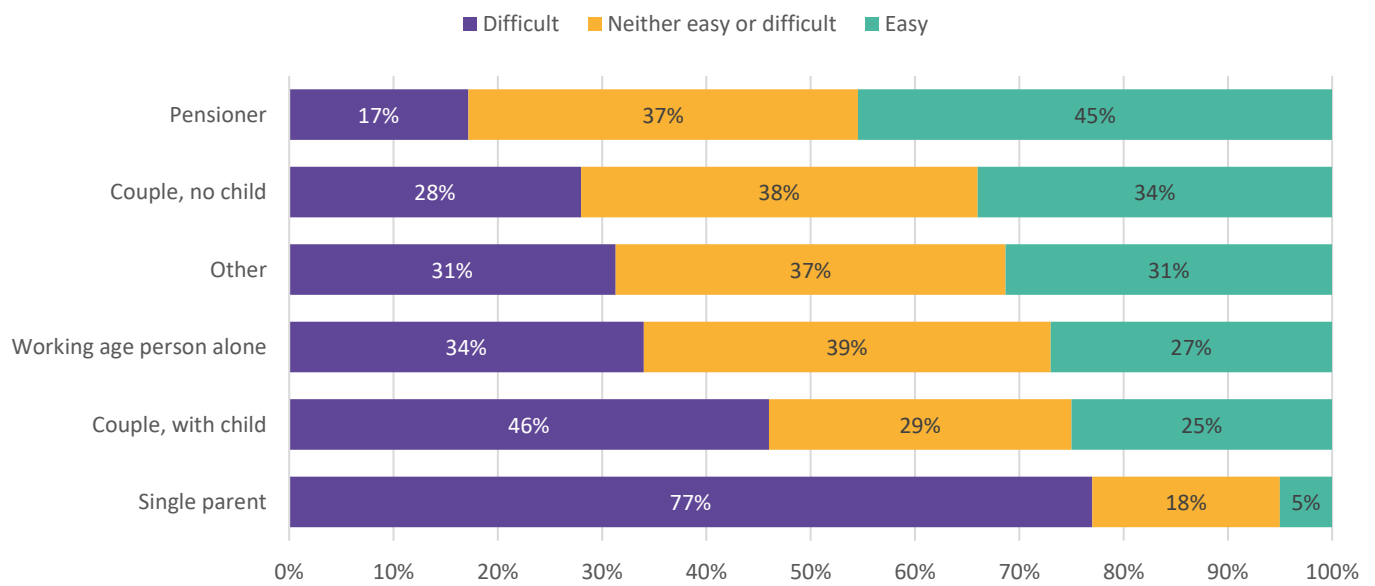
Figure 35: Proportion of households that find it easy or difficult to cope financially, by year



Source: Statistics Jersey, Jersey Opinions and Lifestyle Survey 2023⁵¹

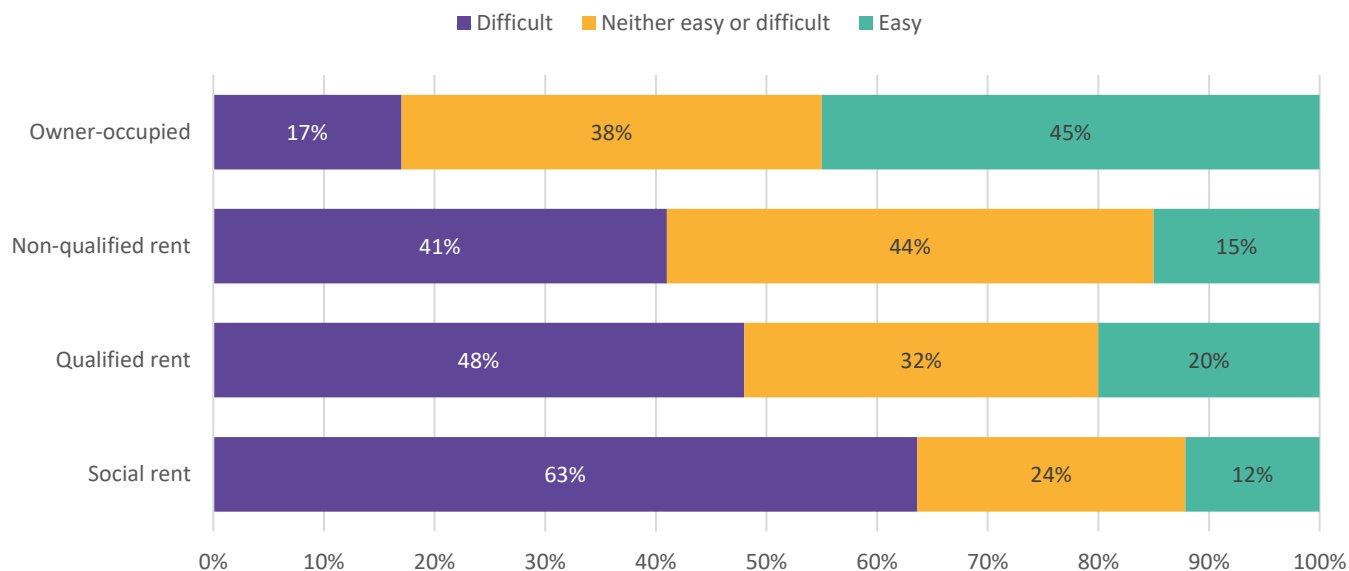
Echoing the results of the household income distribution survey (see above), social renters and single parent families were more likely to report finding it difficult to cope financially.⁵¹

Figure 36: Proportion of households that find it easy or difficult to cope financially, by household type, 2023



Source: Statistics Jersey, Jersey Opinions and Lifestyle Survey 2023⁵¹

Figure 37: Proportion of households that find it easy or difficult to cope financially, by tenure, 2023

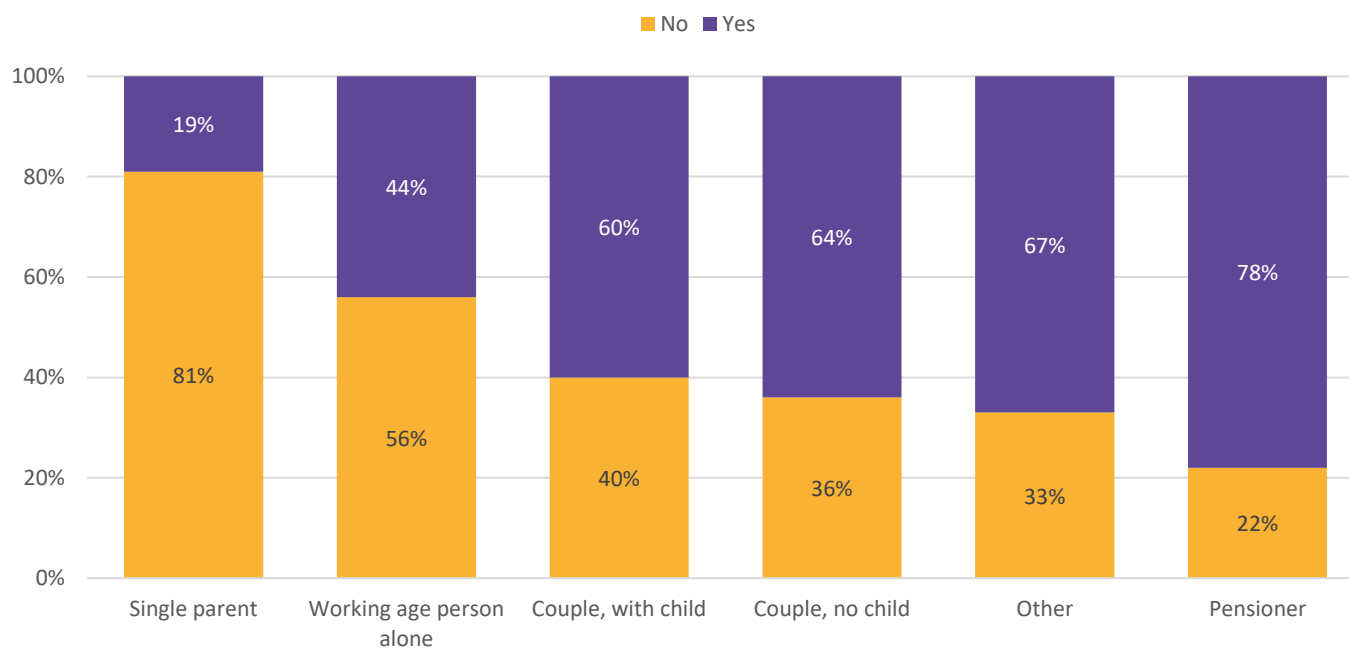


Source: Statistics Jersey, Jersey Opinions and Lifestyle Survey 2023⁵¹

Variation was also seen across different ethnic groups, with over half of Portuguese (52%) and Polish (54%) finding it difficult to cope financially compared to around a quarter (27%) of British households.⁵¹

Unexpected but necessary expenses, such as replacing a washing machine or having to travel off-Island to care for a family member, can all put additional financial stress on households struggling to cope financially. Again, variations were seen across different groups of Islanders, with three quarters (75%) of those in social rental accommodation saying that could not afford an unexpected but necessary, household expense of £1,250 compared to less than one in five (18%) of those in owner-occupied accommodation. Overall, one in three Islanders (36%) reported not being able to afford such an expense.⁵¹

Figure 38: Could your household afford an unexpected, but necessary, expense of £1,250, by household type, 2023



Source: Statistics Jersey, Jersey Opinions and Lifestyle Survey 2023⁵¹

The survey found that overall, a third (35%) of households had gone without at least one essential item because of a shortage of money over the last 12 months, including:

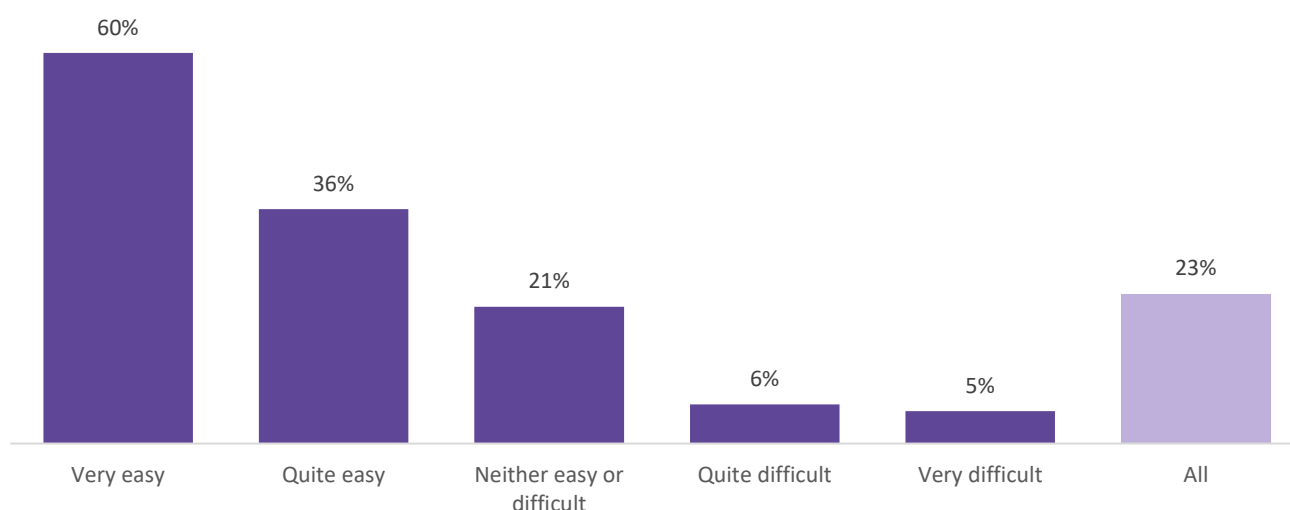
- Almost a quarter (23%) of households going without enough heating to keep their home warm
- 25% going without new clothes for adults
- 20% going without eating meat, chicken or fish every second day
- 14% without new clothes for children
- 13% without a cooked main meal each day

Over half (58%) of adults said that the cost of an adult dentist appointment stopped them from attending, whilst 46% reported the cost of other health professional appointments stopped them from attending. A similar proportion, 45% of adults, reported that the cost of an optician would stop them from going in 2023.⁵¹

Although not reported in the survey report, it can be assumed that those households who report struggling to cope financially are those who are going without essential everyday items and finding the cost of healthcare appointments prohibitive to them attending, thereby affecting their health and wellbeing.

Those struggling to cope financially were less likely to report having a good private (non-workplace) pension or other income for their retirement compared to those who found it easy to cope financially, and this has implications for their future wellbeing.⁵¹ This will be explored further in the next chapter.

Figure 39: Proportion of adults who agree they have a good private (non-workplace) pension or other income for their retirement, by how well they cope financially, 2023



Source: Statistics Jersey, Jersey Opinions and Lifestyle Survey 2023⁵¹

4.3 Household spending on health

The latest Jersey Living Costs Survey 2021/2022 revealed that the average total expending of Jersey households was £901 per week, with £33 (or 4 per cent) being spent on health. Of this spend on health, more than a third (£12 per week) was spent on dentists and a fifth (£6 per week) on doctors' fees. Meanwhile, the average household spent £18 on alcoholic drinks and tobacco per week.⁵²

The averages, however, hide differences in spending by household income, tenure and household composition as shown in the tables below.

Table 4.2: Average weekly household spending on health by equivalised income quintile, £ per week

Equivalised income quintile group	Lowest	Second	Middle	Fourth	Highest	All
Health	24.50	29.40	30.90	32.70	47.00	32.80
Pharmacy & other medical products	7.50	9.00	8.70	8.80	13.20	9.40
Doctors	5.40	7.10	5.40	7.00	7.10	6.40
Dentists	8.80	9.60	11.70	11.60	17.20	11.80
Opticians	0.70	0.70	0.60	0.70	1.20	0.80
Other medical related services (inc. hospital)	2.00	3.00	4.40	4.60	8.20	4.40
Total expenditure	464.70	643.30	775.90	1,003.00	1,640.50	900.80
Percentage of average weekly household spend spent on Health	5	5	4	3	3	4

Source: Statistics Jersey, Household spending 2021/2022⁵²

Table 4.3: Average weekly household spending on health by tenure, £ per week

Tenure	Without mortgage	With mortgage	Qualified rental	Social rental	Non-qualified accom.	All
Health	49.60	36.10	24.70	17.40	13.60	32.80
Pharmacy & other medical products	12.70	10.10	8.40	7.10	3.30	9.40
Doctors	8.60	6.40	6.00	4.80	2.70	6.40
Dentists	18.90	14.20	7.20	3.60	6.20	11.80
Opticians	0.80	1.10	0.50	1.00	0.50	0.80
Other medical related services (inc. hospital)	8.60	4.30	2.60	0.90	0.90	4.40
Total expenditure	755.70	1,457.00	920.50	435.50	535.70	900.80
Percentage of average weekly household spend spent on Health	7	2	3	4	3	4

Source: Statistics Jersey, Household spending 2021/2022⁵²

Owner occupiers without a mortgage spent the greatest amount on health, reflecting the older demographic of households owning their home outright. Whereas those in social rental accommodation spent the least on dentists.

Table 4.4: Average weekly household spending on health by household composition, £ per week

Household composition	Couple (both not pensioners)	Couple with at least one dependent child	Single parent at least one dependent child	Person living alone (not pensioner)	Person living alone (pensioner)	Couple – both pensioners	Other
Health	30.30	34.30	25.60	16.30	28.00	57.20	40.60
Pharmacy & other medical products	11.30	9.60	5.70	4.60	8.60	12.70	12.10
Doctors	6.30	6.40	4.60	3.90	6.00	8.50	8.70
Dentists	7.90	14.90	12.30	5.30	9.20	24.30	12.40
Opticians	0.90	0.90	0.70	0.40	0.80	1.30	0.60
Other medical related services (inc. hospital)	4.00	2.40	2.20	2.10	3.40	10.40	6.80
Total expenditure	1,148.00	1,365.20	746.90	569.20	423.20	741.90	1,066.30
Percentage of average weekly household spend spent on Health	3	3	3	3	7	8	4

Source: Statistics Jersey, Household spending 2021/2022⁵²

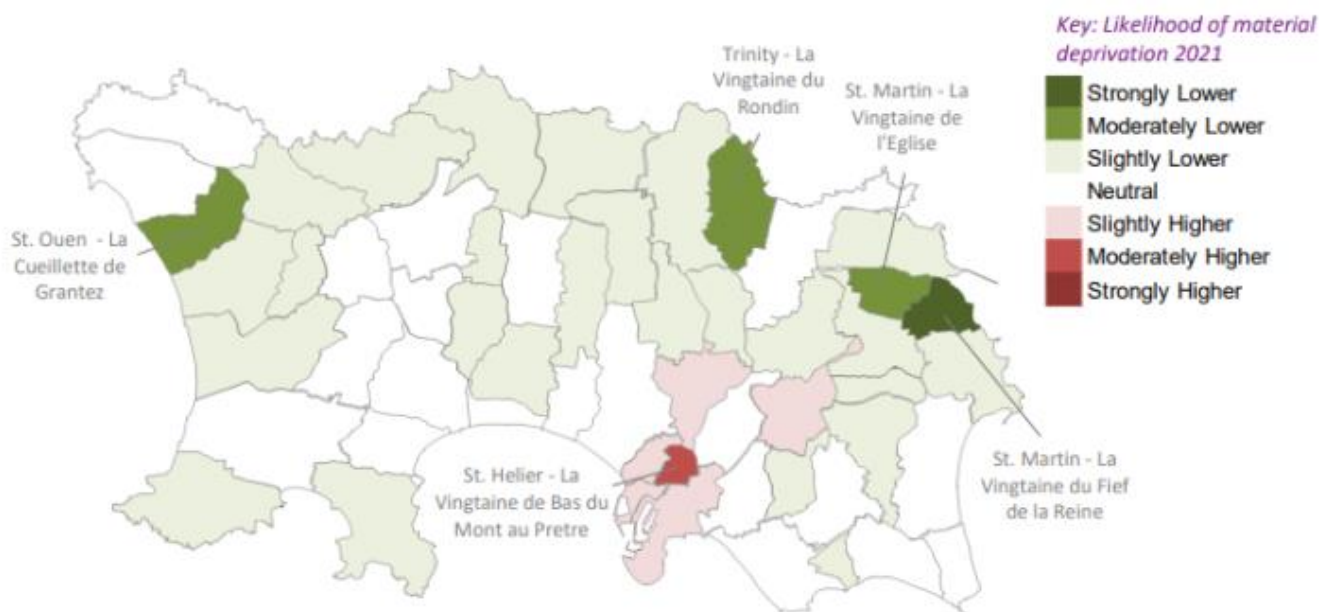
Comparing household spending on health in Jersey with that in the UK, shows that the greatest relative differences for expenditure were on Health and Education, with Jersey households spending, on average around three to four times more on these groups than households in the UK (£33 in Jersey on health, compared to £9 in the UK).⁵²

4.4 Deprivation

Measuring resources at an area level (for example, a vingtaine) rather than for individuals or households is possible from census and administrative data and from measures of deprivation which help us understand variation between different places. They are useful in looking at population health because of the well-established links between deprivation and health. People living in areas of higher deprivation tend to have poorer health for a wide range of reasons such as poorer access to good housing, education, nutritious food, green spaces, and healthcare.^{3, 49}

Using data from the 2021 census, Statistics Jersey created a component index of deprivation for parish vintaines in the Island using 10 indicators derived from census data.⁵³ Two combined indices were produced: one including the pensioners indicator, and one excluding it; each has value depending on the purpose. These combined indices allow for a comparison of potential deprivation between vintaines, giving an indication of which areas are more or less likely to be deprived.

Figure 40: combined index of deprivation (including pensioners indicator), 2021



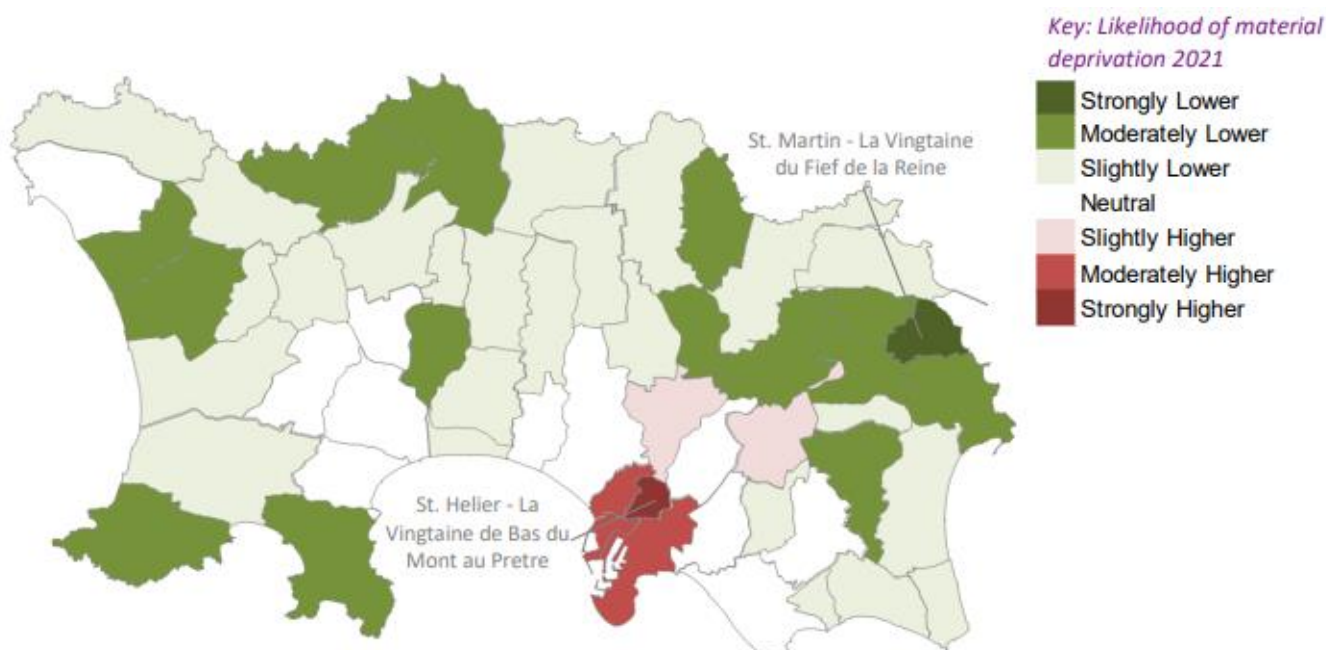
Source: Statistics Jersey, Indicators of Deprivation by Parish Vingtaines⁵³

In 2021, the combined index suggests that La Vingtaine de Bas du Mont au Pretre was more likely to be materially deprived. La Vingtaine du Fief de la Reine in St. Martin along with three other vingtaines were less likely to be materially deprived.⁵³

For some purposes, the proportion of pensioners would not be considered an indicator of deprivation (for example when specifically focussing on proportion of households with children that might be materially deprived), therefore a version excluding this indicator is shown.

In 2021, all four vingtaines around the centre of St. Helier were more likely to be materially deprived (when excluding the pensioners indicator) than the rest of the Island. La Vingtaine du Fief de la Reine in St. Martin was less likely to be materially deprived than other vingtaines when the pensioners indicator is excluded.⁵³

Figure 41: combined index of deprivation (excluding pensioners indicator), 2021



Source: Statistics Jersey, Indicators of Deprivation by Parish Vingtaines⁵³

Work is ongoing to assess the suitability of the indicators included in the component deprivation index for measuring material deprivation in an Island context; for example, for someone living in St Helier, not having a car may be a choice due to lack of need rather than an indicator of lacking resources. It is hoped that an index of multiple

deprivation can be created for Jersey which measures all components of deprivation that affect Islanders and can be more regularly updated from administrative data to provide better timeliness of data in the future.

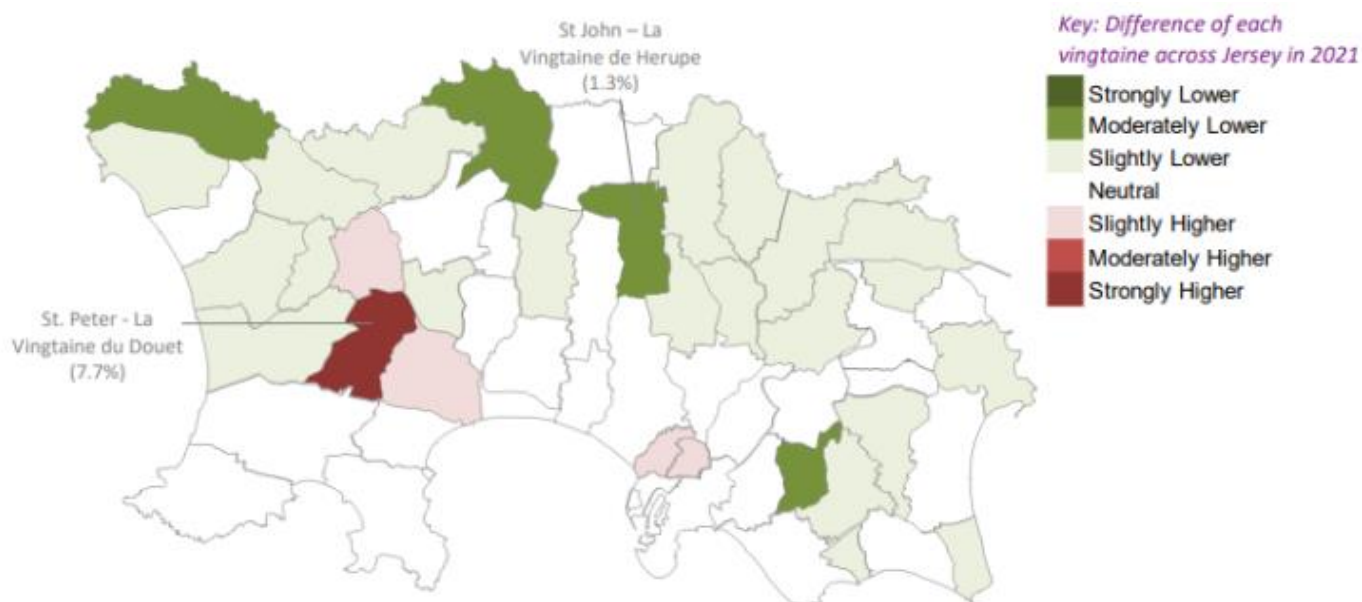
4.5 Variation in health outcomes

So far, this chapter has explored the data showing differences between Islanders in the distribution of income, coping financially, expenditure on health activities and how deprivation might be distributed across the Island. How does this affect the health and health behaviours of Islanders? This next section explores the data currently available that shows the burden of ill health is not borne equally across the population.

4.5.1 Self-reported health and long-standing illness

In 2021, across the whole of Jersey, around one in twenty-five (4.1%) people self-reported having poor or very poor health. This proportion varied across vingtaines, from around one in a hundred (1.3%) people living in La Vingtaine de Herupe in St. John, to one in thirteen (7.7%) people in La Vingtaine du Douet, St. Peter. Four vingtaines had moderately lower proportions of people with poor health than the proportions seen across all Jersey vingtaines. La Vingtaine du Douet in St. Peter had a strongly higher proportion of people with poorer health.⁵³

Figure 42: Self-reported poor health, by parish vingtaine, 2021



Source: Statistics Jersey, Indicators of Deprivation by Parish Vingtaines⁵³

More recently, the Jersey Opinions and Lifestyle Survey (2023) found that the proportion of adults describing their health as ‘Good’ or ‘Very good’ generally declined with age, whilst the proportion of those reporting longstanding physical or mental health conditions or illnesses increased with age. The report also found that the proportion of adults reporting their health as ‘Good’ or ‘Very good’ increased with household income; 54% of adults living in households earning less than £20,000 a year reported their health as ‘Good’ or ‘Very good’ compared to 89% of those with an annual household income of £80,000 or more.⁵¹

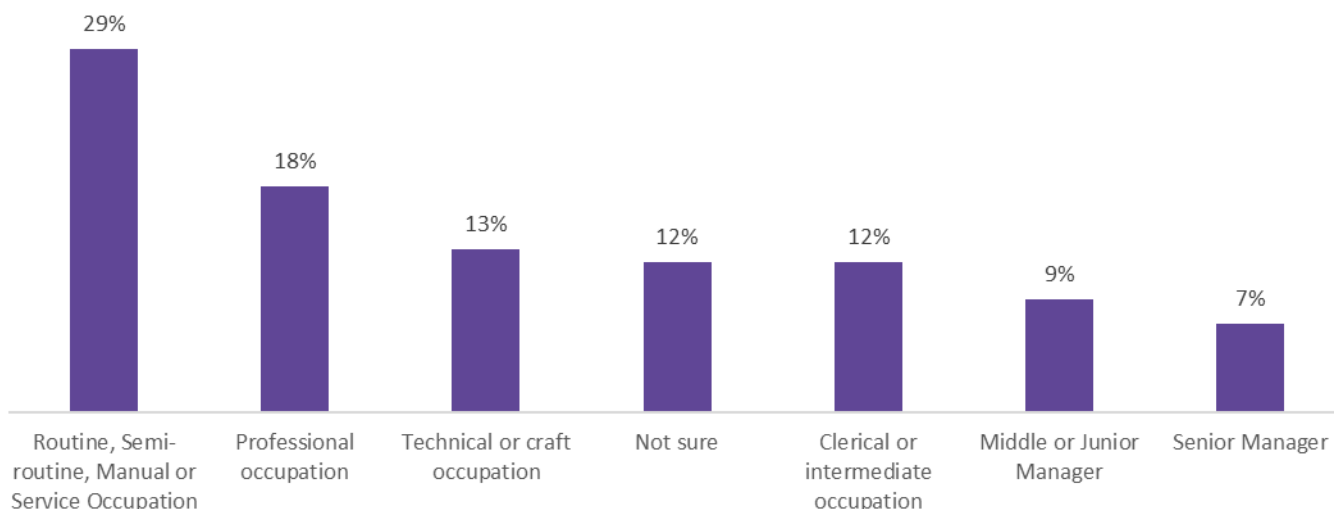
4.5.2 Smoking

Smoking harms health: 50% of smokers will die of smoking-related disease.⁵⁴

Over the last decade, Jersey has seen a reduction in the overall proportion of adults who smoke (daily or occasionally); down from 22% in 2013 to around one in seven (15%) in 2023. There is a definite socio-economic correlation with smoking, as demonstrated in the most recent Smoking Profile (2021).¹⁵ The report found that in 2021, the highest proportions of daily smoking were among people working in manual and routine professions,

where 29% smoked daily. Of those working in managerial and professional occupations 18% smoke daily, while 13% of those working in technical or craft occupations reported daily smoking (Figure 43).¹⁵

Figure 43: Prevalence of smoking, by profession, 2021



Source: Public Health Intelligence, Smoking Profile 2021¹⁵

One in five (19%) of those living in social housing, one in six (16%) of those living in non-qualified accommodation and one in seven in qualified rental accommodation (14%) reported smoking daily, this compared to around one in twenty (4%) of those in owner-occupied accommodation. There was a significantly higher proportion of current smokers (daily or occasional) in social rented accommodation (29%) than owner-occupied accommodation (6%).¹⁵

There was also variation seen in smoking prevalence amongst children and young people, with around one in seven children at fee-paying schools reporting they had smoked at least once, compared to one in five in non-fee paying schools in 2021.¹⁵

4.5.3 Diet

After smoking, the quality of the food we eat has the biggest impact on health.⁵⁵

We can see that diet varies by how well people are coping financially, and by ethnicity. The Jersey Opinions and Lifestyle Survey (2023) asked how many portions of fruit and vegetables respondents had eaten the previous day. On average, 32% of people ate five or more portions a day, but this varies by financial status; less than a quarter (23%) of those who found it very difficult to cope financially ate the recommended daily minimum portion of fruit and vegetables compared to over four in ten (43%) of those who found it very easy to cope financially. There were also some differences in response to this question between ethnic groups, with only one in five (20%) of those of Portuguese or Madeiran ethnicity eating the recommended minimum number of portions compared to over a third (36%) of those classifying themselves to be of Jersey ethnicity.⁵¹

As mentioned in the money matters section, there was evidence of some Islanders going without everyday essential items because of a shortage of money over the last 12 months. This has an impact on diet - 20% reported going without eating meat, chicken or fish every second day and 13% without a cooked main meal each day.⁵¹

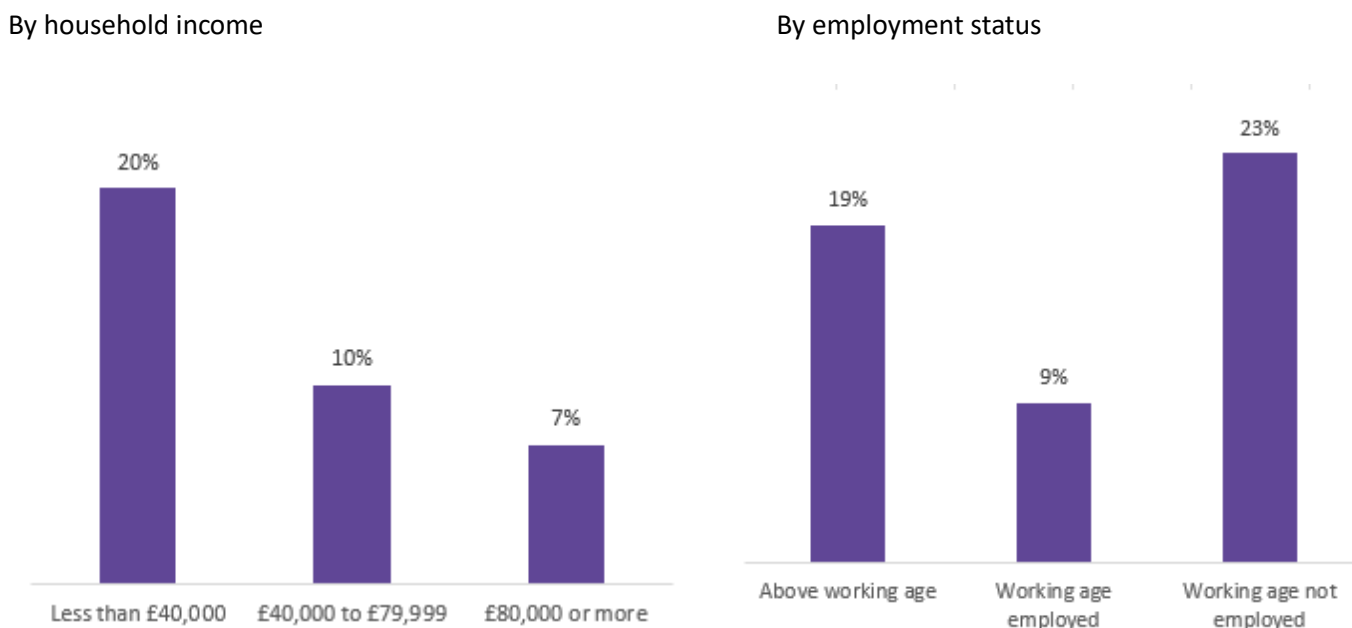
4.5.4 Alcohol

The most up to date research shows that the more we drink, the worse our health tends to be.⁵⁶ In fact, the WHO recently stated that there is no safe amount of alcohol consumption that does not affect health.⁵⁷

Jersey has a relatively high level of alcohol consumption, as demonstrated in the latest Alcohol Profile (2022).¹⁴ Alcohol consumption is a causal factor in more than 200 diseases, injuries and other health conditions. Interestingly,

alcohol consumption doesn't follow the same socio-economic gradient seen for other health-related behaviours like smoking. For instance, in Jersey, levels of teetotalism were higher in lower income households and those of working age who were unemployed (Figure 44).¹⁴

Figure 44: Percentage of adults that reported NEVER drinking alcohol, by household income and employment status



Source: Public Health Intelligence, Alcohol Profile 2022¹⁴

Levels of binge drinkingⁱⁱⁱ were assessed in the latest alcohol profile which found:

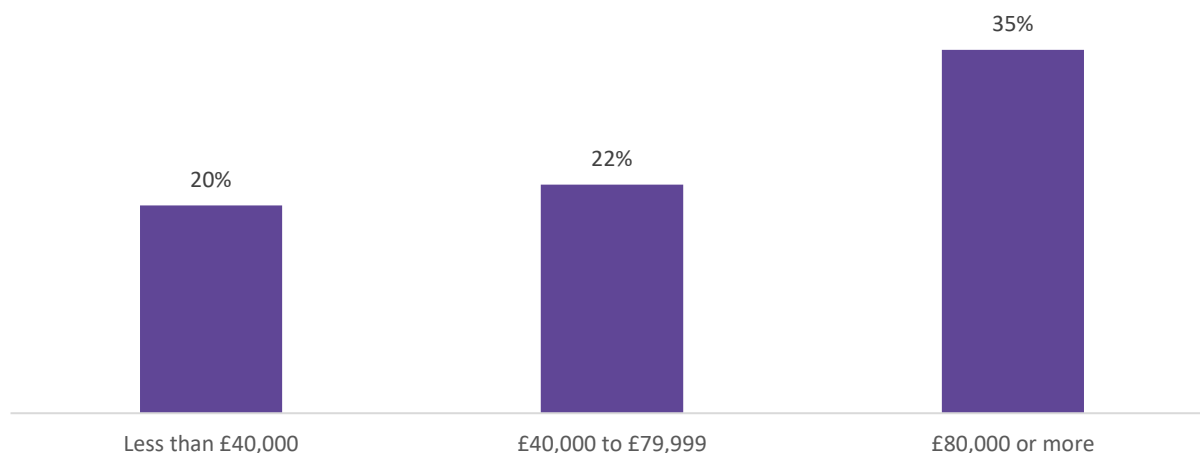
- females, those on low incomes, those on social rent, and those above working age were **less likely** to report binge drinking
- males, those with higher household incomes (more than £80,000 per year), those living in non-qualified dwelling (people with registered status), and employed people of working age were **more likely** to report binge drinking¹⁴

The report also included an assessment of harmful and hazardous drinking, defined using the NHS Health Development Agency's FAST screening test. A quarter (25%) of respondents to the 2022 Jersey Opinion and Lifestyle survey had a FAST score which indicated drinking at a level hazardous or harmful to their health. Levels of hazardous and harmful drinking were higher in higher income groups (Figure 45).¹⁴

ⁱⁱⁱ The UK Office for National Statistics (ONS) defines binge drinking as:

- males who drink more than 8 units on one day (around four pints of normal strength beer or three quarters of a bottle of wine)
- females who drink 6 units or more on one day (around three pints of normal strength beer or two large glasses of wine)

Figure 45: Percentage of adults with a FAST score indicating drinking at harmful or hazardous levels, by household income



Source: Public Health Intelligence, Alcohol Profile 2022¹⁴

4.5.5 Exercise

Meeting the recommended levels of physical activity^{iv} has many health benefits, both physical and mental.⁵⁸ However, not everyone meets these recommended levels and there is significant variation across different groups. As might be expected, those who report having very good health were more likely to meet the recommend levels (74%) compared to those with very bad health (7%), according to the latest Jersey Opinions and Lifestyle Survey (2023). More surprising is the variation by household income (Figure 46). This shows a clear socio-economic gradient for meeting the recommend level of physical activity, with those with higher incomes being more active.⁵¹

Figure 46: Proportion of adults who meet the recommended weekly time of physical activity, by household income



Source: Statistics Jersey, Jersey Opinions and Lifestyle Survey 2023⁵¹

^{iv} Physical activity guidelines (Office for Health Improvement and Disparities and NHS) indicate that adults aged 19 and over should aim for at least:

- 150 minutes of moderate aerobic activity (such as cycling or walking) in bouts of 10 minutes or more, each week or
- 75 minutes of vigorous aerobic physical activity (such as running or a game of singles tennis) each week or
- a mixture of moderate and vigorous aerobic activity which equates to 150 minutes of moderate intensity activity (a general rule of thumb is that 1 minute of vigorous activity provides the same health benefits as 2 minutes of moderate intensity activity)

4.5.6 Obesity

Excess body weight (obesity) increases the risk of long-term illnesses that are common in Jersey, such as high blood pressure, diabetes, and some cancers. It is also associated with poorer mental health.⁵⁹

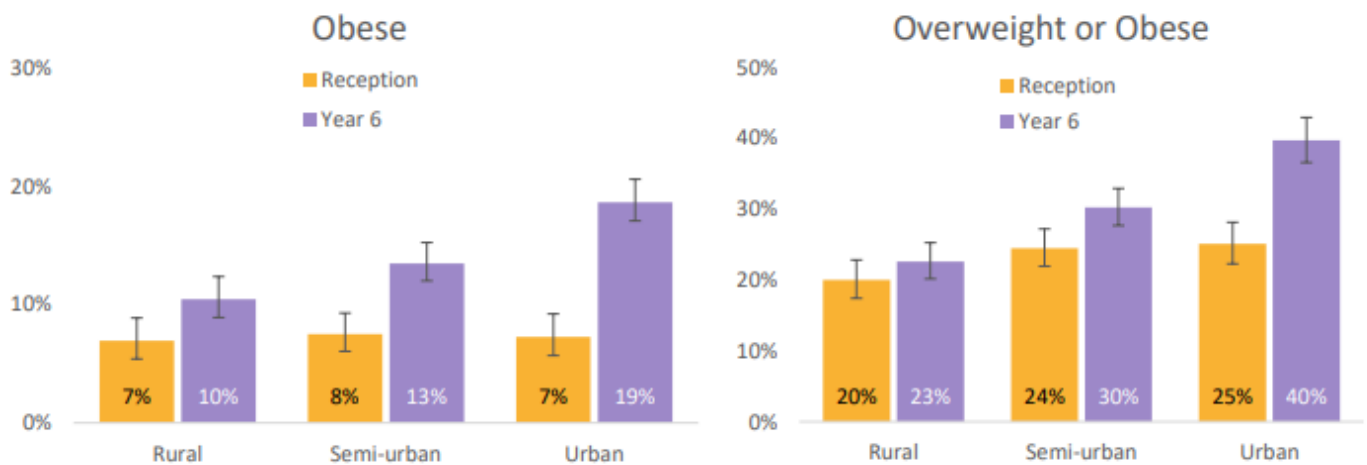
There are currently 11,635 adults who are classified as obese by their GP and appear on the JQIF obesity register. The multimorbidity report shows that a large proportion of these also have other long-term conditions such as diabetes or high blood pressure.⁵

The Jersey Opinions and Lifestyle Survey (2023) uses a calculation of Body Mass Index (BMI) from self-reported height and weight measurements to monitor the weight of Islanders.^v The latest report found that since 2008 the proportion of adults classified as normal weight has decreased from 53% to 44%, whilst the proportion classified as obese, very obese or morbidly obese has increased from 12% to 21%. A third (33%) of adults were in BMI category overweight, and one fifth (21%) were obese, very obese or morbidly obese in 2023. Variations were reported for age group and by whether the respondent met the recommended level of physical activity.⁵¹

The Jersey Child Measurement Programme monitors the weight of children in Reception (4 to 5-year-olds) and Year 6 (10 to 11-year-olds). The latest report on the programme found that one in five children in Reception (20%) was overweight or obese, whilst around three in ten children in Year 6 (29%) were overweight or obese.¹⁶

Significant variation was seen depending on where children lived, with children living in rural areas in Year 6 being less likely to be overweight or obese than those living in urban areas (Figure 47).¹⁶

Figure 47: BMI classifications by parish type, Jersey, 2021-2023 (three-year average), based on parish of child

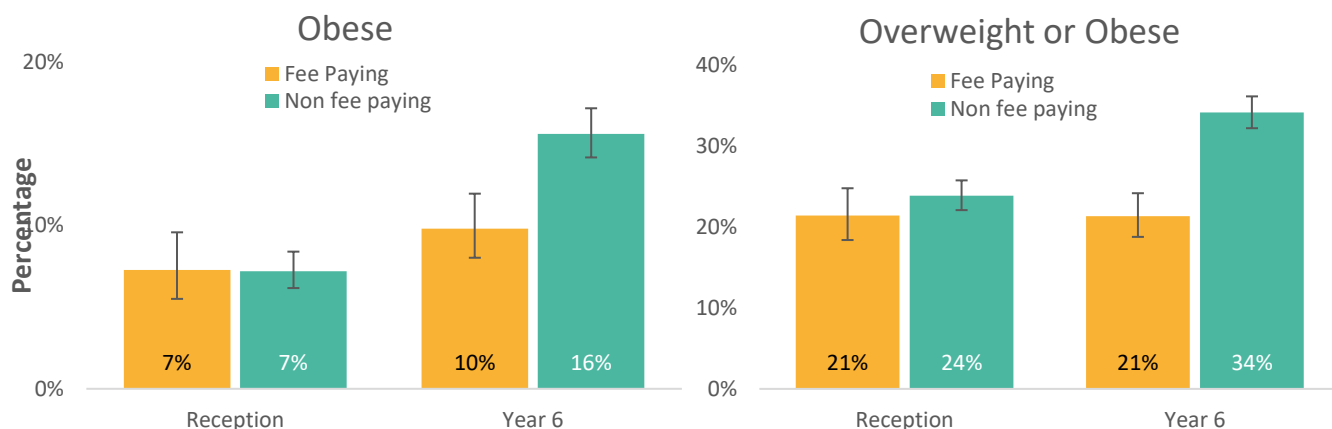


Source: Public Health Intelligence, Jersey Child Measurement Programme 2023/2024¹⁶

Over a three-year-period, a similar proportion of children who attended non-fee-paying schools in Reception were overweight or obese (24% of children) compared to those who attended fee-paying schools (21%); in contrast, a higher proportion of children who attended non-fee-paying schools in Year 6 were overweight or obese (34%) compared to those attending fee-paying schools (21%) (Figure 48).¹⁶

^v Self-reported height and weight tends to underestimate obesity, especially in overweight and obese people. This underestimation tends also to be more common in women than men, particularly overweight or obese women.

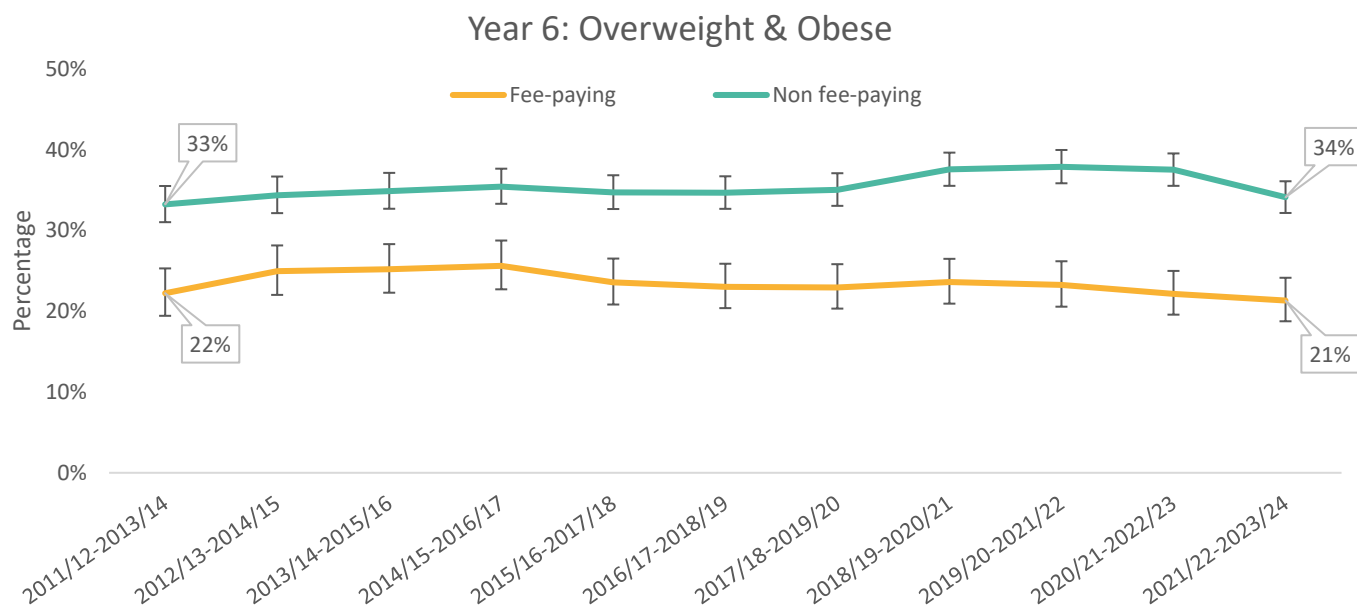
Figure 48: BMI classifications by school type, percentage, Jersey, 2021/22-2023/24 (three-year average)



Source: Public Health Intelligence, Jersey Child Measurement Programme 2023/2024¹⁶

It should be noted that the gap between obesity prevalence of children in Year 6 in fee-paying and non-fee-paying schools has decreased in the last year after increasing over a nine-year period prior (Figure 49), which could suggest a reduction in previously widening health inequalities, although further years of data will be needed to understand whether this trend has changed.¹⁶

Figure 49: Proportion of children in Reception who were overweight or obese, by school type, Jersey, academic year 2007/08-2023/24 (three-year averages)



Source: Public Health Intelligence, Jersey Child Measurement Programme 2023/2024¹⁶

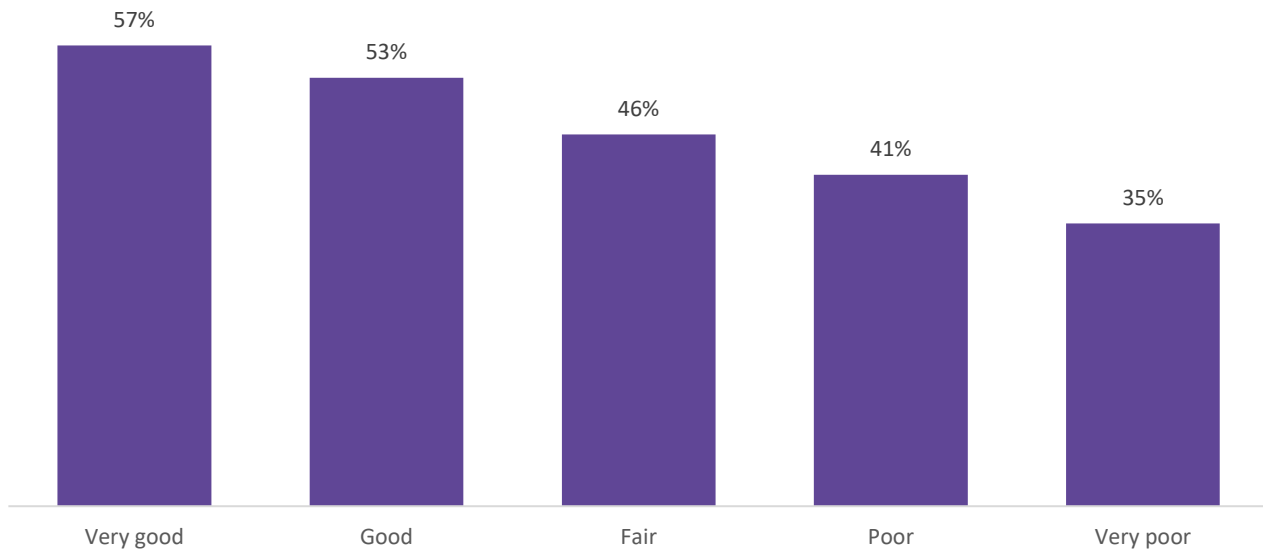
4.5.7 COVID illness

The COVID Recovery Insights Project included work to combine administrative data sets, COVID data and census data to analyse variations in PCR positive results by different population groups. This work, published in the report Insights from Jersey data on COVID-19 vaccinations and positive PCR tests by Statistics Jersey, provides a lens through which

to look at health inequalities during the pandemic^{vi} for those resident in Jersey throughout 2020 and 2021 aged 12 and over.⁶⁰

Figure 50 shows that a much higher proportion of people who reported having 'Good' or 'Very good' self-reported health in the 2021 census results tested positive than those reporting 'Poor' or 'Very poor' health. As shown previously, the proportion of people who reported having 'Poor' or 'Very poor' health was higher for older populations, who were more likely to shield, be protected by restrictions in care homes and may not have travelled as frequently as those with good health, thereby limiting their exposure to the virus.⁶⁰

Figure 50: Proportion of persons (aged 12 and over) that tested positive on a PCR test, by self-reported health status

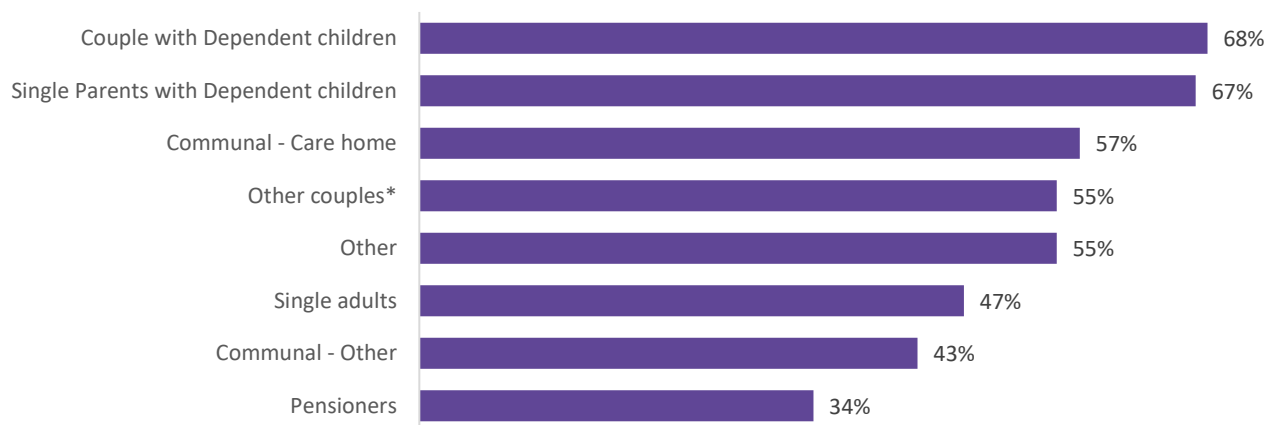


Source: Statistics Jersey, report Insights from Jersey data on COVID-19 vaccinations and positive PCR tests⁶⁰

Pensioners had the lowest proportion of individuals that tested positive on a PCR (34%), whilst those living in households with dependent children had the highest proportion of individuals that tested positive on a PCR (68% for couples and 67% for single parents with dependent children) (Figure 51).⁶⁰

^{vi} It should be noted that variations in the proportions of positive PCR tests between different population groups is not only a reflection of variations in infection rates, it is likely also impacted by the different testing regimes available for people in specific circumstances. For example, certain places of work, or other settings such as care homes and schools may have required individuals to take tests with more frequency, and so positive results were more likely to be captured for those groups.

Figure 51: Proportion of persons (aged 12 and over) that tested positive on a PCR test, by household type

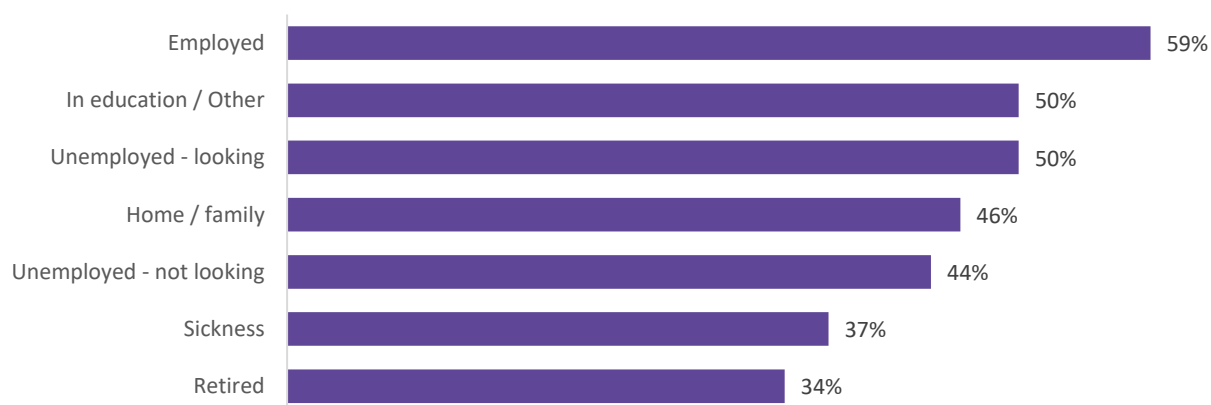


*Couples with no children or with non-dependent children (all aged 16 years and over)

Source: Statistics Jersey, report Insights from Jersey data on COVID-19 vaccinations and positive PCR tests⁶⁰

When considering employment type, employed people had the highest proportion of individuals that tested positive on a PCR (59%) whilst only 34% of those who were retired at the time of the pandemic test positive (Figure 52).⁶⁰

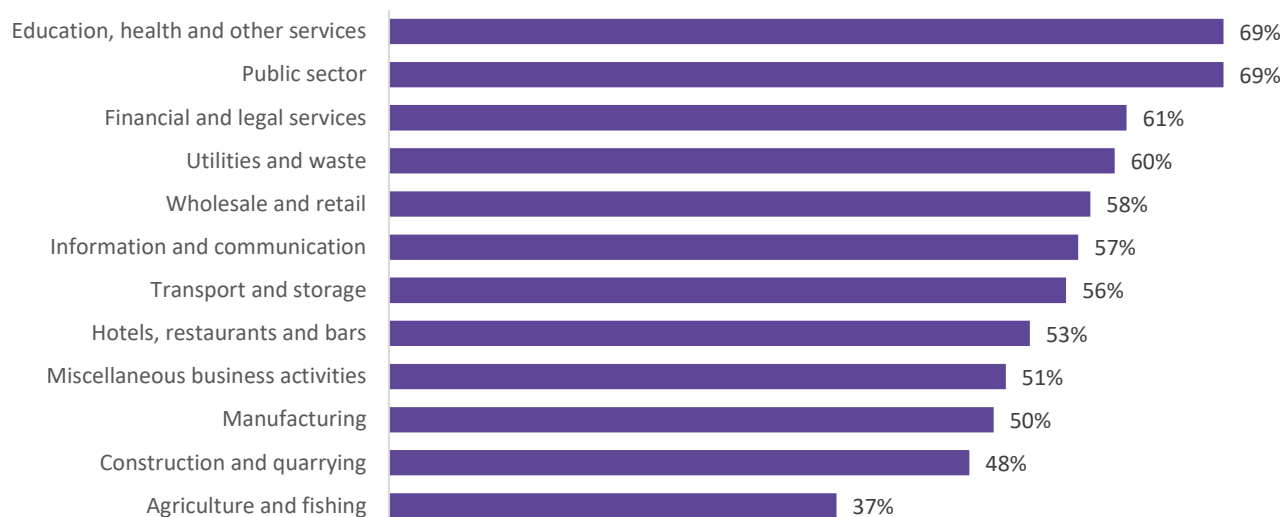
Figure 52: Proportion of persons (aged 12 and over) that tested positive on a PCR test, by employment type



Source: Statistics Jersey, report Insights from Jersey data on COVID-19 vaccinations and positive PCR tests⁶⁰

Variation in PCR positive rates were seen across different industries, with those working in Agriculture and fishing (37%) having the lowest proportion of individuals that tested positive on a PCR whilst those working in the Public sector and in Education, health and other services had the highest proportion of individuals that tested positive on a PCR (69%) (Figure 53).⁶⁰

Figure 53: Proportion of persons (aged 12 and over) that tested positive on a PCR test, by industry



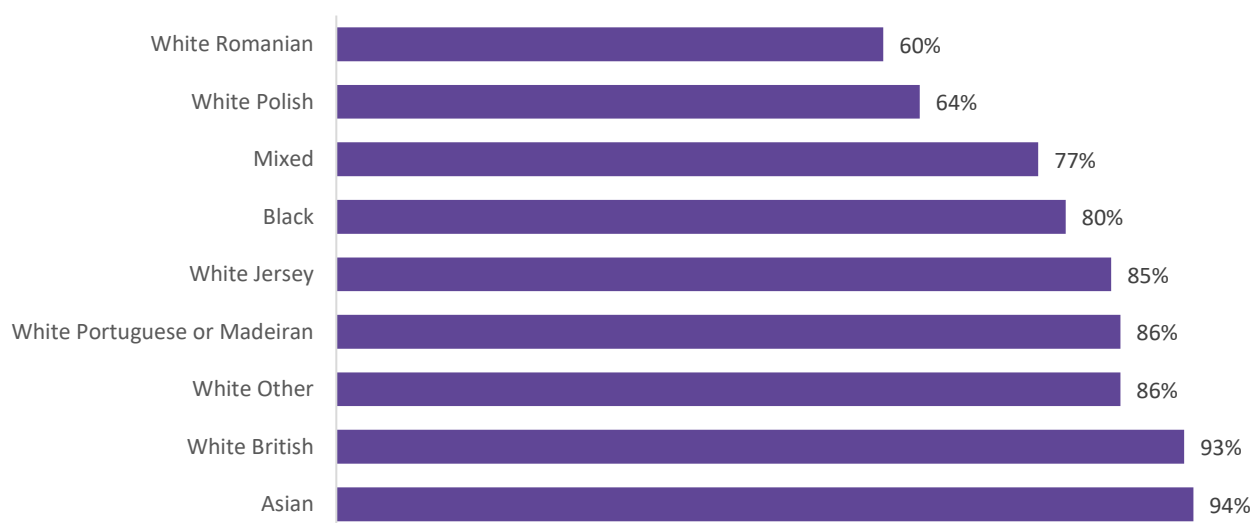
Source: Statistics Jersey, report Insights from Jersey data on COVID-19 vaccinations and positive PCR tests⁶⁰

When considering the industry that Islanders were working in at the time of the pandemic, those employed in Caring, Leisure and other service occupations had the highest proportion of individuals that tested positive on a PCR test (70%). Interestingly, large differences in rates of testing positive were not seen across different tenures or by parish, suggesting that COVID was not closely associated with deprivation but with where you worked and who you lived with.⁶⁰

4.5.8 Vaccine uptake

The Insights from Jersey data on COVID-19 vaccinations and positive PCR tests by Statistics Jersey also considered the variation in COVID vaccine uptake amongst the Jersey population who were resident throughout 2020 and 2021 aged 12 and over. One of the biggest variations in uptake was seen for different ethnicities, with less than two thirds of White Romanian (60%) and White Polish (64%) having two doses of the vaccine compared to over 90% of White British and Asian residents (Figure 54).⁶⁰

Figure 54: Proportions of persons (age 12 and over) double vaccinated, by ethnicity



Source: Statistics Jersey, report Insights from Jersey data on COVID-19 vaccinations and positive PCR tests⁶⁰

Variation in uptake of two doses of the COVID vaccine was also seen for:

- **Tenure:** lower uptake was seen for lodging houses (77%) and other non-qualified accommodation (78%) compared to 91% of those living in owner-occupied accommodation
- **Employment type:** uptake was lower for those unemployed looking for work was 72%, those not working due to sickness (83%) and high for retired persons (96%)
- **Household type:** single parents with dependent children had the lowest uptake of two doses (65%) compared to 96% of pensioners and those living in communal care homes
- **Overcrowding:** those in overcrowded accommodation^{vii} had a lower uptake of the first two doses (74%) than those meeting the standard number of bedrooms (82%) or those who lived in underoccupied (two bedrooms or more above standard) (94%)⁶⁰

The report suggests potential inequalities, but it is worth bearing in mind the nature of the vaccine rollout to the population. The likelihood of being vaccinated, and speed at which this happened depended on various factors such as eligibility, awareness, motivation, trust in government and ease of access. Motivation to be vaccinated may have also been impacted by factors such as the travel and work-related policies which affected requirements for isolation.

4.6 Summary

This chapter has demonstrated the variation in health outcomes across different groups of society. In general, poor health and risks for poorer health (such as income and health-related behaviours) tend to fall on those with fewer resources. Work is underway to develop an index of multiple deprivation for the Island that would allow for the ongoing monitoring of health inequalities. This would help us focus our efforts to reduce the gap between those with the best and worst health.

The next chapter will look at the future trajectories for health in the Island and make the case for why keeping the population as healthy as possible is an important factor for the future of the Island.

^{vii} According to the 'Bedroom standard' (UK Housing Overcrowding Bill, 2003) which defines the number of bedrooms that would be required by the household, where a separate bedroom is allowed for each married or cohabiting couple, any adults aged 21 or over, pairs of adolescents aged 10-20 of the same sex and pairs of children under 10 years. Unpaired persons of 10-20 years are notionally paired with a child under 10 of the same sex

Future health of Islanders

5 Future health of Islanders

The future health of our Island is important because it has a huge impact on Jersey’s finances and the vibrancy of its community. As we see below, around half of government spending is either on healthcare or social security related to health.

Like other developed economies, Jersey is facing the challenges of an aging population and declining levels of productivity, as outlined in the recently published *Strategy for Sustainable Economic Development*.⁴¹ As more Islanders reach retirement age, replaced by fewer Islanders of working age, tax revenues will reduce. This will have an impact on public services, including healthcare. We can use prevention to keep people healthy for longer, reducing and delaying healthcare spend and protecting productivity.

This chapter:

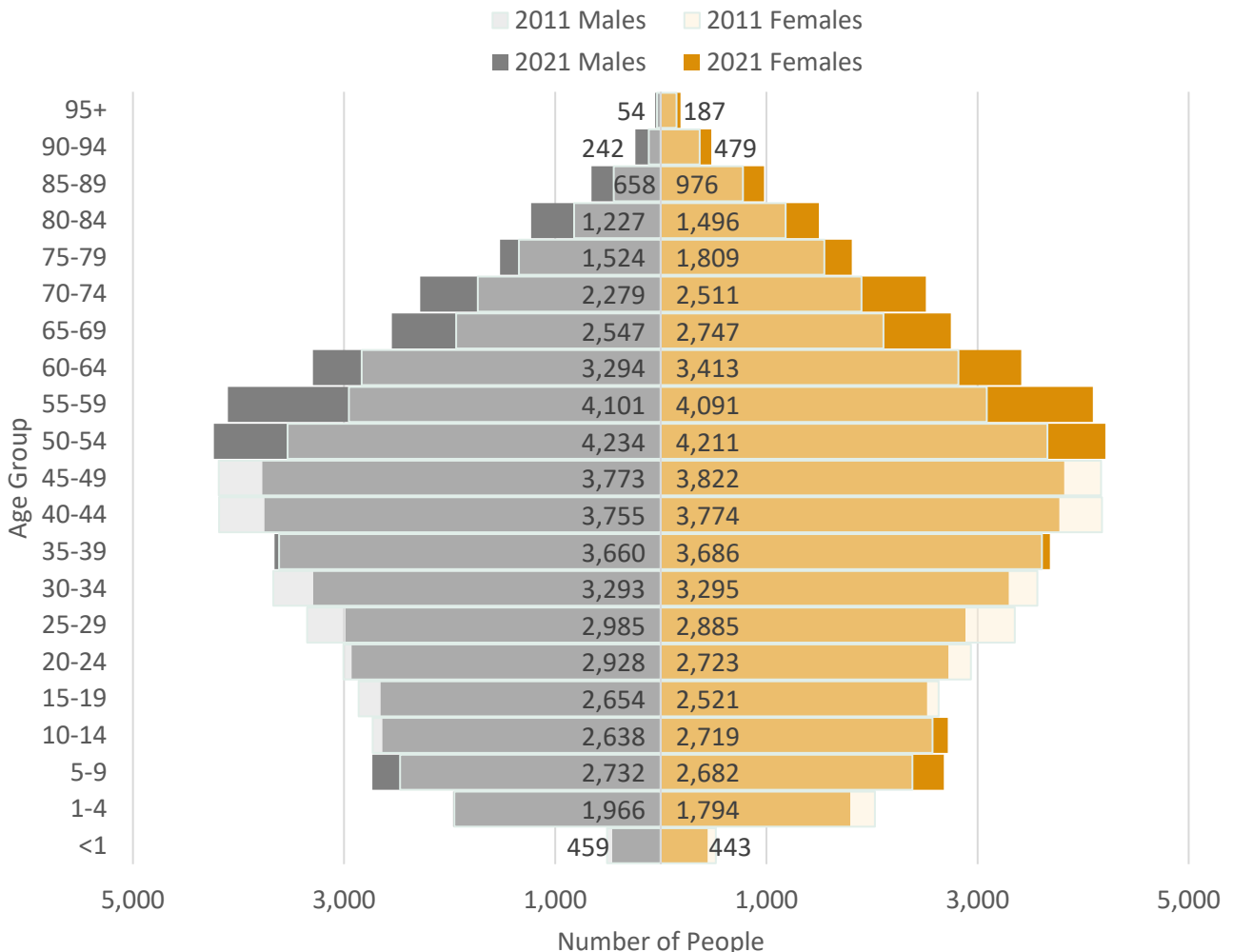
- Sets out the evidence for an aging population
- Describes the possible future burden of ill health and
- Explains a way of thinking about population health from birth to death, known as the life course.

5.1 A growing, aging population

Jersey’s population has grown considerably over recent decades, from a population of 55,244 in 1951 to 103,267 at the time of the 2021 census. Much of this growth has been driven by people coming to the Island (net inward migration) as opposed to natural growth from being born in Jersey. Over this time period, the average age of residents has increased, from a median age of 36 in 1951 to 43 years more recently (2021).⁷

The largest proportion of the population are currently in their 50’s, as shown in Figure 55.

Figure 55: Population structure of Jersey (Numbers represented here are referencing 2021 population numbers with 2011 Census overlaid)

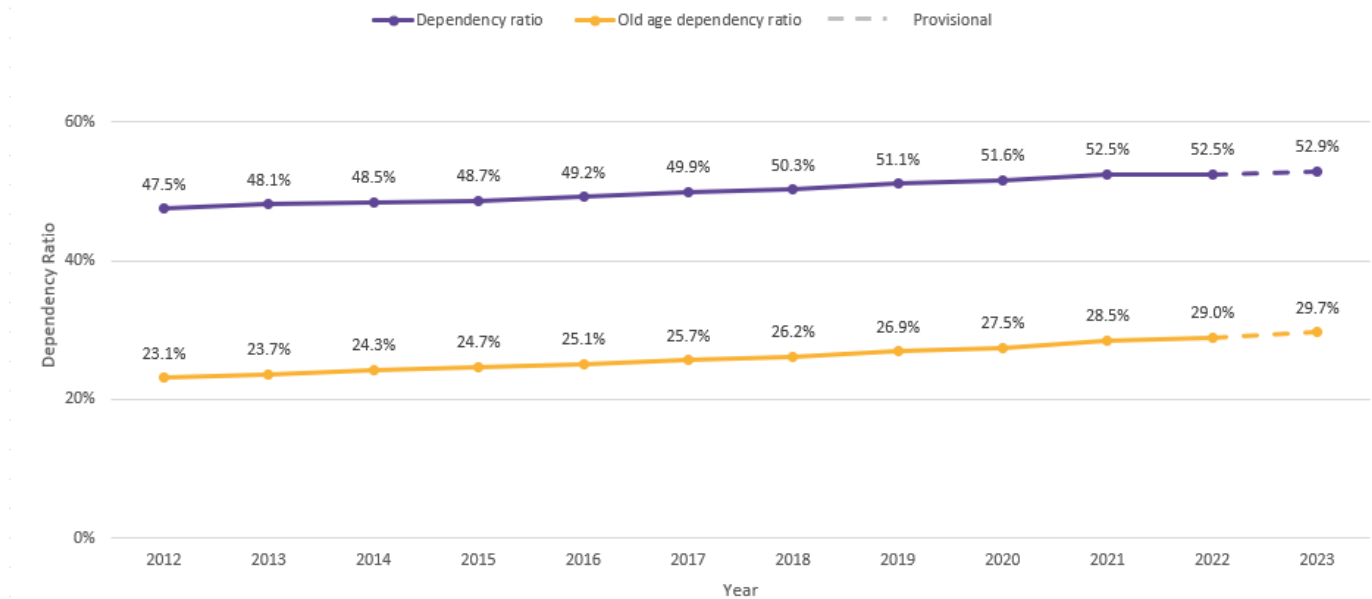


Source: Statistics Jersey⁷

5.1.1 Dependency ratio

The dependency ratio is the ratio of the dependent population (under 16 or 65 and over) to the working age population (16-64 years). Over the last decade, there has been a steady increase in the dependency ratio and old age dependency ratio (dependents aged 65 and over only) as shown in Figure 56.¹⁷ In other words, there are fewer people of working age supporting the very young and the old.

Figure 56: Dependency ratio and old age dependency ratio, 2012-2023



Source: Statistics Jersey¹⁷

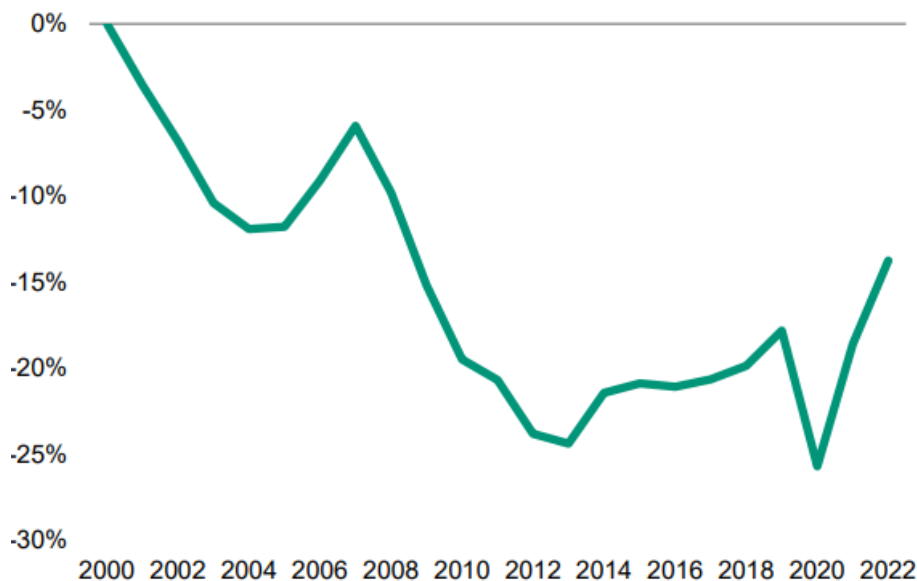
5.2 Living standards

5.2.1 Gross Value Added

Living standards can be estimated using a measure called Gross Value Added (GVA) per person. GVA can be used to estimate living standards because it provides a measure of the average income or economic output per person in an economy.

As Figure 57 shows, real GVA per capita has fallen nearly 15% in the past twenty years, or about £9,000 per person. This means that Jersey’s economy has grown much more slowly than the population.⁴¹

Figure 57: Real GVA per capita, 1998-2022

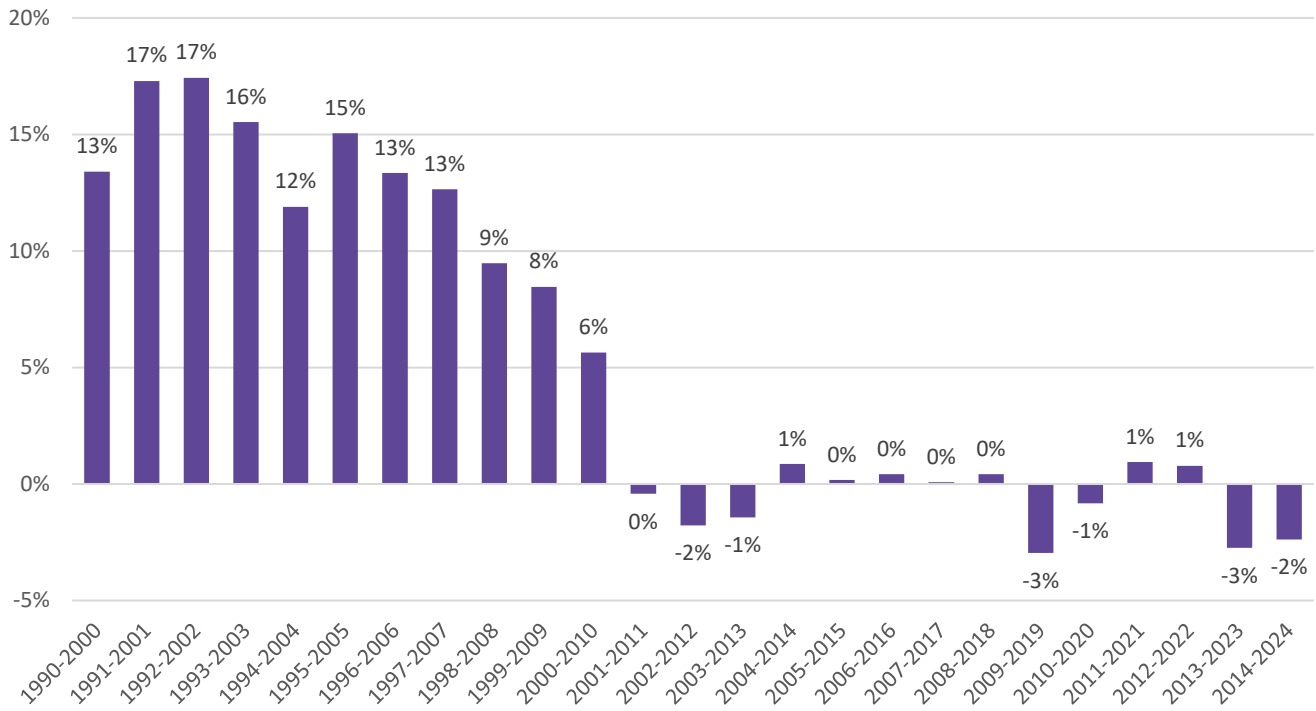


Source: Statistics Jersey⁴¹

5.2.2 Average earnings and inflation

Another way to think about living standards is to consider the changes in average earnings in comparison to inflation. Figure 58 shows the percentage change in real earnings, as a series of 10-year comparisons, between 1990 and 2024. In the 1990s earnings grew faster than inflation and people were better off year on year. By contrast, average earnings fell by 2% in real terms over the past 10 years, making people worse off.

Figure 58: Rolling 10-year total change in average earnings, in real terms



Source: Statistics Jersey ⁴¹

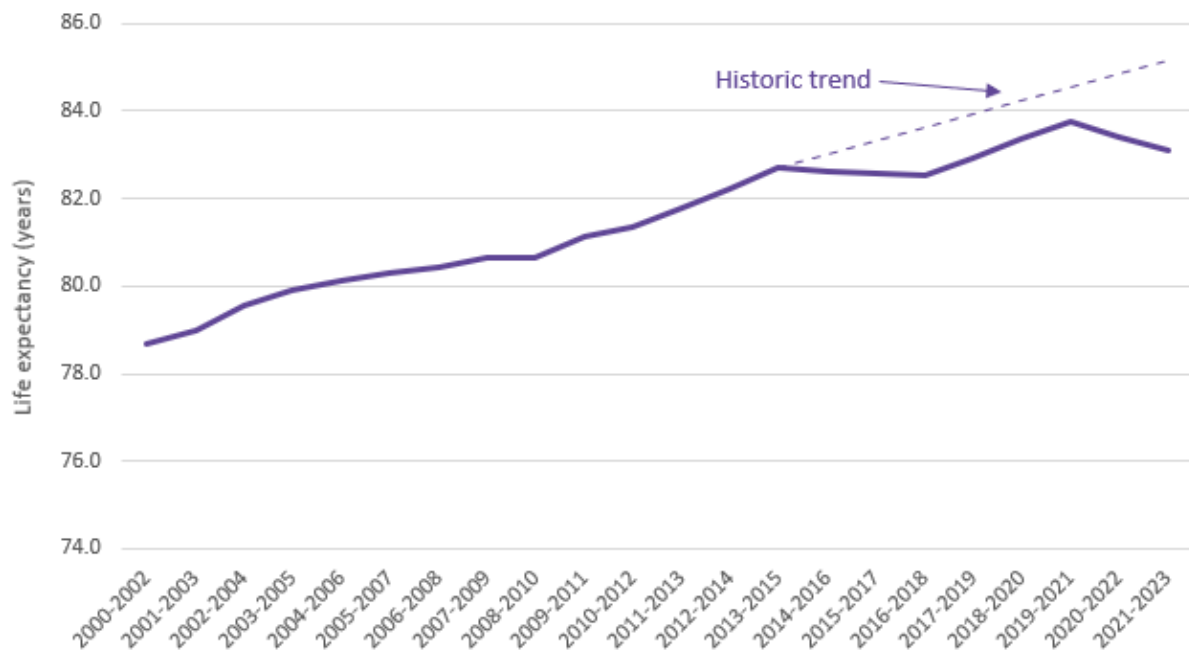
These changes in living standards affect individuals and families, especially those who are on lower incomes, as they have less flexibility in their budgets. They also put pressure on government finances because lower earnings and profits generate less tax revenue. This makes it harder for government to afford vital public services.

5.3 Slower increases in life expectancy

Over the last decade, life expectancy in Jersey has remained high, but the historic upward trend has slowed, as shown in Figure 59. Although life expectancy continued to increase again in Jersey after 2016-2018, if the pre-2013-2015 trend had continued, life expectancy in the most recent period would be some 2 years higher than it actually was in 2021-2023.⁴ England has seen a similar plateau; over the period 2013-2015 to 2016-2018, life expectancy remained stable at around 82.5 years, having previously seen increases in the three-year life expectancy calculations since 1900.^{61,viii}

^{viii} Like the Office for National Statistics in the UK, Jersey uses three-year averages to smooth relatively small year-to-year fluctuations caused by events such as a colder than average winter or high rates of flu, both of which tend to cause higher than average mortality rates.

Figure 59: Period life expectancy at birth, 2000-2023



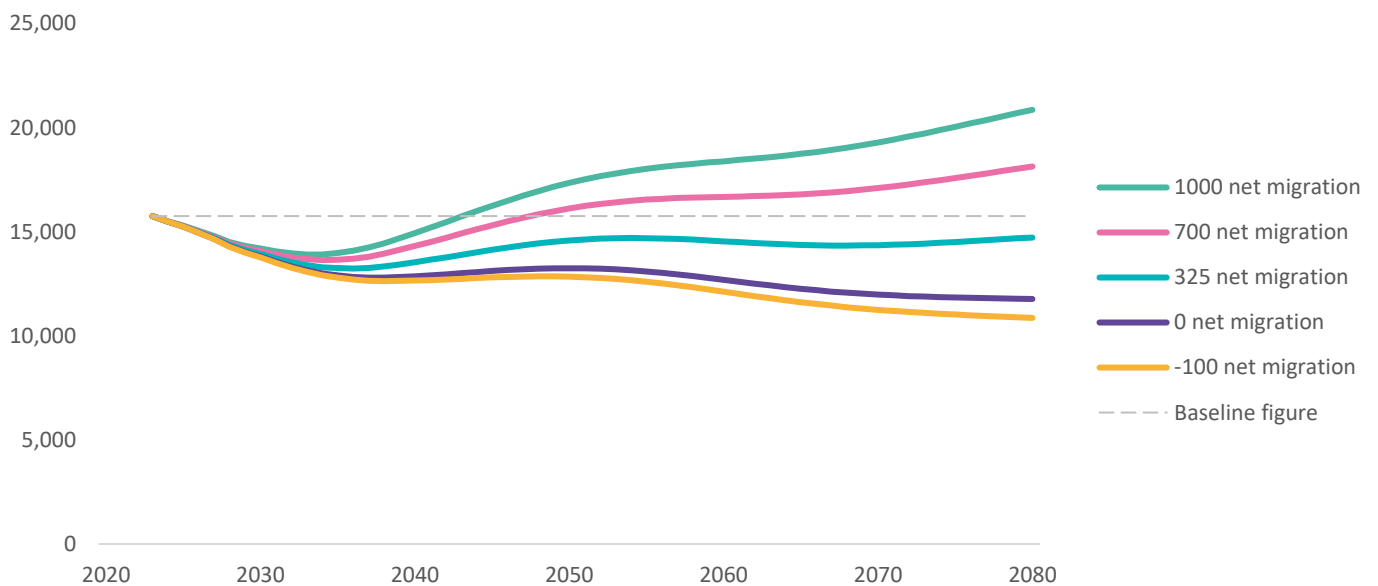
Source: Public Health Intelligence⁴

5.4 Future population changes

Having looked at past changes to the Island’s population, we now turn to estimating future demographic trends. These are important because, without improved prevention, an aging population means greater demand for healthcare.

Statistics Jersey recently published population projections for 2030-2080, based on a number of different scenarios.⁶² These range from -100 net migration to +1,000 net migration.^{ix} As you would expect, the level of net migration heavily influences the projected population size over the period that the projections consider. However, under all scenarios, the number of children (under 16 years of age) is projected to reduce over the next 10-20 years (Figure 60).⁶²

Figure 60: Population aged under 16 over time under different net migration scenarios

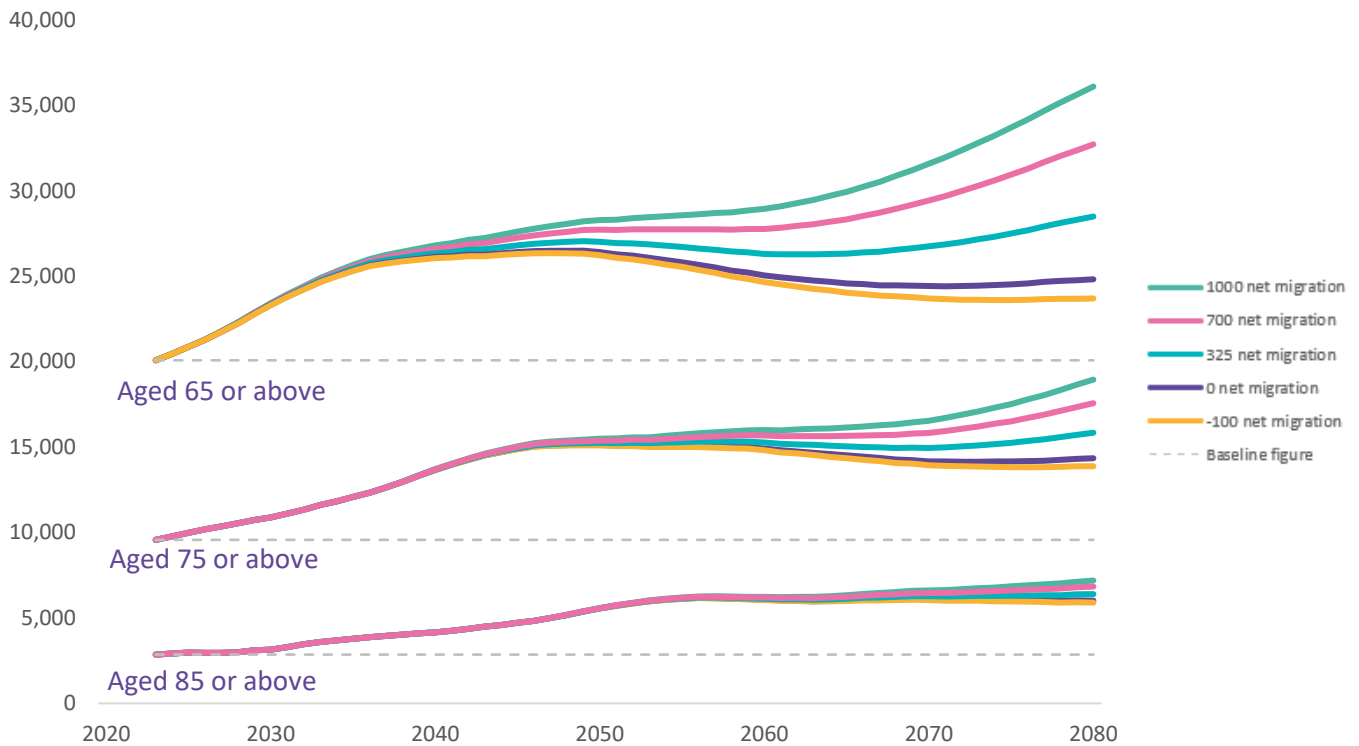


Source: Statistics Jersey⁶²

^{ix} At -100 net migration, 100 more people leave the Island than arrive each year. At +1,000 net migration, 1,000 more people arrive each year than leave.

Equally, regardless of the level of net migration experienced, in all scenarios the older aged population is expected to increase rapidly over the next 20-30 years. This is particularly the case for the older (over 75 and over 85) age groups which are expected to increase by around 50% over the next 20-30 years (Figure 61).⁶²

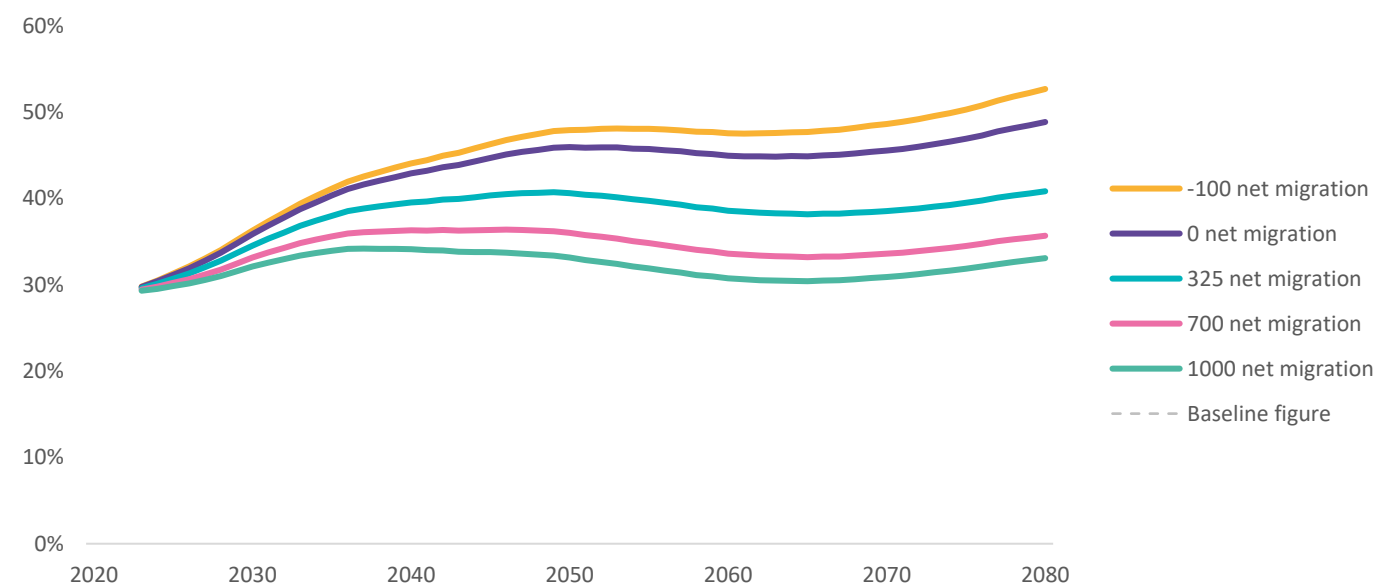
Figure 61: Population aged 65 or above, 75 or above and 85 or above, over time under different net migration scenarios



Source: Statistics Jersey⁶²

Changes to the level of net migration primarily influences the working age population. Higher levels of net migration would result in a lower dependency ratio over the period of the projections because more working-age people would be moving in. The lower net migration scenarios experience much higher dependency ratios, particularly in the first 20-30 years of the projections because fewer working-age people would be moving into the Island.⁶²

Figure 62: Old age dependency ratio over time, under different migration scenarios



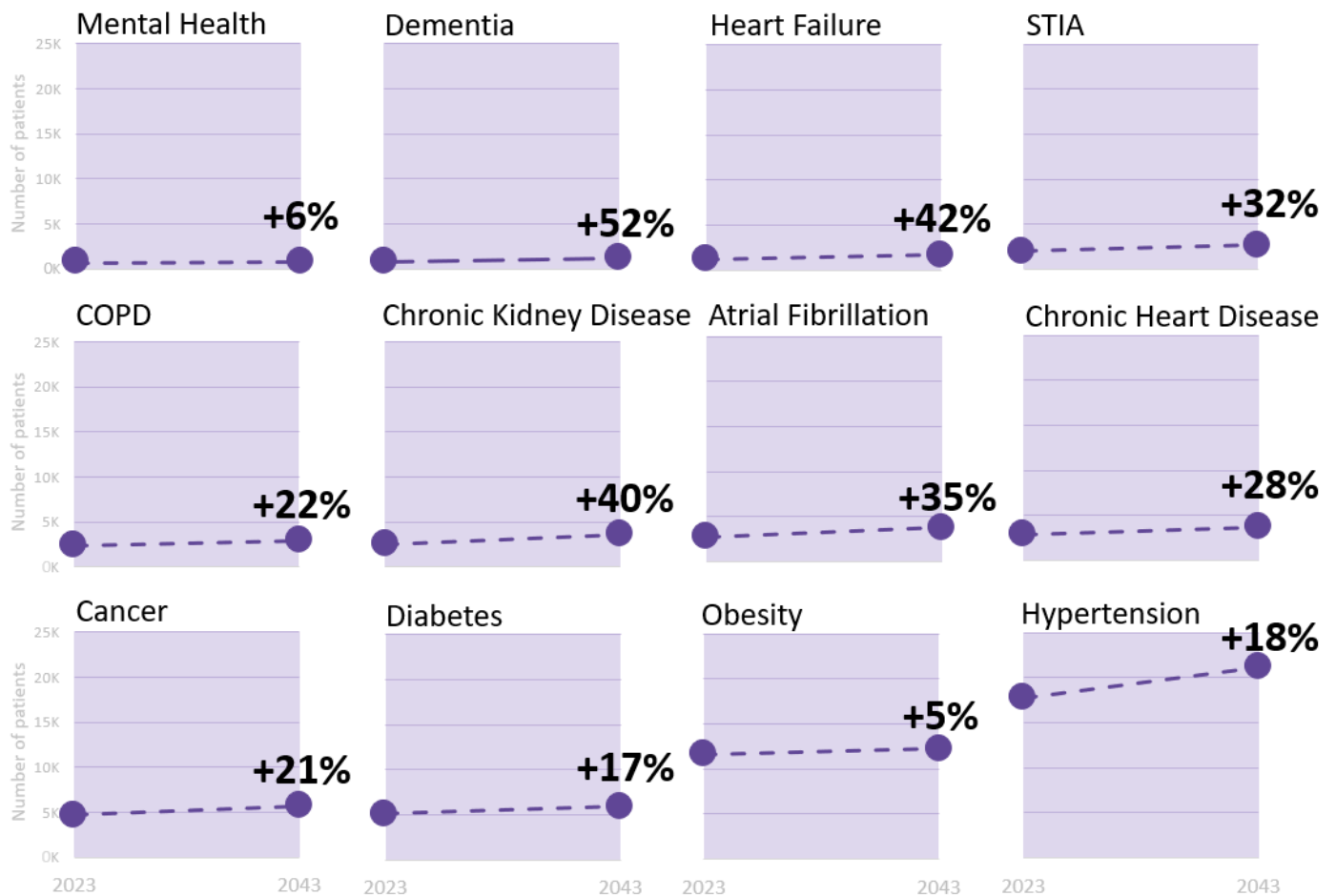
Source: Statistics Jersey⁶²

5.5 Future disease projections

5.5.1 Long-term illness

The Public Health Intelligence Team used these projections to estimate the impact on the future health of our island's population. As the number of older people increases (as it does in every population projection), we anticipate significant rises in long-term illness, especially in those which disproportionately affect older people such as dementia (52%) and heart failure (42%) (Figure 63).¹⁹

Figure 63: Projected total number of cases of 12 long term conditions, 2023 and projected for 2043



*STIA: Stroke and transient ischaemic attack; COPD: Chronic Obstructive Pulmonary Disease; projections based on +325 annual net migration

Source: Public Health Intelligence

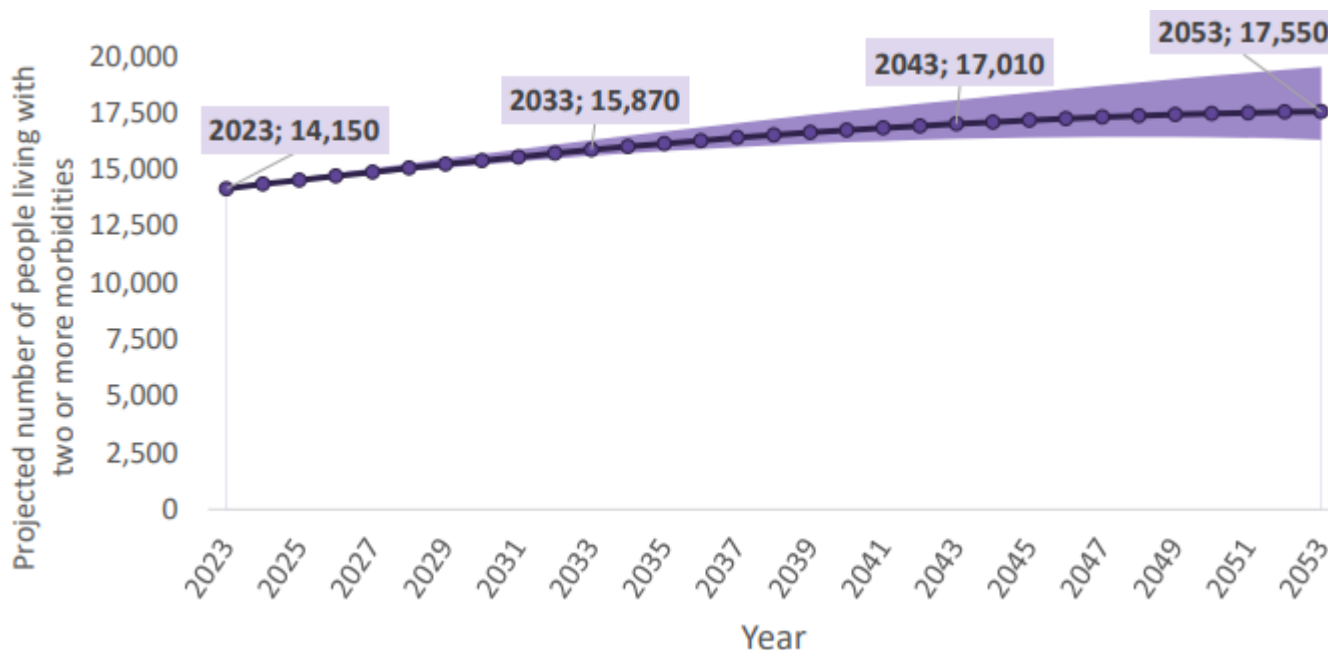
The projections assume that the current rates of disease continue over the next 20-30 years and show the potential numbers of additional cases in the population as it ages. Using the central estimate of +325 net migration we estimate there will be an extra:

- 1,000 cases of chronic kidney disease, cancers and atrial fibrillation
- 3,280 people with hypertension
- 560 people classified as obese

5.5.2 Multiple long-term illnesses

We also produced estimates of the number of people with more than one long-term illness, known as multi-morbidity. Studies show that people with multiple long-term illnesses typically suffer a lower quality of life, spend more time in hospital and may be more likely to die early.⁶³⁻⁶⁵ Managing the health and care needs of people with multiple conditions also becomes increasingly complex. Figure 64 shows the projected increases for those living with two or more morbidities.^x

Figure 64: Projected number of people living with two or more morbidities between 2023 and 2053, under different population scenarios (upper +1,000, lower -100, central +325 net migration per year)



Source: Public Health Intelligence⁵

Our models estimate that, by 2043, under the +325 net migration scenario, there will be an extra:

- 2,860 people with two or more morbidities (an increase of 20%)
- 1,610 people with three or more morbidities (an increase of 28%)
- an increase of around 2% in the overall proportion of Jersey's population who are living with one or more morbidity

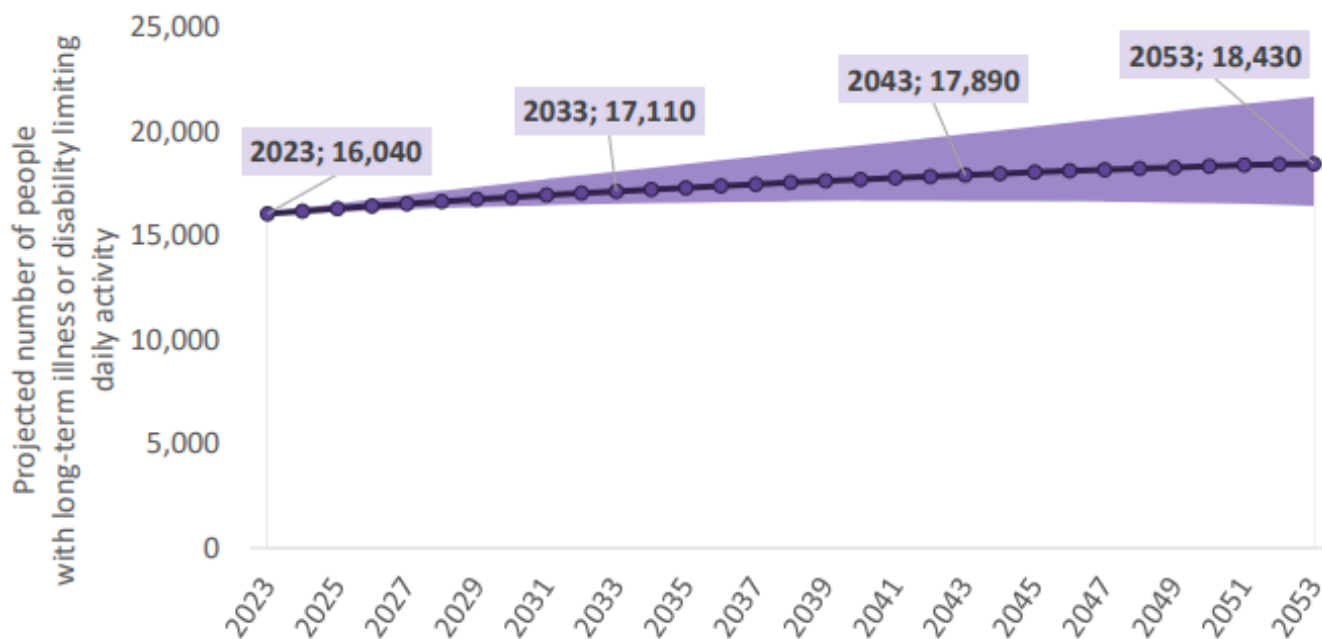
Under the same migration scenario, the number of people in the working age population is likely to decrease by around 1,200 people over the same period.

5.5.3 The impact of long-term illness on day-to-day life

The 2021 census asked respondents if they had a long-term illness or disability that limited their day-to-day activities (not limited to physical or visible disabilities). By combining these responses with future population projections, we have estimated future numbers of people who would consider themselves to have an activity-limiting disability or long-term illness (Figure 65).

^x 12 conditions have been included in this analysis: Asthma, Atrial fibrillation, Coronary heart disease, Chronic kidney disease, COPD, Dementia, Diabetes mellitus, Heart failure, Hypertension, Mental health, obesity and stroke and transient ischaemic attack. Note that cancer is not included in this analysis as it was a new addition to the Jersey Quality Improvement Framework in 2023.

Figure 65: Projected number of people with activity-limiting disability or long-term illness between 2023 and 2053, under different population scenarios (upper +1,000, lower -100, central +325 net migration per year)



Source: Public Health Intelligence

Assuming the prevalence of long-standing illnesses and disabilities remains the same as the current situation, it is likely (under the +325 migration scenario) that there will be an additional 1,850 number of people in the Island whose day-to-day activities will be limited because of their illness or disability by 2043, an increase of 12%.

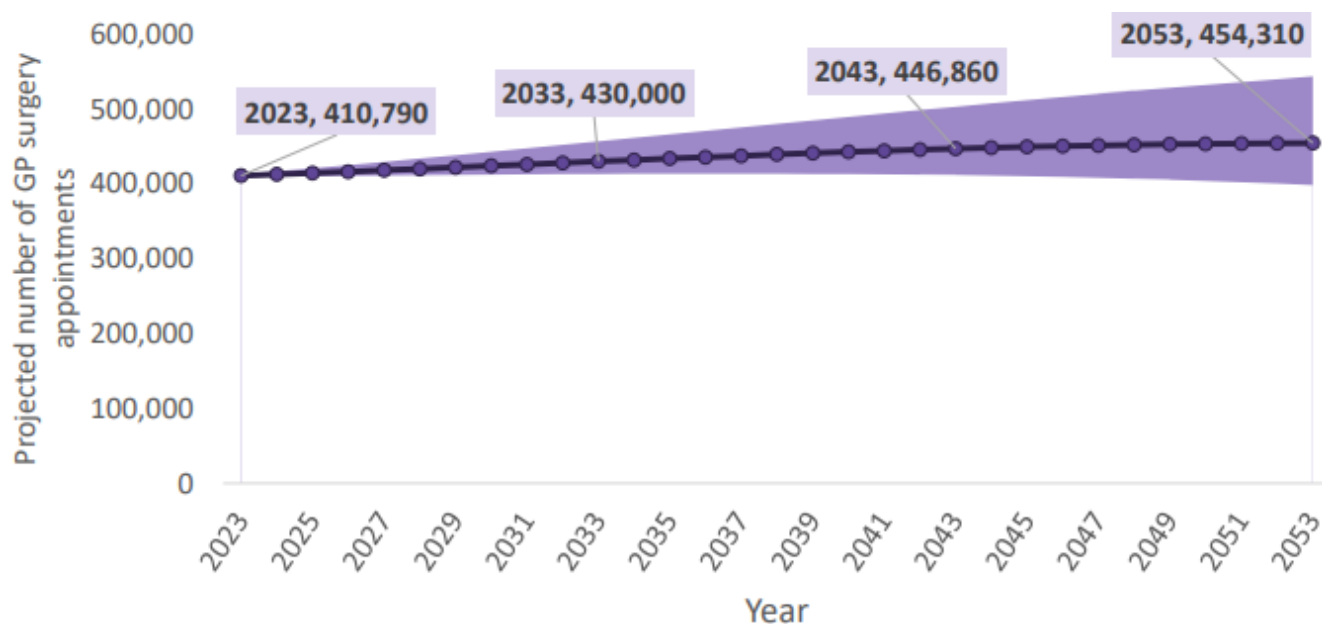
5.6 Future demand for health services

We also used Statistics Jersey’s population projections to estimate the likely impact of an aging population on demand for GP appointments and hospital bed days (assuming the same usage patterns as seen currently).

5.6.1 Future demand for GP appointments

There were around 410,790 GP surgery appointments per year in Jersey, during the period 2021-2023. Older people typically had more GP appointments. Amongst younger people (aged 20 to 60 years) females had more GP consultations on average than males, whilst amongst older people (aged 80+) males had more than females.¹⁹

Figure 66: Projected number of GP appointments between 2023 and 2053, under different population scenarios (upper +1,000, lower -100, central +325 net migration per year)



Source: Public Health Intelligence¹⁹

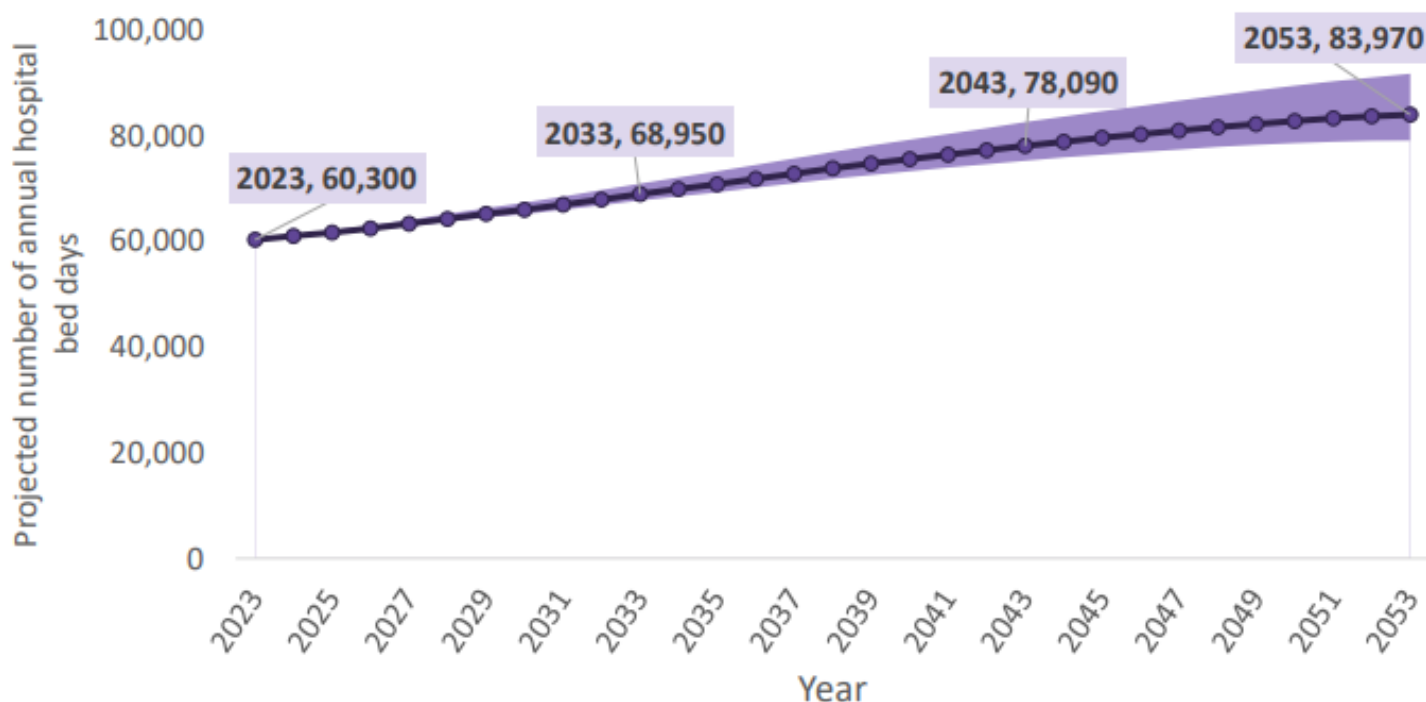
Under the +325 migration scenario, we estimate the need for an extra 43,520 GP appointments per year by 2053, an 11% increase, at an estimated cost of £1.4m.¹⁹

5.6.2 Future demand for hospital bed days

In the period 2018-2022 there was an annual average of around 60,000 hospital bed days in Jersey (including medical, surgical and women and children’s services). The likelihood of needing to spend time in hospital increases steeply with age, with those aged 90 or older staying an average of around 6 bed days per year.¹⁹

As the population changes over the next 30 years the number of annual hospital bed days is projected to increase, if age and gender specific usage remains constant (Figure 67), by an additional 23,670 bed days by 2053, a 39% increase.¹⁹

Figure 67: Projected number of annual hospital bed days between 2023 and 2053, under different population scenarios (upper +1,000, lower -100, central +325 net migration per year)

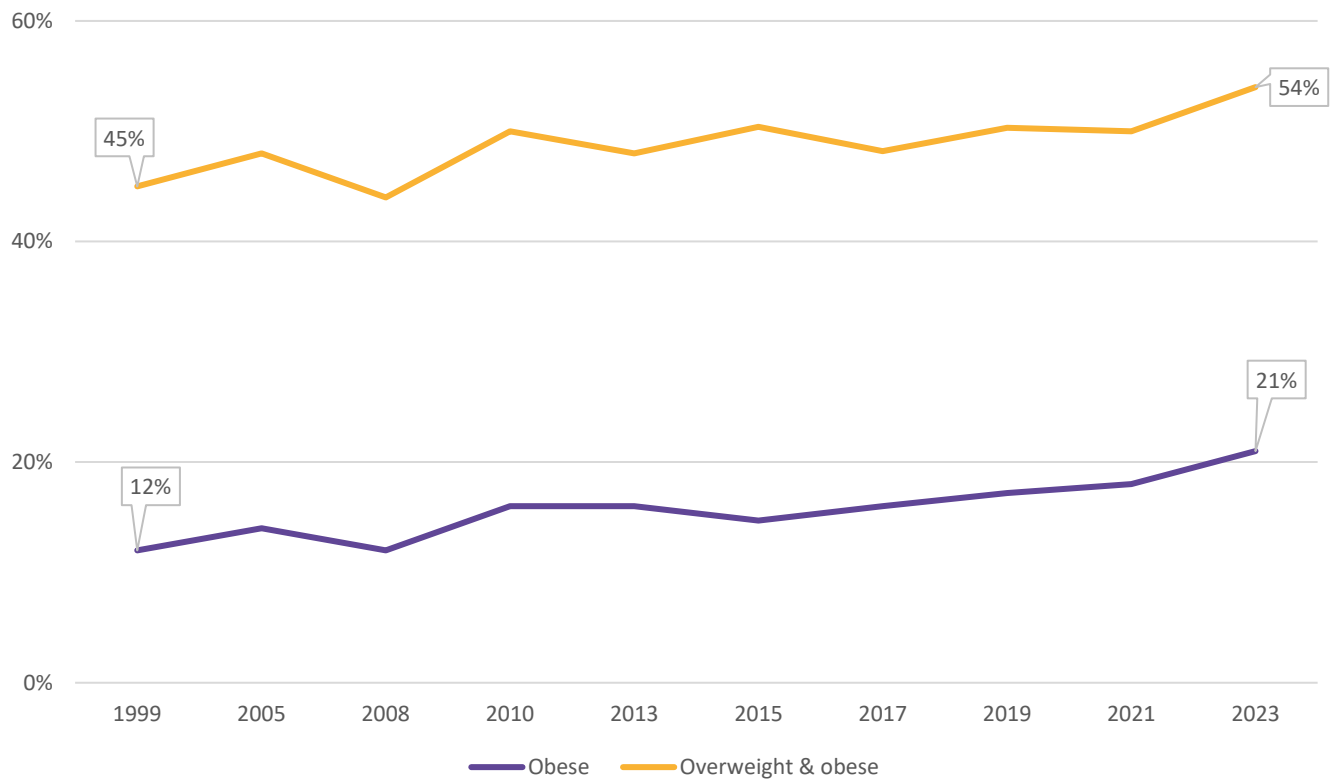


Source: Public Health Intelligence¹⁹

The above projections forecasting an increase in the number of bed days and GP appointments assume the rates of health and healthcare use remain as they are now. Improving population health or delaying the onset of illness will reduce future service demand, whereas worsening population health would result in these projections being underestimates of the future impact.

There is however some evidence that these estimates may be conservative, as there are already some signs that we are becoming unhealthier as an Island. For example, rates of obesity - which increases the risk of poor health - are increasing (Figure 68). Without better prevention, our future, aging population is likely to have a higher risk of poor health for longer than our current population of older people. This makes it likely that we have underestimated the future burden of illness and its associated costs.

Figure 68: Overweight and obesity levels over time, as calculated from BMI

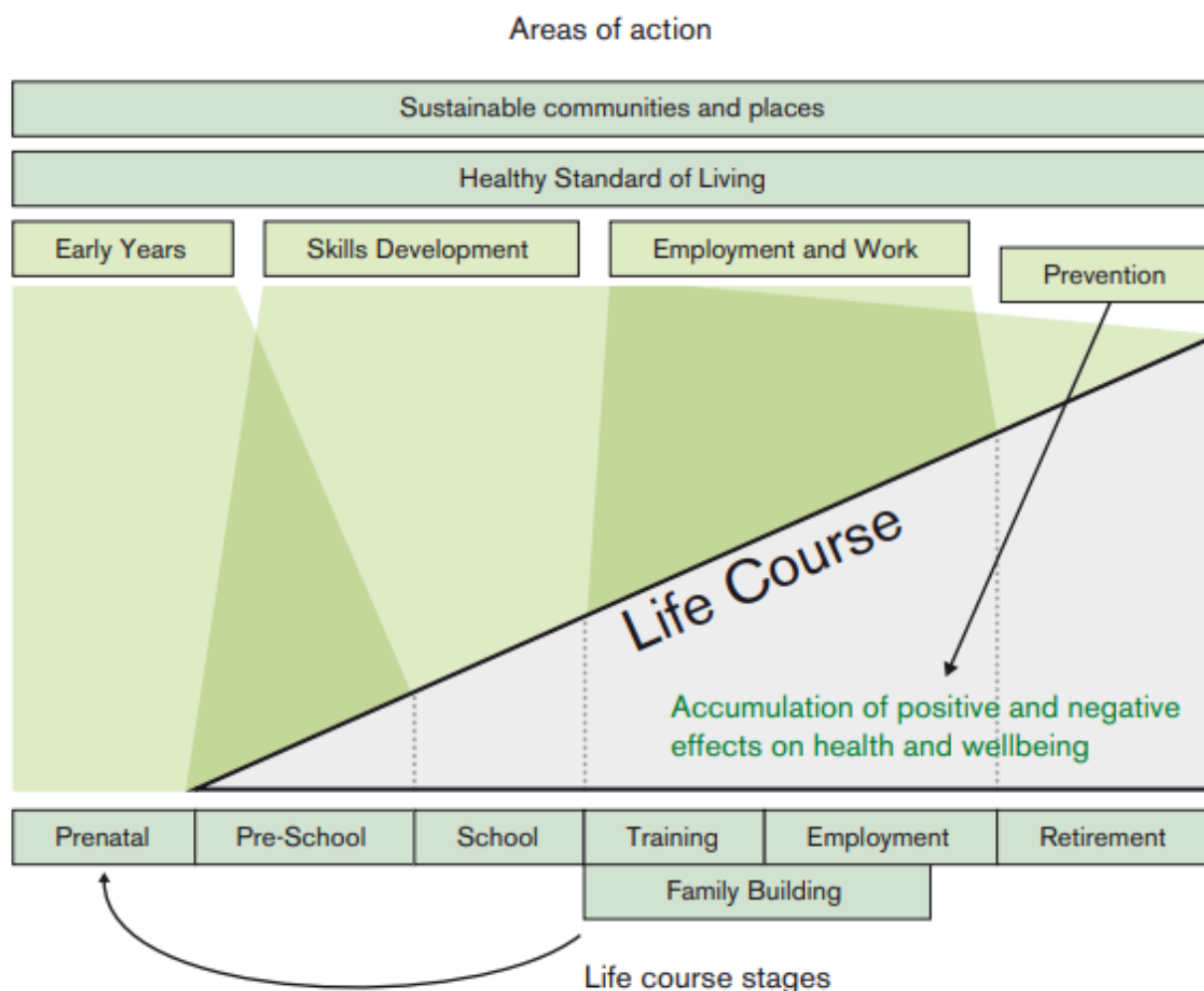


Source: Statistics Jersey, Jersey Annual Social Survey & Jersey Opinions and Lifestyle Survey⁵¹

5.7 Life course approach

The life course approach to public health is based on evidence that early experiences and exposures to social and physical hazards affect health outcomes in later life.⁴⁹ A life course approach considers the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing. For example, there is a great deal of evidence that making sure young children’s physical and social needs are met sets them up for a lifetime of good physical and mental health.⁴⁹ By taking action at different stages across the life course, it is possible to maximise the positive effects and minimise the negative effects of how the building blocks for health influence people's outcomes across the life course (Figure 69).

Figure 69: Action across the life course



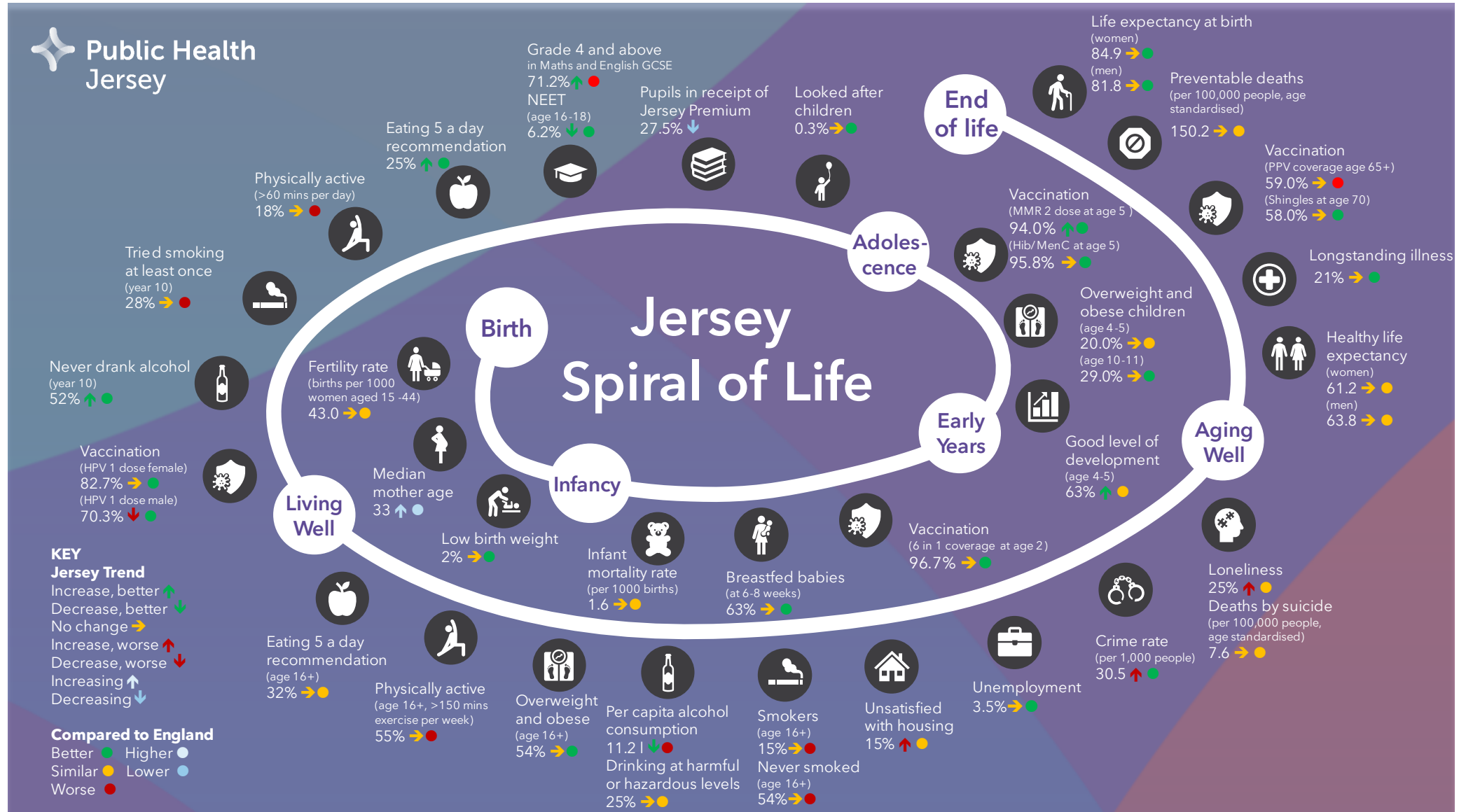
Source: The Marmot Review: Fair Society, Healthy Lives⁴⁹

Figure 70, on the next page, summarises some key data for the Jersey population at different stages of the life course, demonstrating opportunities for improving health from birth to death.

5.8 Summary

Under the central migration scenario (+325 per year), the number of people in the working age population is likely to decrease by around 1,200 people in the next 20 years. Meanwhile, the number of people with long-term illnesses or disabilities that limit their day-to-day activities is projected to increase by 1,850 people over the same time period.⁶² For many long term conditions, such as cancer, heart disease and dementia, the number of patients on the disease registers is likely to increase significantly in the next two decades.¹⁹ This will have implications for the Island's future productivity and standard of living, both of which have already been affected, as well as on the Island's ability to fund the healthcare services that will be needed by those with these conditions. It's clear that allowing the current prevalence rates of often-preventable disease to continue, combined with an aging population, is not sustainable.

Figure 70: Jersey spiral of life diagram



Source: Public Health Intelligence

Costs

6 Costs

There is good evidence that investment in prevention can reduce the burden of ill health and reduce the cost of healthcare in the longer term, as detailed in Appendix 1. This chapter explores the cost of ill health to Jersey's economy. It looks at how much is spent on prevention and healthcare currently and details some of the likely increases in costs given the disease projections and aging population.

The available information on the costs of ill health is not exhaustive. Private healthcare, out of pocket payments, overseas private healthcare for Jersey residents and other costs are not included.

6.1 Societal and human costs

Before considering financial information, we consider first the human cost of poor health. For instance:

- Over 100 families per year in Jersey are bereaved as a result of deaths which are considered preventable⁸
- In 2023, there were at least 485,000 days where workers weren't able to work because they were sick¹⁸
- 2,145 people were living with four or more conditions in 2023, which means having to take multiple medications, have frequent appointments with healthcare professionals and being limited in their day to day lives⁵
- One in every ten Islanders aged over 65 years rated their own health as 'poor' or 'very poor' in the 2021 census⁷
- There were 185 people of working age in 2023 who were not able to work full-time because they were caring for someone who required a very high level of personal care.⁶⁶

This list is by no means exhaustive but does highlight how poor health can affect not just individual Islanders but also their friends and families and wider society.

6.2 Spending on benefits related to ill health

In 2023, a total of £12.9 million was spent on medical benefits to GP practices, which covered 480,000 consultations from the Health Insurance Fund administered by Customer and Local Services. This figure does not include the out-of-pocket spending by individuals visiting the GP practices. In addition, £26.5 million was paid in pharmaceutical benefits (cost of drugs and dispensing) for 2.3 million prescriptions.⁶⁷ This is more than 22 prescriptions per Islander each year.

There were 485,000 days of sickness covered by Short Term Incapacity Allowance (STIA), costing £16.7 million for 2023. Almost 5,000 people claimed Long-term Incapacity Allowance or Invalidity Benefit in 2023, at a cost of £31.0 million. £76.0 million was paid out for long-term care, with 1,463 claims active as at year-end 2023. In total, £165.5 million was spent on benefits related to ill-health in 2023, an increase of £35.6 million from the previous year when £129.9 million was spent.

Table 6.1: Health-related benefits administered by Customer and Local Services, 2023

<i>Benefit</i>	<i>2023 value £ million</i>	<i>Quantity</i>	<i>Measure</i>	<i>Time Period</i>
<i>Long-term Care</i>	76.0	1,463	Claims	Number active at year end
<i>Long-term Incapacity Allowance & Invalidity Benefit</i>	31.0	4,990		
<i>Carers allowance</i>	2.4	185		
<i>Pharmaceutical Benefit (cost of drugs and dispensing)</i>	26.5	2.3 million	Items prescribed	In full year
<i>Short Term Incapacity Allowance</i>	16.7	485,000	Days paid	
<i>Medical Benefits (payments to GPs, including medical benefit for GP consultations, pathology benefit, JQIF, Health Access Scheme, and various contracts with GP practices)</i>	12.9	480,000	Consultations	

Source: Government of Jersey Annual Report and Accounts, 2023⁵³

6.3 Spending on health

In 2023, the Government of Jersey spent £484.1 million on health, an increase of 12% on the previous year (£432.5 million in 2022) in real terms (i.e. accounting for inflation). This was driven by a £30.2 million real-term increase in expenditure on hospital services and a £14.8 million real-term increase in expenditure on outpatient services. Spending on health equates to 29% of overall government spending and is the second largest proportion of government spending after social protection (£520.2million in 2023) as shown in Table 6.2.⁴³ Within the £520.2million spent on social protection in 2023, £78.0 million was spent on sickness and disability and £4.2million on survivors.

Table 6.2: General government expenditure in constant year 2023 prices, £ million, 2022 to 2023

<i>COFOG Division</i>	<i>2022</i>	<i>2023</i>	<i>% Change</i>	<i>% of overall Government spending in 2023</i>
<i>General public services</i>	165.0	164.1	-0.6%	10.0%
<i>Defence</i>	1.7	1.4	-16.4%	0.1%
<i>Public order and safety</i>	88.2	103.1	16.9%	6.3%
<i>Economics</i>	68.3	74.4	9.0%	4.5%
<i>Environmental protection</i>	48.0	52.1	8.6%	3.2%
<i>Housing and community amenities</i>	9.3	9.0	-3.3%	0.5%
<i>Health</i>	432.5	484.1	11.9%	29.4%
<i>Recreation, culture and religion</i>	40.3	37.1	-8.0%	2.3%
<i>Education</i>	187.3	198.7	6.1%	12.1%
<i>Social protection</i>	505.7	520.2	2.9%	31.6%
<i>Total</i>	1,546.3	1,644.2	6.3%	100.0%

Source: Public Spending Statistics 2023⁵³

Breaking down the spending on health into further detail shows over half (58%) of spending in 2023 was for hospital services.^{xi} This is mostly in-patient services, such as general and specialist hospital expenditure, maternity centres and nursing homes (Table 6.3).

Table 6.3: General government expenditure on health in constant year 2023 prices, £ million, 2022 to 2023

<i>COFOG Group</i>	<i>2022</i>	<i>2023</i>	<i>% Change</i>	<i>% of overall health spending in 2023</i>
<i>Medical products, appliances and equipment</i>	25.7	31.6	22.8%	6.5%
<i>Outpatient services</i>	82.0	96.8	18.0%	20.0%
<i>Hospital services</i>	252.3	282.5	12.0%	58.4%
<i>Public health services^{xii}</i>	37.8	27.9	-26.4%	5.8%
<i>R&D health</i>	0.1	0.1	-41.8%	0.0%
<i>Health N.E.C.^{xiii}</i>	34.5	45.3	31.3%	9.4%
<i>Division total</i>	432.5	484.1	11.9%	100.0%

Source: Public Spending Statistics 2023⁵³

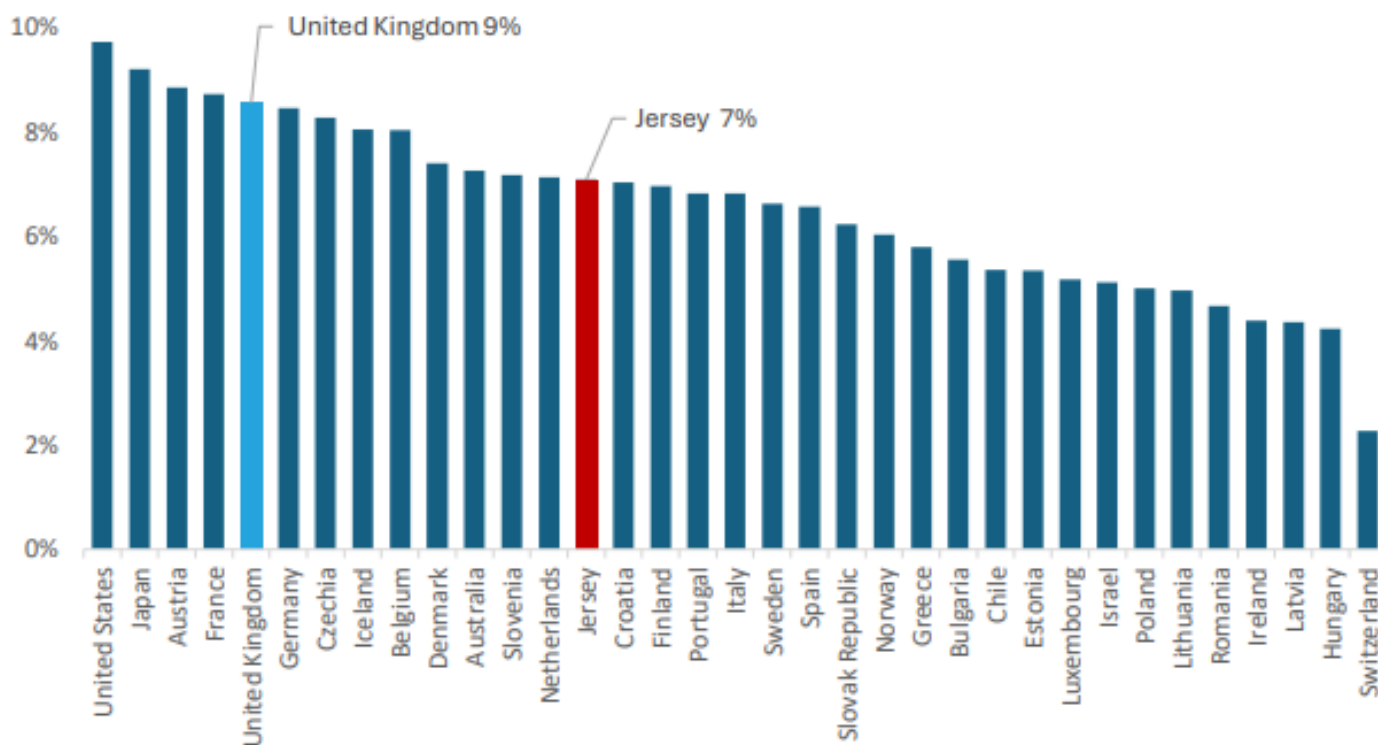
Data on how Jersey compares with its OECD neighbours in terms of overall spend and healthcare spend is interesting. Firstly, total government spend as a proportion of Gross Domestic Product (GDP) is considerably lower in Jersey than most other OECD countries; only Ireland had a lower spend in 2022. And while Jersey's government spends a higher proportion of its income on healthcare (28%) than any other OECD country, its healthcare spend as a proportion of Gross Domestic Product (GDP) is firmly middle of the pack (Figure 71). As a small Island nation, Jersey's relatively high health spending is influenced by fixed healthcare costs, a lack of economies of scale, and relatively high wages.

^{xi} These figures do not include capital expenditure – for further details see the report [Public Spending Statistics 2023](#)

^{xii} *Public Health services include* Provision of public health services; administration, inspection, operation or support of public health services such as blood-bank operation (collecting, processing, storing, shipping), disease detection (cancer, tuberculosis, venereal disease), prevention (immunization, inoculation), monitoring (infant nutrition, child health), epidemiological data collection, family planning services and so forth; preparation and dissemination of information on public health matters. Includes: public health services delivered by special teams to groups of clients, most of whom are in good health, at workplaces, schools or other non-medical settings; public health services not connected with a hospital, clinic or practitioner; public health services not delivered by medically qualified doctors; public health service laboratories.

^{xiii} Nec: not elsewhere classified.

Figure 71: General government expenditure on health as a proportion of GDP, 2022



Source: Public Spending Statistics 2023⁴³

6.4 Cost of ill-health to the economy

There is currently no central estimate of sickness absence rates for the Jersey workforce, nor government statistics on the cost of ill-health to the economy.

As previously seen, in 2023 there were 485,000 days lost to sickness (as covered by Short Term Incapacity Allowance) at a cost of £16.7 million. This is likely an underestimate of the actual number of working days lost due to ill health in Jersey, as sick notes are only required after two days of sickness and not all workers are eligible for allowances. The workforce in Jersey (as measured in June 2023) was 57,650 people which would equate to an average of roughly 8.4 days^{xiv} ill per worker or a sickness absence rate of 3.6% in 2023^{xv} as covered by short term incapacity allowance.

Given Jersey’s productivity in 2023 totalled £6,575million (GDP) with this level of estimated sickness absence included in it, an additional £235million could potentially have been made had those workers not been sick.

Another way to estimate the cost to the economy of poor health is to consider the deaths of those under 65 years of age and the lost years of potential work as a result. Deaths at these ages mean that those individuals are no longer available to contribute to the labour market in the future. In the earlier chapter on the current burden of ill health, it was noted that there were 130 deaths of working age individuals in 2022 which equated to around 1,590 years of working life lost. In 2022, each full-time equivalent worker contributed around £90,000 to the economy on average^{xvi}

^{xiv} Assuming a 5 day working week with 5 weeks holiday per year giving roughly 235 days of work per worker per year or 13,547,750 total days worked in Jersey in 2023

^{xv} As a sense check, reported sickness absence rates for the public sector were 8.8 days (4.4% working time lost) in 2022 and 7.1 days (4.3% working time lost) in 2023 as reported in the [Government of Jersey Annual Report and Accounts 2023](#)

^{xvi} Statistics Jersey, [Measuring Jersey’s economy: GDP and GVA 2023](#), published 4 October 2024

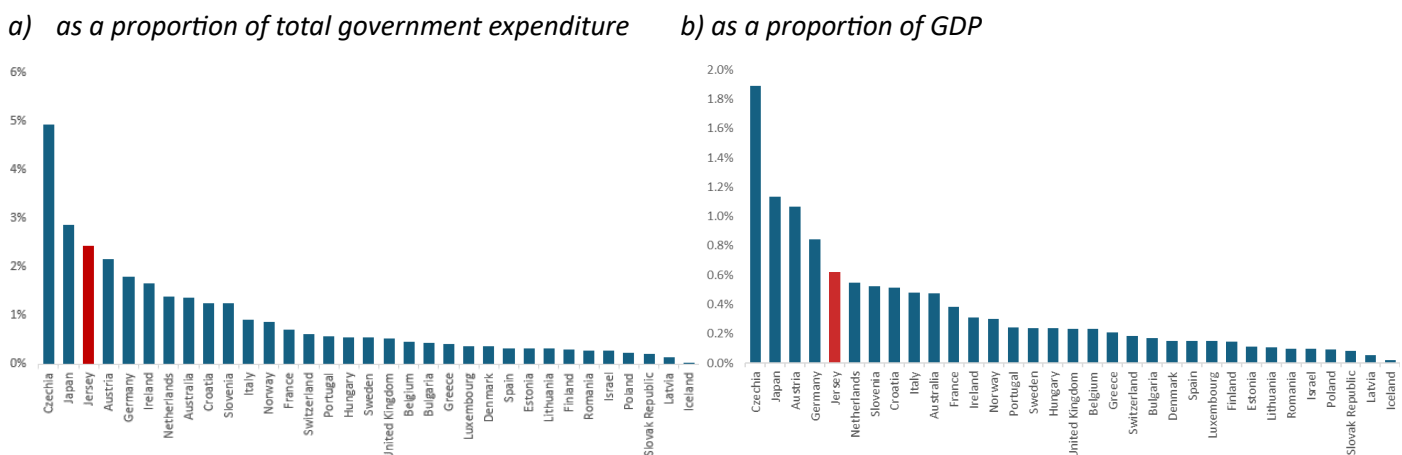
(based on 2023 real term values). This means that, assuming each year of potential lost working life continued to contribute to the economy at average 2022 prices, a potential total of £143,100,000 was lost through deaths which occurred in 2022.

Potential lost productivity from working age deaths in 2022 equated to
£143 million
 (assuming 2022 productivity levels continued for the rest of their potential working life)

6.5 Spending on prevention

Spending on public health services in 2022 by government was 2.4% of overall public spending, putting Jersey above most OECD countries (Figure 72), although spending on public health services fell by 26.4% in 2023.

Figure 72: General government expenditure on public health services, 2022 (before 26.4% reduction in spending in 2023)



Source: Statistics Jersey⁴³

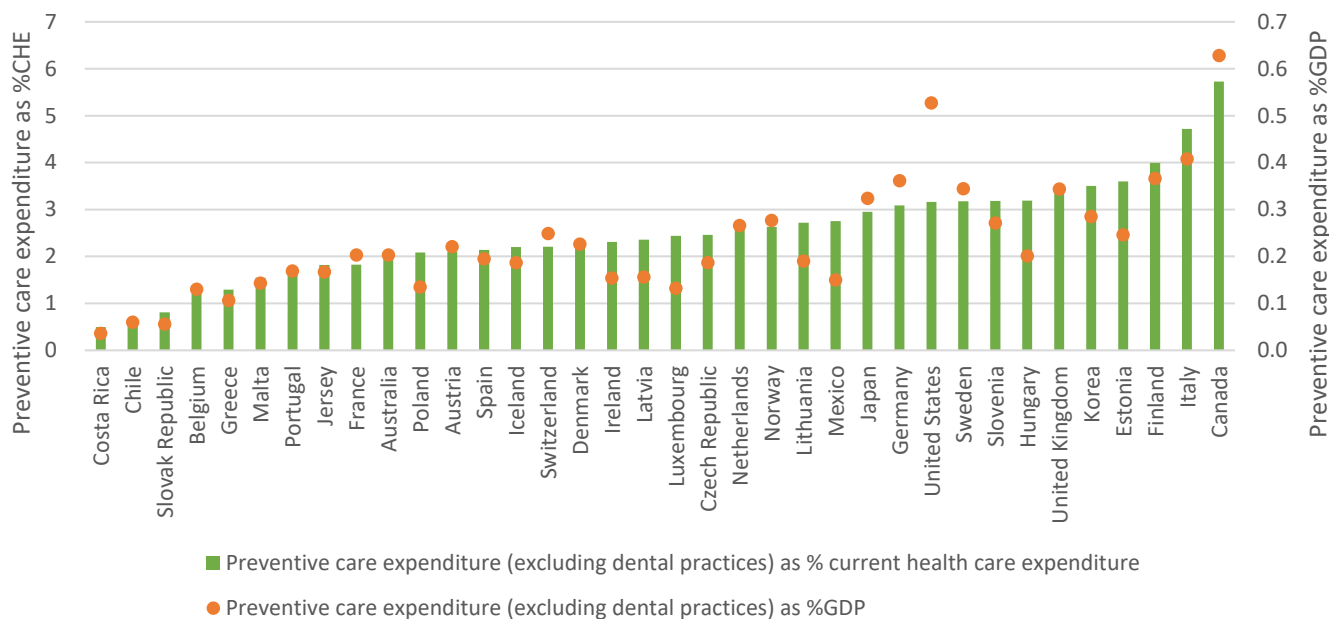
The definitions used by the OECD as part of their System of Health Accounts (SHA 2011) define preventive care as health measures aimed at reducing the risk of disease (such as vaccination and public health information campaigns) and supporting the early detection of diseases (such as screening programmes, check-ups and epidemiological surveillance).

Work by the Health Economics Unit to quantify Jersey spend on preventive care found the largest elements in Jersey included:

- Estimates for the proportion of dental expenditure on check-ups and hygiene activity
- Child and family services provided by Family Nursing and Home Care
- Immunisation programmes
- Strategic public health and healthy lifestyles programmes
- “Help to quit” smoking cessation and alcohol advice services
- Health Insurance Fund funding for GP-provided preventive services under the Jersey Quality Improvement Fund (JQIF) scheme
- Estimates for employer-funded occupational healthcare.

Measuring and comparing preventive care is difficult. Nonetheless, Jersey’s spend on preventive care as a proportion both of current healthcare spending and GDP appears to be low (Figure 73).

Figure 73: Expenditure on preventive care as a percentage of current healthcare expenditure and as a percentage of GDP, 2019



Source: Health Economics Unit, Jersey Health Accounts (unpublished data, used with permission)

Notes: 1. Excludes expenditure in dental practices. 2. Colombia, Israel, New Zealand and Türkiye are excluded due to incomplete data.

6.6 Potential savings

The estimated minimum cost of ill-health to the economy in 2023 is in the region of £576 million^{xvii}. This includes:

- £165.5 million spent on health-related benefits
- £410.9 million healthcare costs (excluding public health services, R&D health and health not elsewhere classified in the government spending figures).

Given these large sums, improving health through better prevention has the potential to reduce government spending. Much of the illness that affects our Island population is preventable and prevention activities known to provide excellent value for money (see appendix 1).

^{xvii} These figures do not include costs such as those associated with carers taking time out of the workplace, those who are ill changing their normal behaviours and spending patterns and the impact of bereavements, which are harder to quantify.

To illustrate the value of potential reductions in spending on poor health

Table 6.4 shows what a **hypothetical** reduction of 1% and 5% of the spend in 2023 would amount to.

Table 6.4: Spending on ill health and hypothetical reductions, 2023

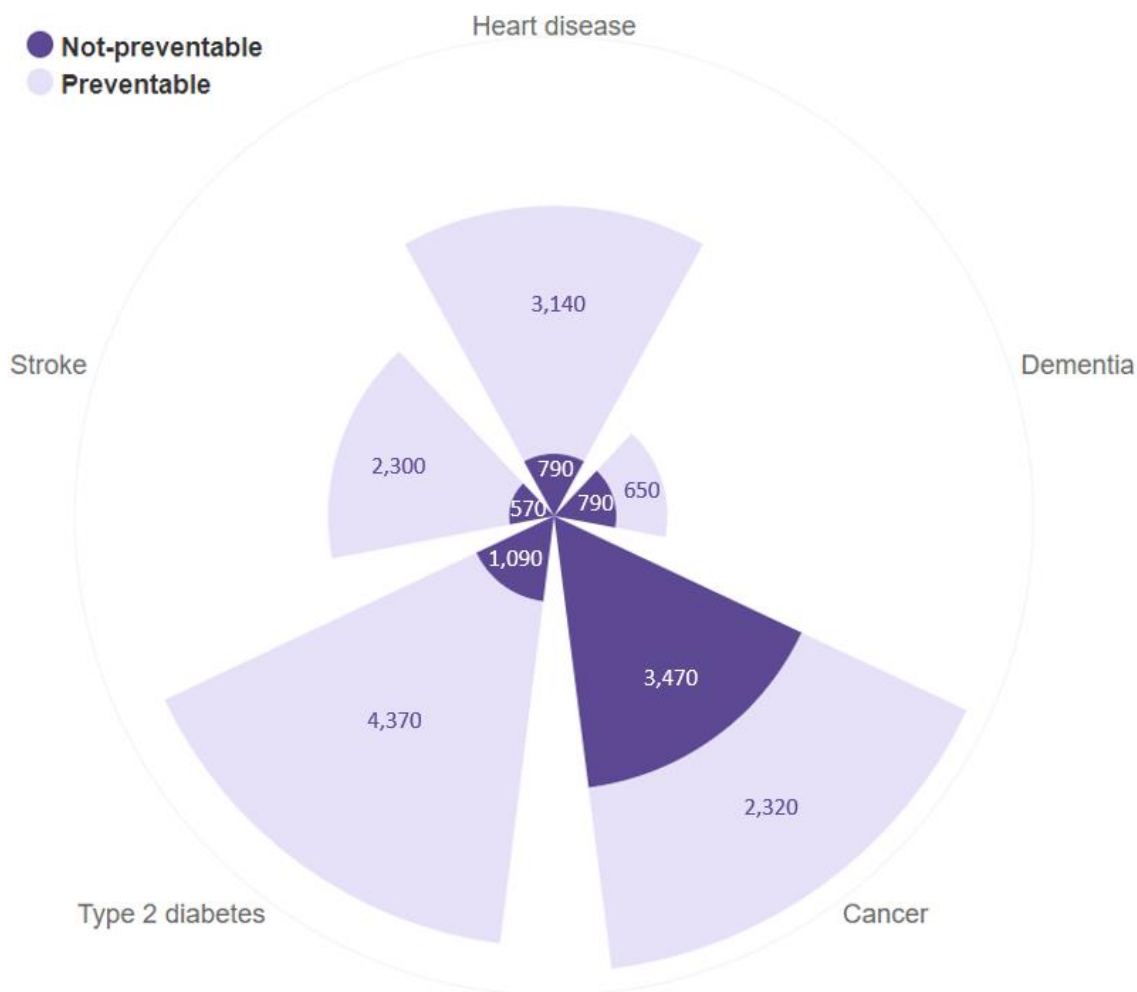
<i>Description</i>	<i>2023 Cost</i>	<i>1% reduction</i>	<i>5% reduction</i>
<i>Days lost due to illness (STIA)</i>	£16,700,000	£167,000	£835,000
<i>Prescriptions (cost of drugs & dispensing fees)</i>	£26,500,000	£265,000	£1,325,000
<i>Medical Benefits (payments to GPs, including medical benefit for GP consultations, pathology benefit, JQIF, Health Access Scheme, and various contracts with GP practices)</i>	£12,900,000	£129,000	£645,000
<i>Long-term Care</i>	£76,000,000	£760,000	£3,800,000
<i>Long-term Incapacity Allowance & Invalidity Benefit</i>	£31,000,000	£310,000	£1,550,000
<i>Carers allowance</i>	£2,400,000	£24,000	£120,000
<i>Medical products, appliances and equipment</i>	£31,600,000	£316,000	£1,580,000
<i>Hospital services</i>	£282,500,000	£2,825,000	£14,125,000
<i>Outpatient services</i>	£96,800,000	£968,000	£4,840,000
<i>Total</i>	<i>£576,400,000</i>	<i>£5,764,000</i>	<i>£28,820,000</i>

Source: Customer and Local Services, Public Spending Statistics 2023⁴³

As noted in the previous chapter, spending on health (as a proportion of a country's GDP) is expected to increase because of increased treatment costs, advances in medical technology and pressures from an aging population. Therefore, these potential savings need to be considered in this broader context of increasing costs and demands to the health system from the aging of Jersey's population.

Another way to consider the potential savings is to apply some hypothetical reductions to the disease prevalence figures. The Chief Medical Officer in England estimated that "up to 80% of new cases of heart disease, stroke, and type 2 diabetes and 40% of cancer incidence could be prevented simply by changing four sets of behaviours (smoking, unhealthy diet, consumption of alcohol and insufficient physical activity)".⁹ The Lancet Commission also identified 14 modifiable risk factors that could prevent up to 45% of new cases of dementia.¹⁰ Figure 74 shows the potential reduction of the disease registers for the five mentioned conditions by 2053 (under the central migration scenario of +325) given this estimate of what is preventable.

Figure 74: 2053 disease projections showing potential number of new cases which could be prevented



Source: Public Health Intelligence

Assuming that all cases on the disease registers will be new cases over the next 30 years, it is estimated that:

- Over 3,100 cases of heart disease could be prevented, leaving around 790 cases on the disease register compared to the current 2,930 (as at 2023)
- Around 2,300 cases of stroke could be prevented, leaving around 570 cases on the disease register. There are currently around 2,020 cases
- There are currently around 5,060 Islanders registered as diabetic with their GP, some 91% with Type 2 diabetes. It is estimated that there will be 6,000 cases on the disease register by 2053 (+325 migration scenario). Assuming 9% are type 1 diabetic, there could be around 5,460 people with Type 2 diabetes in 30 years' time or 1,090 if 80% of new cases are prevented
- Around 2,300 cases of cancer could be prevented in the next 30 years
- Around 650 cases of dementia could be prevented, leaving disease registers at a similar level to 2023

6.7 Summary

This chapter has demonstrated many of the costs to society of illness within the population. It has estimated the significant possible savings associated with improved health through better prevention. It has shown how much of the illness afflicting Islanders is preventable and provided an estimate of how many people could live in better health, if a best-case scenario were brought about.

On the other hand, we have also outlined the likely increase in demand for future services, if current trends continue. The message is clear; improved prevention is a key tool to help Jersey deal with its strategic challenges of an aging population, falling productivity and rising demand for healthcare.

Conclusion

7 Conclusion

*“To truly reduce demand for public services in the long run, we need to not only prevent problems from arising, but create the conditions for flourishing and resilience within communities. Achieving this means investing in those foundational goods which create the social capital that enables us to lead better lives, without state intervention. Only then can a truly preventative state emerge.”⁶⁸ (Demos, *The Preventative State*)*

In this report, we have shown:

- There is a significant burden of poor health on the Island that is preventable. This burden is not felt equally by all Islanders and falls particularly on those with fewer resources.
- This illness carries a significant financial and human cost. As an Island community, we rely on each other, so improving health is in everyone’s interests.
- Because our population is aging, if we don’t invest in prevention, this burden will become greater over time. This will place increasing strain on public finances, and make Jersey a less attractive place to live, work and do business.
- If we were to focus more on prevention, using well-evidenced programmes and activities, we could prevent much of this illness.
- Healthcare services are crucial when we are ill but have a relatively minor role to play in keeping us healthy. Around 70% of what makes us healthy can be attributed to the building blocks of health^{xviii} and the behaviours that these building blocks influence.

Jersey currently uses over half a billion pounds a year on health-related spending. If we were to prevent even 1% of the demand for health services, we would save more than £5m. A 5% reduction would save nearly £29m.

I’ll end with a question. What would a good prevention plan look like in Jersey? There is lots of evidence from around the world on how to keep people healthy. These methods often save money and have a good return on investment. Jersey is like other places but also unique. We need to work together to use prevention to keep our Island’s people healthy for as long as possible. If we do this, Jersey will stay a great place to live, work, and do business.

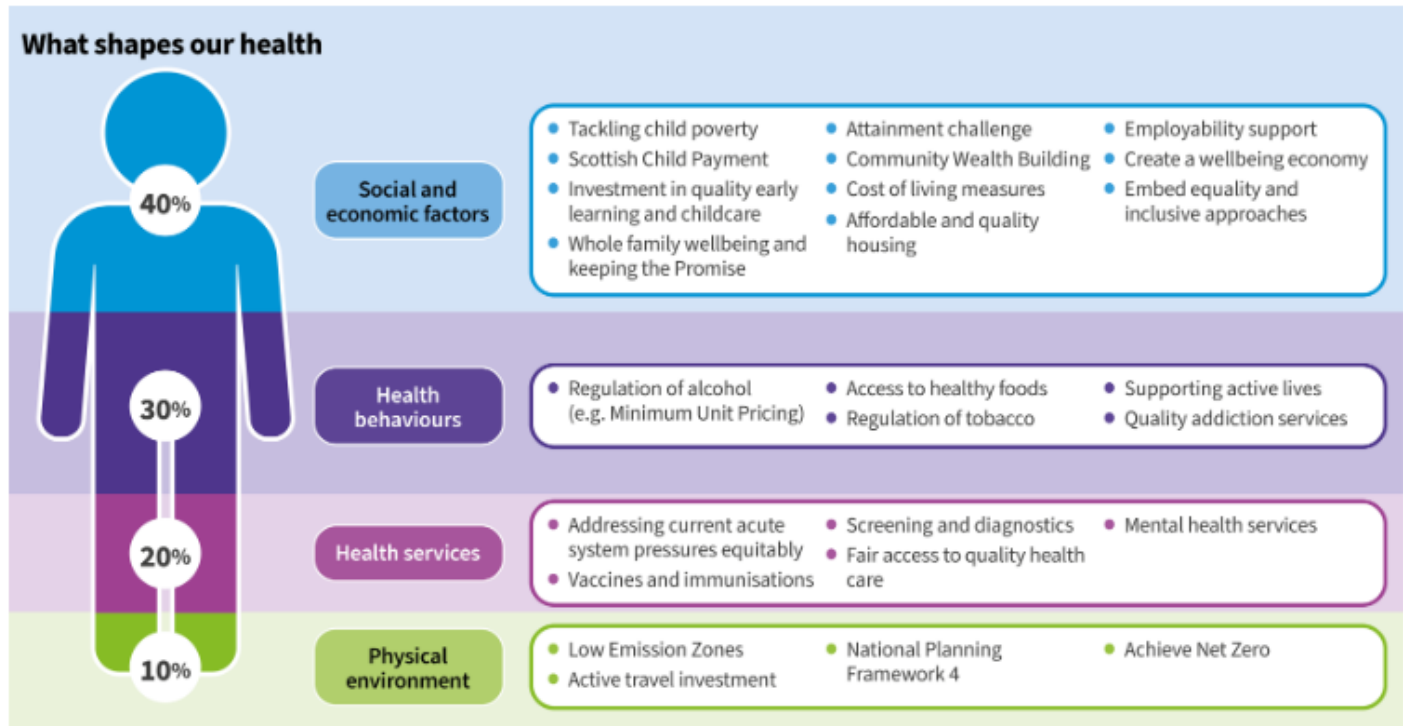
^{xviii} The building blocks of health are: good food; good work; good housing; education and skills; family, friends and communities; transport; money and resources; our surroundings.

8 Appendix 1: A summary of the evidence for prevention

8.1 The causes of poor health

Although healthcare consumes the lion's share of public funding, it plays a relatively small role in our overall health across our lifetime. Social and economic factors, and health behaviours account for 70% of what makes us healthy (Figure 75).⁶⁹

Figure 75: What shapes our health



Source: Public Health Scotland, 2024, Public Health approach to prevention ⁶⁹

Our social and economic conditions have a profound impact on how we behave. For example, having a good education may mean you can get a good job which provides a good income and access to good quality housing and leisure facilities, all of which can support good health. On the other hand, a more limited education (or lack of access to skills training as an adult) may limit these opportunities. If your local shop sells appealing, nutritious food at reasonable prices it is much easier to look after your health than if it stocks mostly snacks, cigarettes and alcohol, especially if you lack the time and money to go elsewhere.

We call these social and economic conditions the building blocks of health (Figure 76). These building blocks are: good food; good work; decent housing; education and skills; having enough money and resources; being part of a community of family and friends; access to transport; and the quality of our surroundings.³ As you can see, many of these are outside of any one individual's control.

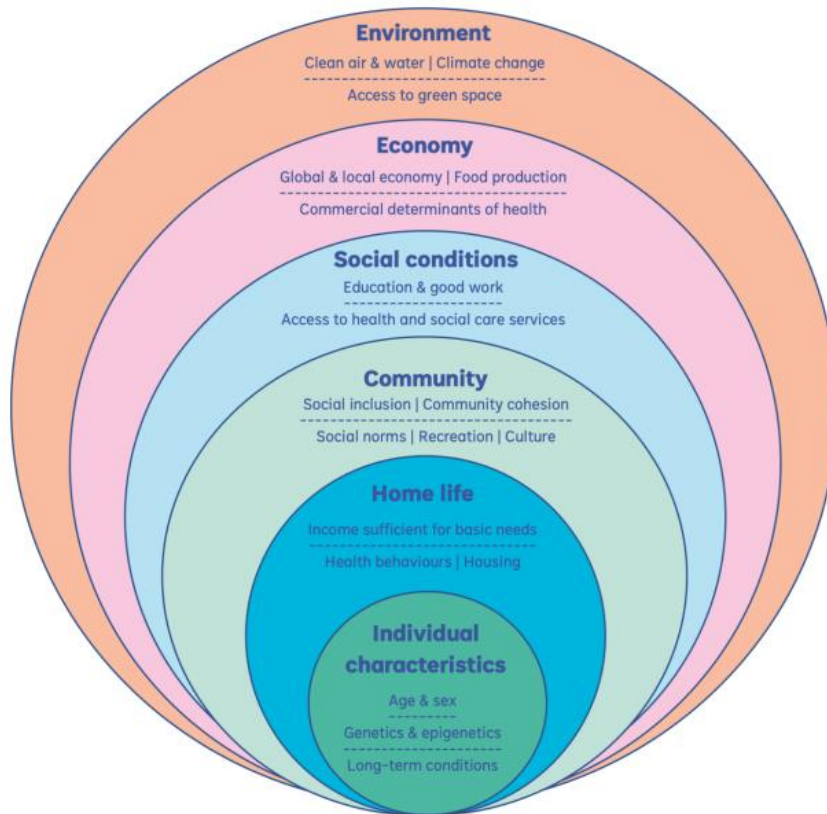
Figure 76: The Building blocks of health



Source: The Health Foundation³

These building blocks of health are also known as the social determinants of health, as outlined in our public health strategy (Figure 77).¹

Figure 77: The social determinants of health



Source: Public Health Jersey¹

There is a robust evidence base for the influence that access to the building blocks of health has on health. For example, The Marmot Review in 2010 showed that those with the greatest access to the resources that fundamentally promote health had the best health overall, while those with the least resources tend to have the worse health. Marmot also showed there was a gradient - everyone sits somewhere on the spectrum between best and worst health. This is important because it shows that, if you make small improvements across a large number of people, then most people's health will improve.⁶¹ In 2010 the report found a 7 year difference in life expectancy between the richest and poorest, and a 17 year difference in healthy life expectancy.⁶¹ A follow up report 10 years later found the gap in how long people live and how long they stay healthy had increased.⁴⁹

8.2 Making the case for prevention

“There is a bunch of things that we know work that are simply not happening, but if they happened to most people at risk, things would improve really quite fast.”² (Dr Chris Whitty, Chief Medical Officer for England)

In 2002 Derek Wanless was commissioned to make a comprehensive assessment of likely future healthcare costs. The ‘Wanless Report’ as it became known, costed three likely scenarios with differing levels of prevention. ‘Slow uptake’ of prevention activities cost the most in the long run for the smallest increase in health. ‘Solid progress’ modelled some investment in prevention and showed modest health gains for a medium cost. The ‘fully engaged’ scenario costed a transformation of healthcare, where prevention efforts were central; this showed the biggest gains for the smallest cost. Unfortunately, the situation today - with some notable exceptions like the fall in smoking rates - looks a lot like the slow uptake scenario: very significant increases in costs for very small gains or even a deterioration in overall health.⁷⁰

Although treating sickness accounts for less than 30% of our health status it consumes 90% of health-related resources.² The English Chief Medical Officer's (CMOs) report, updated in November 2023, argues for the value of prevention as a way of delaying the onset of illness and so shortening the number of years lived in poor health. The different rate at which people age (biologically, rather than chronologically) depends on their social circumstances. People living in the poorest areas spend, on average many more years (26.4 years) in poor health than those in the richest areas (15.6 years).⁷¹

Physical and mental health are the biggest drivers of wellbeing - people who are unwell are less happy. At a population level, poor health increases demand for healthcare and social support and reduces labour supply and economic growth. Taken together, these increase costs to society. The 2024 King's Fund paper, a Covenant for Health, concludes: “a person who is in good enough health is likely to be happier, to keep in work, to pay taxes, not to require welfare or social care support, and to be able to support others”.² The report then sets out workable actions for addressing the main drivers of preventable ill health: smoking, poor diet, alcohol, low physical activity and air pollution. It also addresses the need for better early detection and treatment of existing illness (or risks for illness, like high blood pressure). Finally, it focusses on the importance of place, showing that a greater focus is needed in areas with poorer health.²

Picking up on the drivers of poor health, a report by the World Health Organisation outlines many recommended preventive activities for tackling the world's major long-term conditions. It focusses on cost effective ways to improve diet, reduce smoking, increase physical activity and reduce alcohol consumption. These activities would help with a range of long-term illnesses, in particular cardiovascular disease, diabetes, cancer and respiratory disease. Multiple interventions are highly cost-effective across a range of settings.^{72, 73}

Work has also been done to find effective ways to prevent dementia. A recent Lancet Commission found 14 risks for dementia which could theoretically be prevented or delayed. Together, these account for about 45% of dementia risk worldwide. They include less education, hypertension (high blood pressure), hearing impairment, smoking, obesity, depression, physical inactivity, diabetes, low social contact, excessive alcohol consumption, traumatic brain injury, air pollution, untreated vision loss and high LDL cholesterol.¹⁰

The Organisation for Economic Co-operation and Development (OECD) assessed the economic value of cancer prevention, estimating that around 40% of cancer cases could be prevented. Achieving WHO targets on six key risks could reduce spend on cancer by 9% across the OECD. For example, the report outlines the impact of improved

tobacco control, better diets, reduced alcohol consumption and improved vaccination against the human papilloma virus (HPV) (the main cause of cervical cancer). The possible savings across these wealthy countries are huge. For example, better tobacco control could save an estimated €13.3 billion.³⁸

The value of early detection, and various treatments to manage risks for poor health like high blood pressure and raised cholesterol, is highlighted in a 2023 report by the Tony Blair institute. The arguments here are firmly in the camp of treatment for individuals rather than societal changes, but it argues elegantly for a healthcare system that “focuses on early detection and early therapy as well as anticipating disease with targeted prevention. Such a strategy would create a genuine “health system” rather than a “sickness system”, which we operate now”. It notes that 80% of a person’s lifetime with long-term illness is spent in the pre-symptomatic phase, with biological markers of raised risk (e.g. high blood pressure or cholesterol) for which there are effective treatments. The report notes that increased costs to the taxpayer now would be offset by projected future gains healthcare.⁷⁴

The Early Intervention Foundation estimated the cost of providing ‘late intervention’ - rather than preventative services - for children and young people at £17 billion/year. It defines late intervention as, “the acute, statutory and essential benefits and services that are required when children and young people experience significant difficulties in life, many of which might have been prevented”.⁷⁵ The Health Foundation/Demos report updates this figure to £22 billion in 2023 terms.⁷⁶

The evidence of the cost effectiveness of public health interventions is substantial. The University of Cambridge and Cambridge Public Health assessed the cost-effectiveness of interventions paid for by the public health grant in England. They found 134 interventions were cost-effective, with smoking interventions having the largest evidence base. This report also notes the importance of choosing interventions carefully - they differ widely in their effectiveness, cost-effectiveness and impact on health inequalities.²⁷

In addition, in 2010 two Australian universities attempted to create a hierarchy of preventative activities, by combining assessments of cost-effectiveness and impact on health. They found a number of programmes that were both cost-effective and improved health.³⁰ Meanwhile, a 2012 paper found the majority of public health (preventative) interventions were cost effective and some were cost-saving.²⁸

8.3 The link between productivity and prevention

“Preventative health care can thus provide a triple benefit of a healthier population, a stronger economy with more people in work and an improved fiscal position”.²⁰ (TBI, The Economic Case for Protect Britain)

The Health Foundation have repeatedly made the case for considering health as a shared resource that powers communities, enables an active social life and underpins a vibrant economy.^{22, 23} They argue that health is fundamental to a nation’s wellbeing and that poor health has “significant economic consequences both for society and individuals, whose participation in the labour market may be limited by health problems”.²³ As a result, “poor health carries a high financial cost for the state, including the costs of treating avoidable illness and social security costs associated with poor health”.²³

A 2024 report by the Tony Blair Institute estimated that a 20 per cent reduction in the incidence of six major disease categories that are keeping people out of work could be worth £19.8 billion/year to the UK economy within five years, and £26.3 billion/year in 10 years. These six condition are cancer, cardiovascular disease, chronic respiratory illness, diabetes, mental health and musculoskeletal disorders.³⁴ A further report in the same series made a similar case, based on a narrower modelling of the impact of improved cardiovascular disease prevention. The suggested approach included making use of “upgraded digital infrastructure, better health checks and a wider uptake of existing treatments”. It concludes “preventative health care can thus provide a triple benefit of a healthier population, a stronger economy with more people in work and an improved fiscal position”.²⁰

Meanwhile, Oxera estimated the cost of lost economic output due to poor health among people of working age in the UK at 7% of gross domestic product (GDP), or £150 billion. They estimated a further £70 billion in costs to government in terms of lost tax income, healthcare and social support.³²

The cost of reduced productivity from working while mentally unwell (“presenteeism”) has been estimated at £21.2 billion by The Centre for Mental Health (2018), with an additional £10.6 billion in costs from sickness absence.³⁶

The Rand Corporation also examined this issue, finding that a “lack of sleep, financial concerns and giving unpaid care to family members or relatives are negatively associated with productivity.” They also found associations with mental health, musculoskeletal issues and chronic disease (but not obesity).³⁶ Furthermore, analysis using data from the UK Household Longitudinal Survey during the Covid-19 pandemic to assess the link between mental health and productivity in 2022 found a strong relationship between mental health and productivity. A unit decrease in mental health equated to a 4-minute decrease in productivity per working day.³³

The impact of specific conditions on productivity is also well evidenced. For example Frontier Economics has modelled the cost of obesity in the UK, coming up with a headline cost of £98 billion. £19 billion fell to the NHS, £16 billion to wider society through lower productivity. The other £63 billion represented the economic value of fewer years of quality life and informal support of friends and family. Regardless of the exact figures, the report shows that obesity carries significant healthcare, social care, informal care and human cost.³⁵

The Deloitte Centre for Health Solutions has produced a series of reports on the business case for investing in mental health for employees.⁷⁷⁻⁸⁰ Each of these made the case that investing in mental health prevention was sound business. The first report laid out the case for the importance of considering mental health at work.⁷⁸ The following reports dive deeper into the economics of prevention, finding repeatedly that employer investment in employees’ mental health return £5 of value for every £1 spent.^{77, 79} The third report noted, “proactive interventions have proven to bring better outcomes and higher return on investment than reactive approaches, and with a healthy individual, society usually benefits too”.⁷⁹ The final report concludes that, “The case for investing in employees’ mental health and wellbeing is clear”.⁸⁰

Aside from considering the impact from individual health conditions on productivity, another way to consider the impact of health more generally is to consider healthy aging. The International Longevity Centre (ILC) makes the point that, while longer lives can be framed as a burden (increasing illness leading to greater costs to the state for healthcare and social support), these longer lives also represent an opportunity: “in countries that spend more on health, older people work, volunteer and spend more”. The report identified huge possible financial benefits (£500 billion) from healthier, more active older people.⁴⁰

Finally, Andy Haldane, the former chief economist at the Bank of England, in his 2022 lecture for the Health Foundation argues that “health is wealth”, and that a failure to invest in what he calls a “societal immune system” has compromised the UK’s health which, in turn, has weakened the UK’s economy. He views health as a social asset in which we need to invest.²¹

8.4 Return on Investment

Prevention is great value for money. Multiple academic papers and reports from governments, think tanks and business cite preventative approaches as being effective, cheaper than treatment, with high average returns on investment. In many cases they are also cost-effective, i.e. they save more money than they cost.²⁵⁻³⁰ Preventing illness is approximately four times cheaper than treating it.²⁴

A 2017 systematic review assessed the returns on investment (ROI) of a wide range of preventive interventions. The average (median) ROI for primary prevention was 14.3 to 1. The average ROI for local level interventions was 4.1 (range 0.9 to 19.3) whilst the average ROI for national interventions was 27.2 (range -21.2 to 221). Interventions were also assessed by specialism. When looked at in this way, legislation was found to provide the best ROI, at an average of 46.5 (range 38-55).²⁵ It’s important to note here that return on investment does not equate to money saved. Rather, the figure gives an assessment of the value, in monetary terms, of a range of benefits resulting from the chosen activity.

The Faculty of Public Health (2020) reported that public health (i.e. preventive) interventions funded by the public health grant in England resulted in improvements in health that were about four times cheaper (£3,800) than the equivalent improvement when delivered by NHS treatment services (£13,500).²⁴

The Office for Health Economics recently produced a report that summarises and combines much of the academic evidence. The report highlights “the broad societal benefits achievable through a well-orchestrated prevention strategy”.⁸¹ In other words, public health spending is excellent value for money.

The NHS Confederation have written a series of reports making the case for healthcare and prevention.

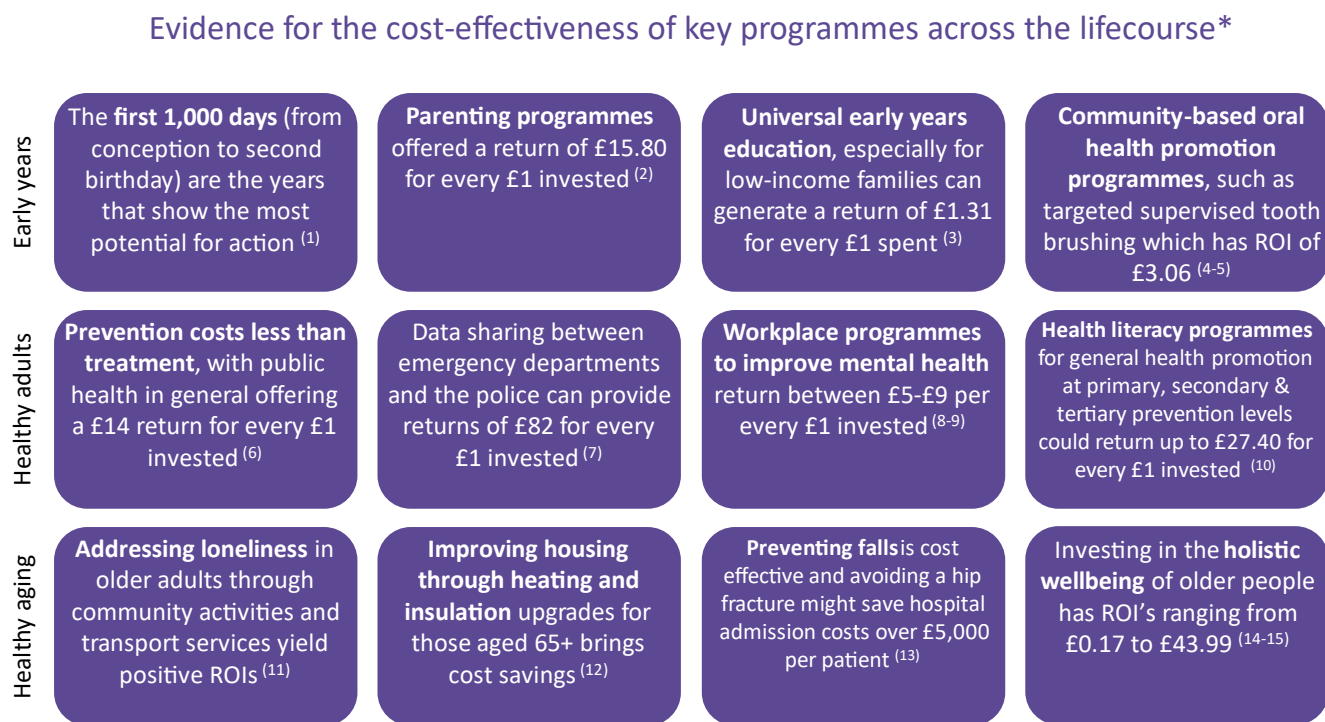
1. The first, from 2022, quotes independent analysis that shows that “every pound invested in the NHS results in around £4 back to the economy through increased gross value added, (GVA), including through gains in productivity and workforce participation”.³⁹ This is an argument for healthcare in general rather than prevention specifically.
2. The second report, from 2023, found an association between increased economic output and health funding. They found that investment in community and primary care interventions generated higher economic returns (£14 per pound spent) than spending in hospitals (£11 per pound spent).³⁷
3. The third report found that increased spend on community care was associated with a reduced demand for acute services. Overall, the report recommends that “community spend is prioritised as a mechanism for reducing long-term pressure on the acute sector, as a crucial contributor to healthcare system productivity and as a direct lever to provide patients with the care they deserve”.⁸²

The final report from the NHS confederation focuses on prevention. It suggests that choosing prevention interventions with the highest returns could significantly increase the value of the public health grant. The report states that the “top 20 interventions by ROI [return on investment] were all community-based with a range of returns from £6.90 to £34.75”. The NHS confederation note the variation in ROI between interventions, with ROI varying by type of intervention and between studies of the same intervention. A locally tailored approach, with strong evaluation, is clearly important. Finally, the report notes that ROIs for children’s interventions matched adult interventions, even though most studies only considered a 5-year timescale for evaluation. Thus interventions aimed at children are likely to be a particularly efficient use of resources.³¹

The evidence for ROI for preventive programmes with a focus on supporting improved mental health was assessed in 2016 by the Faculty of Public Health with two key findings. Firstly, it is important to choose interventions with care as some have vastly different ROIs. Secondly the organisation that delivers the intervention is key; for example, an early intervention for depression in diabetes showed an ROI of 1.08 when delivered by the NHS but 5.03 when delivered outside of the public sector.²⁶

Other work to assess the ROI of a range of various prevention interventions by the King’s Fund, Local Government Association⁸³ and four London boroughs for ROIs varied from 2.5 for drug treatment services to 110 for investment in housing²⁹. This suggests interventions which target the building blocks of health are likely, on average, to produce a greater return on investment.

Figure 78: Evidence for cost-effectiveness of some key programmes across the life course



*Based on work by Public Health Wales, Investing in a Healthier Wales: prioritising prevention, 2025, available from [Investing in a Healthier Wales: prioritising prevention](#)

8.5 Summary

“Genetics, environment, and behaviours drive 70% or more of our health status. Treating sickness accounts for less than 30% but still consumes 90% of resources”.²

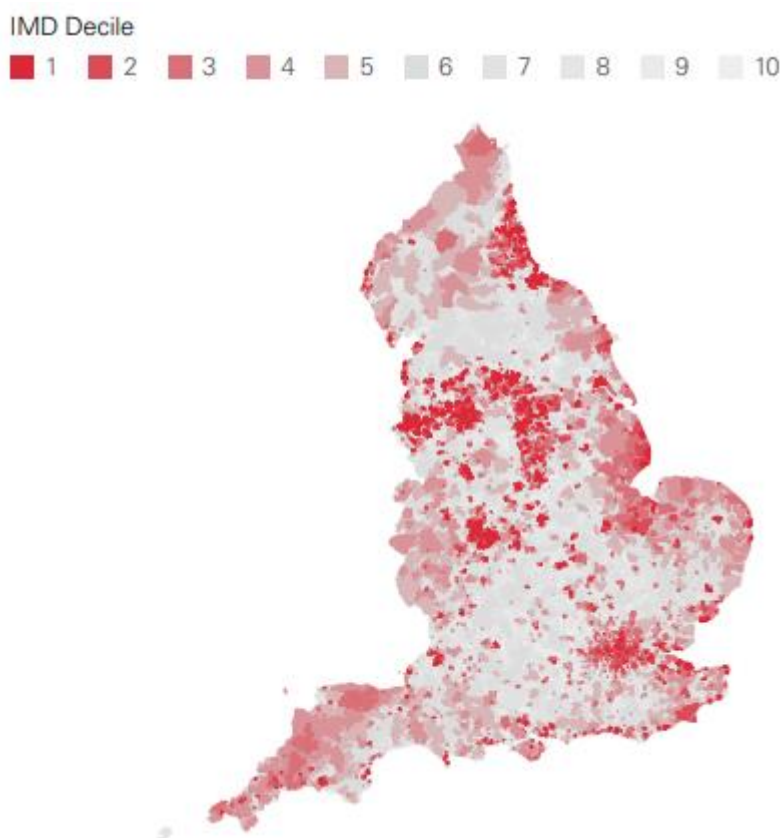
There is an overwhelming consensus from academia, governments, society and business that investing in prevention make sense. There are strong financial arguments - healthier people are more productive. There are compelling moral arguments - since many factors that influence health are outside of our control, it's unfair that some people suffer worse health that could be prevented. As an Island nation, we depend on each other. Investing in our health is an investment in all our lives.

9 Appendix 2: A note on other jurisdictions

Jersey is not the only jurisdiction predicting an increase in the burden of disease in the future, with the Health Foundation Report [Health in 2040](#) and the [Chief Medical Officers Annual Report 2023 – Health in an Ageing Society](#) highlighting similar challenges for England. It is worth considering the impact an aging and unhealthy population in the UK will have on their health service as this may have implications for Jersey residents being sent to UK hospitals for specialist treatment that is not available on the Island.

Many of the UK Hospitals used by Jersey patients are situated in areas where there are high levels of deprivation (see Figure 79) and therefore higher levels of health need. Coastal areas in England also experience higher levels of deprivation, including areas in the South. Whilst metropolitan areas like London, Birmingham and North West also have a higher density of deprived areas. The impact of the current levels of deprivation in these areas on the future health needs will be published by the Health Foundation in due course.

Figure 79: Distribution of the deciles of the Index of Multiple Deprivation (IMD) by Lower Layer Super Output Areas (LSOA) in England, 2015



Source: The Health foundation, [Health inequalities in 2040: current and projected patterns of illness by deprivation in England](#)

10 Glossary

BMI (Body Mass Index): A measure of body fat based on an individual's weight in relation to their height, used to categorize underweight, normal weight, overweight, or obesity.

Building Blocks of Health: Key factors that contribute to health and wellbeing, such as nutrition, housing, education, employment, and access to healthcare.

CHD (Coronary Heart Disease): A condition where the coronary arteries supplying blood to the heart become narrowed or blocked, often leading to heart attacks.

CKD (Chronic Kidney Disease): A long-term condition characterized by reduced kidney function over time.

COPD (Chronic Obstructive Pulmonary Disease): A group of lung diseases, including emphysema and chronic bronchitis, that cause breathing difficulties.

Commercial Determinants of Health: The ways in which commercial practices and products, such as marketing of unhealthy foods or tobacco, affect public health.

Dependency Ratio: The ratio of dependents (children and older adults) to the working-age population, indicating the economic burden on the workforce.

Deprivation: A lack of resources or opportunities, often linked to poverty, poor living conditions, and limited access to education or healthcare.

Diabetes: A chronic condition that affects how the body regulates blood sugar levels, due to insufficient insulin production or resistance to insulin.

FAST Alcohol Screening: A quick screening tool to identify potential alcohol misuse, focusing on frequency, quantity, and patterns of consumption.

GDP (Gross Domestic Product): The total monetary value of all goods and services produced within a country over a specific time period.

GINI Coefficient: A measure of income inequality within a population, ranging from 0 (complete equality) to 1 (maximum inequality).

GVA (Gross Value Added): A measure of the value of goods and services produced in an area, industry, or sector of the economy.

Health Inequalities: Differences in health outcomes and access to healthcare services between different population groups, often influenced by social, economic, and environmental factors.

Healthy Life Expectancy: The average number of years a person is expected to live in good health, without chronic illness or disability.

Hypertension: High blood pressure, a condition that increases the risk of heart disease, stroke, and other health issues.

Life Course: An approach to health that considers how factors throughout a person's life influence health outcomes, from prenatal to old age.

Life Expectancy: The average number of years a person is expected to live based on current mortality rates.

LTIA (Long-term Incapacity Allowance): a Social Security contributory, in work benefit that Islanders can apply for if they have either long term ill health or an injury that has been ongoing for at least 6 months before they apply

Multi-morbidity: The coexistence of two or more chronic conditions in an individual.

Neoplasms: Abnormal growths of tissue, which can be benign or malignant (cancerous).

Net Migration: The difference between the number of people entering and leaving a region or country over a specific time period.

Obesity: A medical condition characterized by excessive body fat that may impair health, typically measured by Body Mass Index (BMI).

Prevention: Measures taken to reduce the risk of disease or injury, or to mitigate its impact when it occurs.

Primary Prevention: Actions aimed at preventing the onset of disease or injury (e.g., vaccinations, healthy lifestyle promotion).

ROI (Return on Investment)/Cost-effectiveness: A performance measure used to evaluate the efficiency or profitability of an investment, often expressed as a ratio or percentage. Cost-effectiveness compares the relative costs and outcomes of different interventions.

Secondary Prevention: Measures to detect and treat diseases early, reducing their progression or severity (e.g., screenings, early diagnosis).

Social Determinants of Health: Conditions in which people are born, grow, live, work, and age that influence their health outcomes.

Social Equity: Fairness in social policy and practices, ensuring equal opportunities and resources for all, particularly for disadvantaged or marginalized groups.

STIA (Short-Term Incapacity Allowance): a benefit which may be paid to Islanders if they can't work due to injury or illness. STIA can be paid for a minimum of 2 days and a maximum of 364 days.

Tertiary Prevention: Interventions to manage and reduce complications of established diseases (e.g., rehabilitation, chronic disease management).

TIA (Transient Ischemic Attack) & Stroke: A TIA, or "mini stroke," is a temporary disruption of blood flow to the brain. A stroke is a more severe and lasting interruption, often causing long-term damage.

Upstream/Downstream: A metaphor describing approaches to health interventions. "Upstream" focuses on addressing root causes and social determinants, while "downstream" deals with immediate, individual-level treatments and outcomes.

11 Background Notes

Public Health Intelligence Reports

A range of public health data sources have been used to present evidence on the current state of health in Jersey, the unequal health of Islanders and the future disease burden. These reports can be accessed via the website www.gov.je

Spiral of life diagram

The spiral of life diagram has been compiled using the latest Jersey data from the Public Health data explorer tool with comparisons to the latest UKHSA public health outcomes framework for England.

Jersey Census

The Jersey Census takes place once every decade. The last census took place on 21 March 2021. The census: • gives us the most accurate and up-to-date estimate of the number of people and households in Jersey • asks questions about you and your household to build a detailed picture of Jersey today • provides a snapshot of who we are as a community and how we live together. Statistics Jersey runs the census. They are professionally and operationally independent from the Government of Jersey. Published bulletins can be found here: [2021 census results \(gov.je\)](#)

Population estimates

The main measure of Jersey's population is provided by the census, which was last held in March 2021. Between each census, population and migration estimates are produced annually using linked administrative data. The latest of these estimates is for the year 2023. Administrative data is data collected by the government for the purposes of running services such as education, health, and social security benefits. The administrative data method uses people's interactions with Government of Jersey to classify whether they were resident at various points in time.

Population Projections

The population projections provide data on the projected future size and structure of Jersey's resident population that would arise under given scenarios of births, deaths and migration patterns.

The projections use a baseline of residents in Jersey based on the latest Jersey population and migration statistics. The population model uses this baseline population and projects the population forwards year by year, by adding births, subtracting deaths and adjusting for inward and outward migration.

It's important to note that the projections are not forecasts and so will differ from the actual future outcomes to a greater or lesser extent. They assume that current trends and behaviour in respect of fertility, mortality and migration continue forward over the projection period. Changes to these assumptions will affect the results, therefore the findings should be considered an estimate based on recent trends to inform decision making.

Jersey Opinion and Lifestyle Survey

Statistics Jersey collects the experiences and opinions of Islanders to help influence government policy through the Jersey Opinion and Lifestyle Survey (JOLS). Over the last 17 years, this survey has allowed 25,000 Islanders to share what life is like for them and play their part in shaping Jersey's future. Only households specifically chosen can complete the survey. This is to ensure that a random, unbiased group of people that truly represents Jersey is sampled. The survey collects detailed information on a wide range of social issues and provides official social statistics about Jersey, allowing everyone in the Island to have a better understanding of social issues and for policy to be made from a more informed standpoint. The survey is run, analysed, and published by Statistics Jersey. Reports can be found here: [Jersey Opinions and Lifestyle Survey \(JOLS\) \(gov.je\)](#)

Jersey Children and Young People's Survey

Formerly known as the Health Related Behaviour Questionnaire (HRBQ) and the Jersey School Survey, this survey and subsequent report was first run in 1996 to record the attitude and behaviour of children and young people in Jersey,

in terms of their lifestyle, health and wellbeing. The survey has been run in-house by Statistics Jersey since 2018, at a frequency of every two years. For continuity, Statistics Jersey continue using a number of questions to measure changes over time. Some of the questions in the questionnaire are taken from, or based on, the work of John Balding, Schools Health Education Unit, Exeter (www.sheu.org.uk). Published reports can be found here: Jersey Children and Young People's Survey (gov.je)

Life expectancy

Period life expectancy is the average number of additional years a person can be expected to live for if he or she experiences the age-specific mortality rates of the given area and time period for the rest of his or her life.

Jersey's age-specific mortality rates (ASMRs) are applied to estimates of Jersey's population by age and gender using an abridged life table methodology. Abridged life tables (based on five-year age groups) were constructed using standard methods. Separate tables were constructed for males and females using numbers of deaths registered in calendar years and annual mid-year population estimates.

Healthy Life expectancy

Healthy life expectancy (HLE) is an extension of life expectancy, that combines mortality data with general health status data, to produce estimates of the span of life that a person can expect to live in 'very good' or 'good' health. Healthy life expectancy can be calculated for any age, to give the further number of years a person can expect to live in good health on average, given the age they have already attained. It is calculated by using local age-specific mortality rates, along with data on self-reported health status to calculate healthy life expectancy in this report. The estimates are made using a Sullivan life table, following methodology set out by the UK Office of National Statistics.

Alcohol and Smoking Related Hospital Admissions and Mortality

These indicators use existing standard methodologies (as published by UK Health Security Agency) to produce numbers of hospital admissions and deaths.

Multi-morbidity

The data used in this report is extracted from the General Practitioner Central Server (GPCS). The registers are calculated based on patients considered 'active' at year end – that is, any patient registered with a Jersey GP practice who had had a consultation within the previous five years, or who had registered with a GP surgery in the previous six months.

Table 11.1 details the criteria used to identify patients on each of the 12 long-term conditions. The criteria are defined as per the Jersey Quality Improvement Framework (JQIF).

Patient counts below 5 are suppressed, and all counts are rounded to the nearest 5 throughout the report.

Disease combinations (e.g. pairs, triads, quads) are inclusive, meaning for each combination all patients with that set of morbidities are included regardless of whether they have other additional conditions.

For example, somebody with 3 conditions (obesity, hypertension, and diabetes) would be counted in all 3 of the following disease pairs:

- Obesity and hypertension
- Hypertension and diabetes
- Diabetes and obesity

The number of possible disease pair combinations is 66, for disease triad combinations is 220 and for disease quad combinations is 715. Not all disease combinations are found amongst Jersey's population. Analysis for this report looked at all combinations, and the report summarises those which were found to be most commonly co-occurring.

Where figures are expressed as a proportion of the population, the population figures from the 2021 Census (published by Statistics Jersey) have been used as a denominator.

Table 11.1: Jersey Quality Improvement Framework (JQIF) disease register descriptions

Code	Condition	Definition
<i>AST001</i>	Asthma	A register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months
<i>CHD001</i>	Coronary Heart Disease	A register of patients with coronary heart disease
<i>CKD005</i>	Chronic Kidney Disease	A register of patients aged 18 years or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)
<i>COPD001</i>	Chronic Obstructive Pulmonary Disease	A register of patients with COPD
<i>DEM001</i>	Dementia	A register of patients diagnosed with dementia
<i>HF001</i>	Heart Failure	A register of patients with heart failure
<i>HYP001</i>	Hypertension	A register of patients with established hypertension
<i>MH001</i>	Mental Health	A register of people with schizophrenia, bipolar disorder and other psychoses and other patients on lithium therapy
<i>OB002</i>	Obesity	A register of patients aged 16 or over with a BMI greater than or equal to 30 in the preceding 12 months.
<i>STIA001</i>	Stroke and Transient Ischemic Attack	A register of patients with stroke and TIA

Avoidable (treatable and Preventable) Mortality

In 2020, a new **avoidable mortality** definition was created by an OECD working group. This revised definition of avoidable mortality uses a broader definition of preventable mortality, including causes of death that should be avoidable through public health and primary prevention interventions to reduce the onset of diseases or injuries. Alongside this, a narrower definition of amenable mortality, which is referred to as ‘treatable’ mortality, is used including causes of death that could be avoided through health care interventions including secondary preventive actions, for example screening programmes, and treatments to reduce fatality after the onset of diseases. The implementation of the new avoidable mortality definition means Jersey’s statistics are internationally comparable, as well as comparable between local administrations and over time at national and subnational level.

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