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September 2021

Isle of Man Health and Lifestyle Survey 2019

Nadia Butler, Zara Quigg, Rebecca Bates, Madeleine Sayle, Henrietta Ewart

Public Health Institute, Liverpool John Moores University, 3rd Floor Exchange Station, Tithebarn Street, Liverpool, L2 2QP

Contact: N.L.Butler@ljmu.ac.uk, ISBN: 978-1-912210-81-7

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Authors:
Nadia Butler, Zara Quigg, Rebecca Bates
Public Health Institute, Liverpool John Moores University[a]

Madeleine Sayle, Henrietta Ewart
Public Health Directorate, Isle of Man[b]

[a] Public Health Institute (PHI)
Faculty of Education, Health and Community
Liverpool John Moores University
Henry Cotton Building
3rd Floor Exchange Station, Tithebarn Street, Liverpool L2 2QP
0151 231 4148 / n.l.butler@ljmu.ac.uk

[b] Public Health Directorate, Cabinet Office, Isle of Man Government
Cronk Coar, Nobles Hospital Site, Strang, Douglas, Isle of Man, IM4 4RJ
01624 642648 / Madeleine.Sayle@publichealth.dhss.gov.im

Contributorship

Nadia Butler planned and conducted the analyses of the survey data, and drafted the report. Zara Quigg advised on data analysis plan and reviewed the report. Rebecca Bates cleaned the data set and designed the infographic. Madeleine Sayle and Henrietta Ewart (and colleagues) planned and implemented the survey and commissioned data analyses and report production. All authors contributed to and edited draft reports, and agreed the final text.

Acknowledgements

We are very grateful to all Isle of Man residents who kindly participated in the survey, and Dr Henrietta Ewart, Director of Public Health, for supporting the development and implementation of the survey. Further, we would like to thank Jennifer Lovelady at the Public Health Institute for designing the report front cover and Zoe Ball for proofing the report.

September 2021
ISBN: 978-1-912210-81-7 (web)
Available at: www.ljmu.ac.uk/phi

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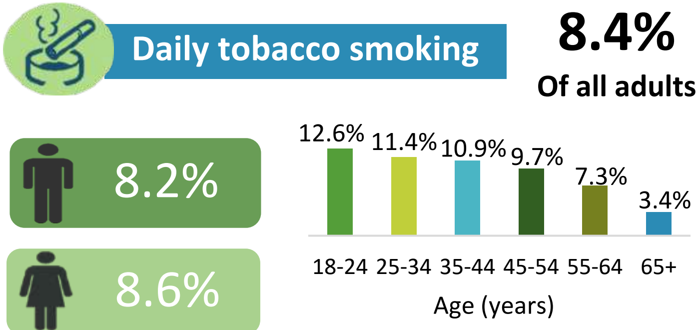
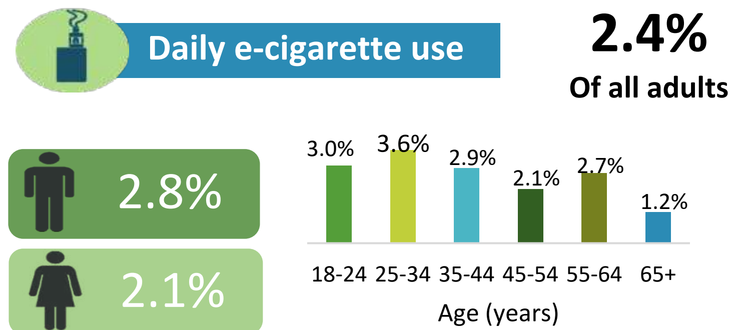
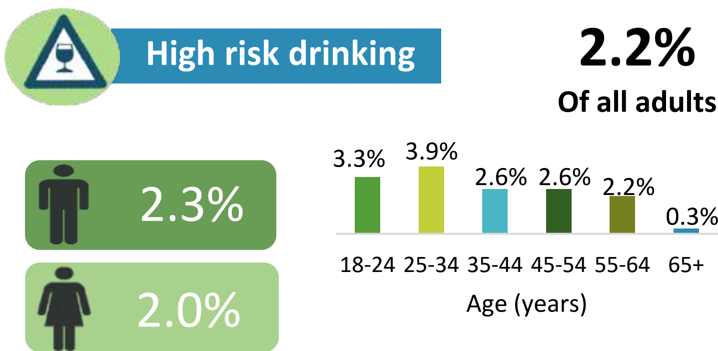
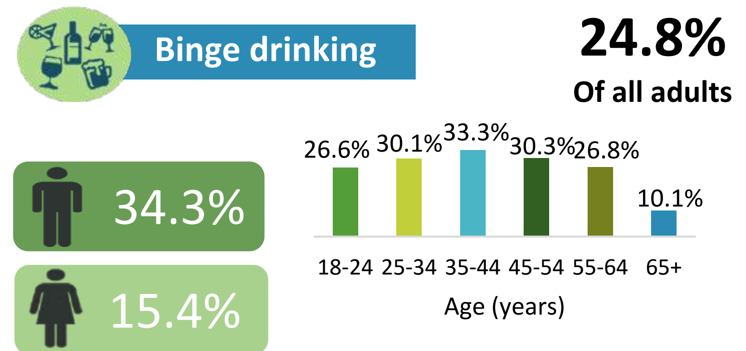
Isle of Man Health and Lifestyle Survey 2019

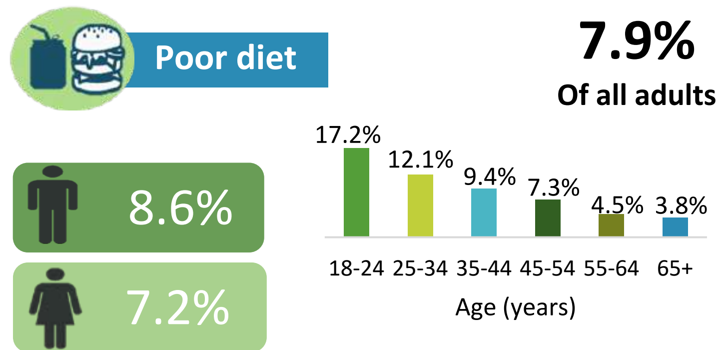
The survey aimed to examine general health and wellbeing amongst the Island's adult population. The questionnaire recorded basic demographic information on participants, including gender, age, income level, sexuality, relationship status, employment status, qualification level, home ownership, place of birth as well as a range of questions on a series of key health issues including smoking, alcohol, diet and nutrition, exercise, weight, general health and wellbeing.

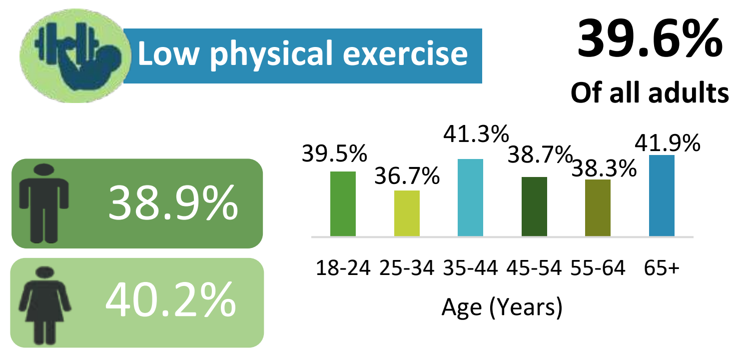


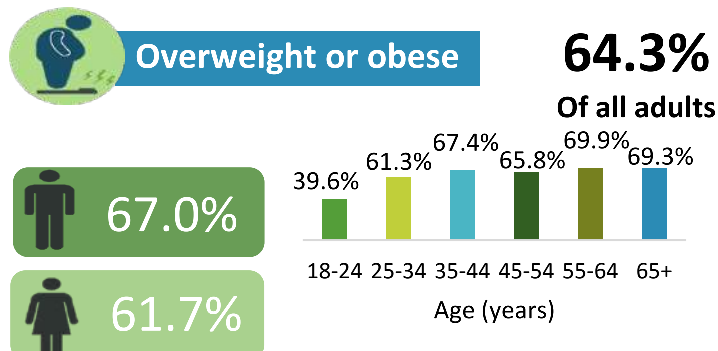


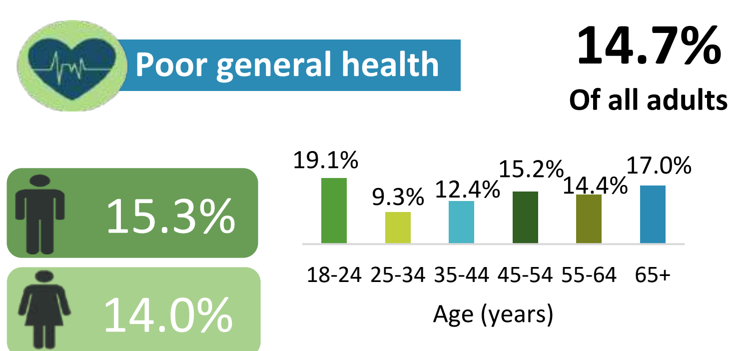


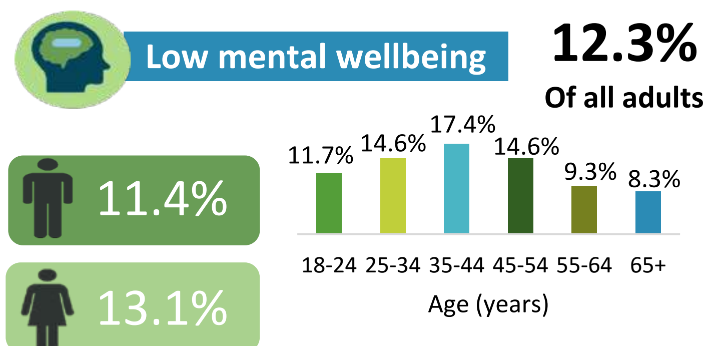


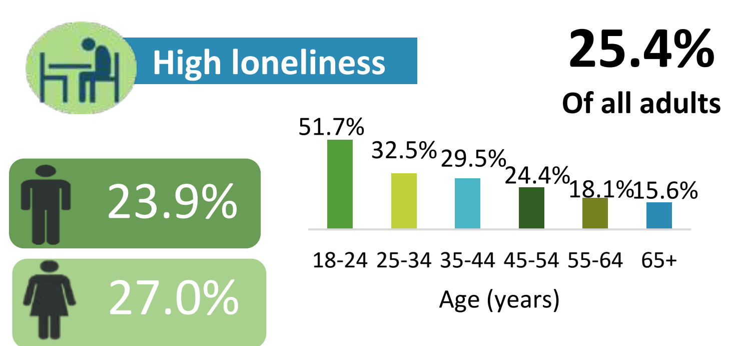








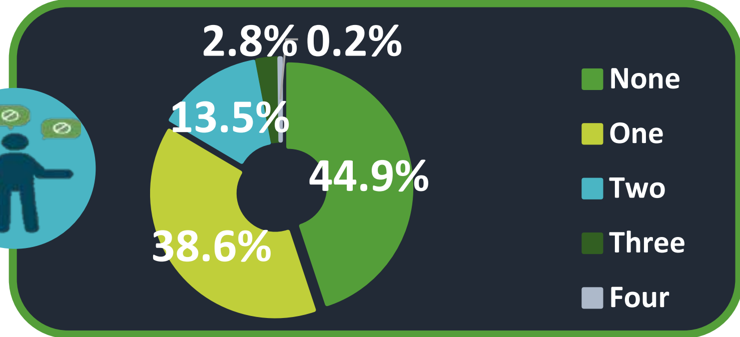




Clustering of unhealthy behaviours

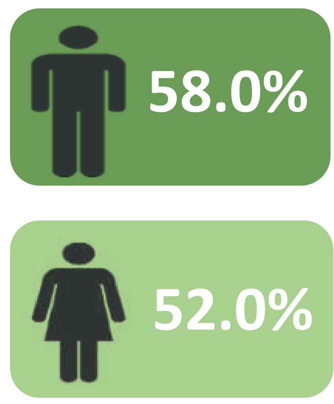
55.1% of adults had at least one unhealthy behaviour (daily tobacco smoking, binge drinking, poor diet and low physical exercise).

Multiple unhealthy behaviours

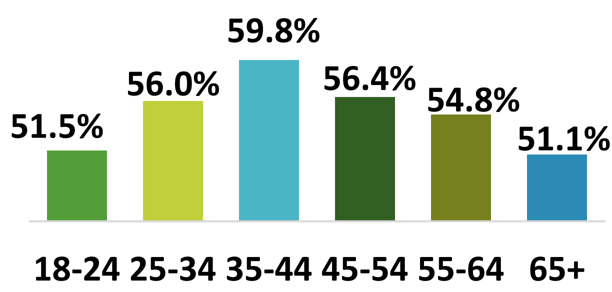


At least one unhealthy behaviour by sociodemographics

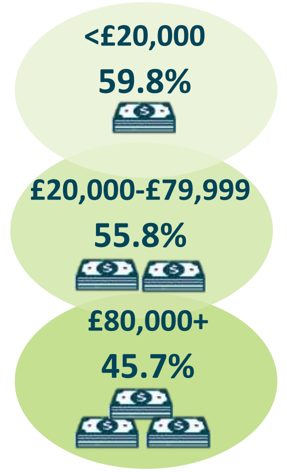
Gender



Age (years)

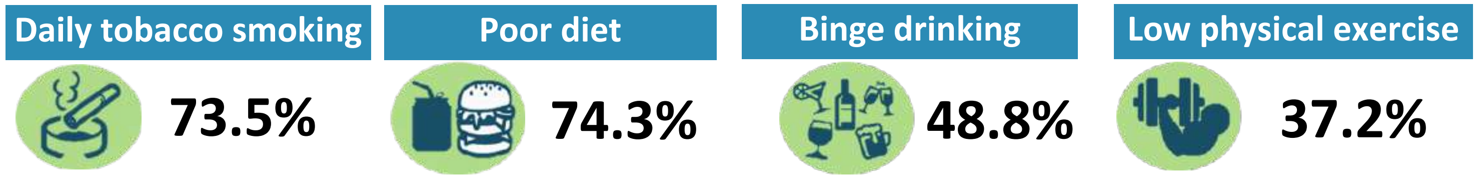


Income



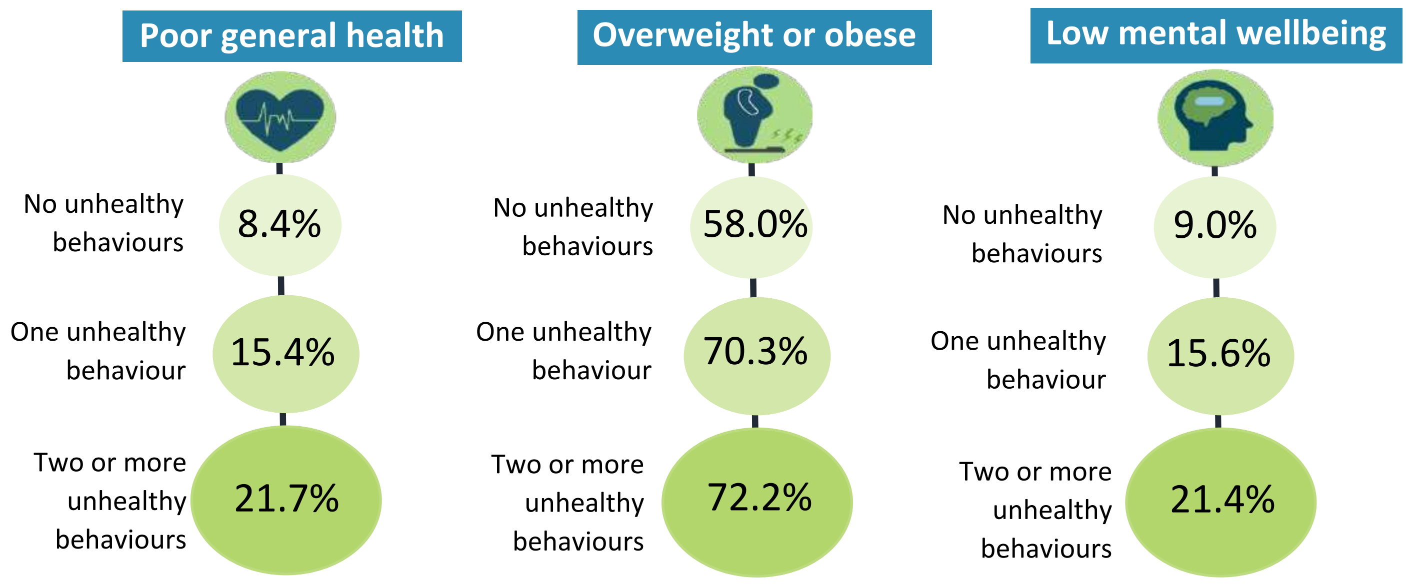
Combination of unhealthy behaviours

Adults who reported the following health harming behaviours also reported at least one other health harming behaviour



Clustering of unhealthy behaviours and health outcomes

The association between the number of unhealthy behaviours and experiencing poor health outcomes



Executive summary

The Isle of Man Health and Lifestyle Survey 2019 aimed to examine the general health and wellbeing amongst the Island's adult population. The questionnaire was conducted online, with a paper-based version available on request. Sampling was conducted in two phases; phase 1 was an invited representative sample (n=7,000) of the Isle of Man population, while phase 2 was open to all members of the public who wished to respond. In total, 3,122 responses were received which equates to 4.7% of the Island's adult population. The questionnaire included a range of questions on a series of key health issues including: smoking, alcohol, diet and nutrition, exercise, weight, general health, and wellbeing. In addition the questionnaire collected information on basic demographics of participants and included a number of validated instruments for identifying and measuring health-related issues. The Public Health Institute (PHI), Liverpool John Moores University were commissioned to analyse the data from the survey and produce a report presenting the findings[1].

Smoking

- 12.0% of adults were current tobacco smokers. 8.4% of adults smoked tobacco on a daily basis, with a slightly higher proportion of females (8.6%) compared to males (8.2%) reporting daily tobacco smoking. The prevalence of daily smoking reduced as age group increased, with the highest prevalence amongst those aged 18-24 years (12.6%) and lowest amongst those aged 65+ years (3.4%). In sample (unweighted) analyses, daily tobacco smoking was significantly associated with age ($p<0.001$) but not gender. Daily tobacco smoking was also significantly associated with: income level (<£20,000, 13.4%, £20,000-£79,999, 7.5%; £80,000+, 2.4%;); home ownership status (does not own home, 16.0%; owns home, 4.9%;); relationships status (single, 11.1%; in a relationship, 5.4%;); qualification level (no qualifications, 15.7%; qualifications, 6.5%;) and, employment status (employed, 8.8%; unemployed, 6.2%).

- 42.4% of adults were regularly exposed to other people's tobacco smoking.

- 57.4% of smokers were planning to stop smoking.

- 3.7% of adults were current e-cigarette users. 2.4% of adults used e-cigarettes on a daily basis, with a slightly higher proportion of males (2.8%) compared to females (2.1%) reporting daily e-cigarette use. The prevalence of daily e-cigarette use was highest amongst those aged 25-34 years (3.6%) and lowest amongst those aged 65+ years (1.2%). In sample (unweighted) analyses, using e-cigarettes daily was not significantly associated with age or gender. Daily e-cigarette smoking was significantly associated with: home ownership status (does not own home, 4.4%; owns home,

[1] All figures given in the report are sample data weighted by age and gender to align with the population of the Isle of Man, unless otherwise stated.

1.5%); relationship status (single, 3.1%; in a relationship, 1.7%); and, qualification level (no qualifications, 4.3%; qualifications, 2.0%).

Alcohol

- 65.2% of adults consumed alcohol in the past week.
- 18.2% of adults drank above the recommended weekly limit for alcohol.
- Using the AUDIT tool, 14.6% of adults were classified as abstainers, 64.8% as lower risk, 18.5% as increasing risk, 1.4% as higher risk and, 0.7% as possible dependence. 2.2% of adults had a score of 16 or over on the AUDIT and were classed as high risk drinkers[2], with a higher prevalence of males (2.3%) classified as high risk drinkers compared to females (2.0%). The prevalence of high risk drinking generally decreased as age increased, with the lowest amongst those aged 65+ years (0.3%). In sample (unweighted) analyses, high risk drinking was significantly associated with age but not gender. High risk drinking was significantly associated with: home ownership status (does not own home, 3.1%; owns home 1.4%) and, employment status (employed, 2.7%; unemployed, 0.7%).
- 24.8% of adults were classified as binge drinkers (i.e. consuming six (females)/eight (males) or more standard alcoholic drinks on one occasion, at least once a week), with binge drinking higher amongst males (34.3%) compared to females (15.4%). The lowest prevalence of binge drinking was amongst those aged 65+ years (10.1%), whilst highest was amongst those aged 35-44 years (33.3%). In sample (unweighted) analyses, binge drinking was significantly associated with age and gender. Binge drinking was also significantly associated with: income level (<£20,000, 17.6%; £20,000-£79,999, 26.8%; £80,000+, 33.2%); and, employment status (employed, 31.2%; unemployed, 14.8%).
- 20.3% of adults had been affected by someone in their family's use of alcohol and/or drugs.

Diet and nutrition

- 44.0% of adults had not consumed the recommended five or more pieces of fruit or vegetables on the previous day. 7.9% of adults were classified as having a poor diet (i.e. eating less than 2 pieces of fruit and/or vegetables a day), with a higher proportion of males (8.6%) reporting a poor diet compared with females (7.2%). There was also a decrease of reporting a poor diet with age, those in the youngest age group were most likely to report having a poor diet (17.2%) compared with those in the oldest age group 65+ (3.8%). In sample (unweighted) analyses, having a poor diet was significantly associated with age but not gender. Poor diet was also significantly associated with: place of birth (IoM, 8.2%; other, 5.8%); home ownership status (does not own home, 11.2%; owns home, 5.1%); relationship status (single, 9.8%; in a relationship, 4.3%);

[2] Including higher risk and possible dependence categories. Figures differ due to rounding.

sexuality (heterosexual, 6.5%; other, 12.6%) and, employment status (employed, 8.2%; unemployed, 4.5%).

- 13.2% of adults consumed convenience or fast food/takeaways twice a week or more.
- 45.5% of adults reported that they were currently eating as healthy as possible.
- 43.6% of adults reported all or most of the people in their household eat a main meal together on 7 or more occasions a week.
- 61.6% of adults consumed the recommended six or more glasses (250ml) of fluid on an average day.

Exercise

- 43.8% of adults were usually sitting down during the day and did not walk about much.
- 17.8% of adults use active forms of travel (i.e. walking or cycling) to and from work.
- 22.8% of adults spent 7 hours or more participating in sport or recreational activity in the past week.
- 24.6% of adults felt they were currently doing enough exercise.
- 27.7% of adults reported that the reason they did not exercise more was due to a lack of leisure time.
- 39.6% of adults were classified as having low physical activity (i.e. taking part in less than 2.5 hours of physical activity (e.g. walking quickly, cycling, sports or exercise) in the past week), with a slightly higher proportion of females (40.2%) having lower physical activity compared with males (38.9%). Participants aged 25-34 years were least likely to report low physical activity (36.7%) whilst participants aged 65+ reported the highest prevalence of low physical activity (41.9%). In sample (unweighted) analyses, low physical activity was not significantly associated with age or gender. The prevalence of low physical activity was significantly associated with: income level (<£20,000, 43.6%, £20,000-£79000, 40.1%; £80,000+, 33.7%); home ownership status (does not own home, 45.4%; owns home, 37.9%); and, qualification level (no qualifications, 48.9%; qualifications, 39.0%).

Weight

- 34.6% of adults were classified as normal weight. 64.3% of adults were classified as overweight or obese (i.e. had a BMI of 25 or more), with a slightly higher proportion of males (67.0%) than females (61.7%) being classified as overweight or obese. The highest prevalence of overweight or obese individuals was amongst those aged 55-64 years (69.9%), whilst the lowest was amongst those aged 18-24 years (39.6%). In sample (unweighted) analyses, being overweight or obese was significantly associated with age and gender. The prevalence of being overweight or obese was also associated with: income status (<£20,000, 71.7%; £20,000-79,999, 65.9%; £80,000+, 61.8%);

relationship status (single, 62.9%; in a relationship, 67.4%); and, qualification level (no qualifications, 76.3%; qualifications, 64.4%).

- 31.2% of adults underestimated their weight classification compared to their BMI classification.

General health

- 72.3% of adults had very good/good self-reported general health. 14.7% of adults were classified as having poor general health (i.e. one standard deviation (18.2) below the mean score (78.7) on the EQ VAS measure), with a higher proportion of males (15.3%) having poor health compared with females (14.0%). Participants aged 25-34 years were least likely to have poor health (9.3%) whilst participants aged 18-24 years had the highest prevalence of poor general health (19.1%). In sample (unweighted) analyses, having poor general health was not significantly associated with age or gender. Poor general health was significantly associated with: income level (<£20,000, 7.8%; £20,000-£79,999, 12.1%; £80,000+, 25.7%); home ownership status (does not own home, 21.0%; owns home, 12.1%); relationship status (single, 17.0%; in a relationship, 12.4%); qualification level (no qualifications, 24.7%; qualifications, 12.9%); and, employment status (unemployed, 20.7%; employed, 10.2%).
- 42.8% of adults had a physical or mental health condition or illness lasting or expected to last 12 months or more.
- 81.3% of adults had attended a dental check within the past five years.
- Over six in ten (61.9%) adults aged 60+ years had attended colorectal (bowel cancer) screening in the last five years[3].
- Over seven in ten (73.5%) women aged 50+ years had attended breast mammography (breast cancer screening) in the last five years[4].
- Over seven in ten (73.5%) women aged 25-64 years had attended cervical smear testing in the last five years[5].

Wellbeing

- 28.2% of adults had high mental wellbeing. 12.3% of adults had low mental wellbeing (i.e. one standard deviation (10.2) below the mean (49.1) on WEMWBS), with a higher proportion of females (13.1%) having low mental wellbeing compared with males (11.4%). The highest prevalence of low mental wellbeing was amongst adults aged 35-44 years (17.4%). In sample (unweighted) analyses, low mental wellbeing was significantly associated with age but not gender. Low mental wellbeing was also

[3] Bowel cancer screening is available on the Isle of Man for men and women aged 60-75, and adults over the age of 75 years by request.
[4] Breast cancer screening is available on the Isle of Man for women aged 50-70, and women over the age of 70 years by request.
[5] Cervical screening is available on the Isle of Man for women aged 25-64 and is done every three years for women aged 25-49 and every five years for women aged 50-64.

significantly associated with: income level (<£20,000, 21.2%; £20,000-£79,999, 14.7%; £80,000+, 6.6%); place of birth (Isle of Man, 16.7%; other, 13.1%); home ownership status (does not own home, 23.3%; owns home, 11.3%); relationship status (single, 17.9%; in a relationship, 11.9%); and, sexuality (heterosexual, 13.8%; other, 29.3%).

- 11.6% of adults experienced a large amount of stress.
- 18.5% of adults had bad/very bad sleep quality.
- 26.8% of adults were highly anxious.
- 19.2% of adults had low life satisfaction.
- 22.1% of adults had low happiness.
- 22.8% of adults felt the things they do in life are unworthwhile.
- 29.6% of adults had low social interaction. 25.4% of adults had high levels of loneliness (i.e. always, sometimes or often feeling lonely), with a higher proportion of females (27.0%) having high loneliness compared with males (23.9%). The highest proportion of adults who had high loneliness was amongst those aged 18-24 years (51.7%), and decreased as age group increased, with the lowest prevalence amongst those aged 65+ years (15.6%). In sample (unweighted) analyses, high loneliness was significantly associated with age and gender. High loneliness was also significantly associated with: income level (<£20,000, 29.1%; £20,000-£79,999, 22.9%; £80,000+, 16.3%); place of birth (Isle of Man, 26.0%; other, 21.9%); home ownership status (does not own home, 34.4%; owns home, 19.6%); relationship status (single, 31.8%; in a relationship, 17.0%); and, sexuality (heterosexual, 22.7%; other, 39.8%).

Clustering of unhealthy behaviours

- 55.1% of adults had at least one unhealthy behaviour (i.e. daily tobacco smoking, binge drinking, poor diet, and/or low physical exercise). Over four in ten (44.9%) adults had none of the four unhealthy behaviours, 38.6% had one unhealthy behaviour, 13.5% had two, 2.8% had three, and 0.2% had all four unhealthy behaviours.
- A higher proportion of males (58.0%) than females (52.0%) had at least one unhealthy behaviour. The proportion of adults who had at least one unhealthy behaviour was highest amongst aged 35-44 years. The proportion of adults who had at least one unhealthy behaviour was highest amongst the lowest income group and decreased as income group increased (<£20,000, 59.8%; £20,000-79,999, 55.8%; £80,000+, 45.7%).
- In sample (unweighted analysis) there was a significant association between number of unhealthy behaviours and poor general health. There was a graded relationship between the number of unhealthy behaviours and poor general health, with the prevalence of poor general health increasing as the number of unhealthy behaviours increased (none, 8.4%; one, 15.4%; two or more, 21.7%).

- In sample (unweighted analysis) there was a significant association between number of unhealthy behaviours and being overweight or obese. There was a graded relationship between the number of unhealthy behaviours and being overweight or obese, with the prevalence increasing as the number of unhealthy behaviours increased (none, 58.0%; one, 70.3%; two or more, 72.2%).
- In sample (unweighted analysis) there was a significant association between number of unhealthy behaviours and low mental wellbeing. There was a graded relationship between the number of unhealthy behaviours and low mental wellbeing, with the prevalence of low mental wellbeing increasing as the number of unhealthy behaviours increased (none, 9.0%; one, 15.6%; two or more, 21.4%).

1. Introduction

Public Health's role is to improve the health and wellbeing of the population. The health intelligence function assesses, measures and describes health and wellbeing, as well as identifying health risks, health needs and health outcomes for the population of the Isle of Man. This is done by collecting, analysing and interpreting health-related data into meaningful information.

There have been three lifestyle surveys so far. 2016 was general health and lifestyle with a particular interest in drug and alcohol consumption, 2017 was health and lifestyle with a particular interest in gambling and 2018 was for DHSC staff only on wellbeing in the workplace.

This 2019 survey's main aim is to examine general health and wellbeing amongst the Island's adult population.

The Health and Lifestyle Survey is an important tool providing an overview of the health and wellbeing of the local population. The survey will provide vital information to enable the Public Health Directorate and stakeholders to set goals, policy and programming decisions – based on robust evidence. It will also allow monitoring of outcomes. The results of the survey will also be used to compare Isle of Man health indicators with other jurisdictions.

Results from some of the questions will feed directly into the Isle of Man Public Health Outcomes Framework (PHOF). Questions have also been designed so that they feed into other Public Health Directorate work streams and projects such as: active travel, tobacco, substance misuse, mental health and wellbeing, workplace wellbeing and health protection.

Scope includes health and lifestyle survey questions that are either aligned with Public Health England PHOF measures for population level indicators or will feed directly into an Isle of Man Public Health project. All questions are for adults aged 18 and over.

2. Methods

2.1 Questionnaire design

The questionnaire asked a range of questions on a series of key health issues including:

- Smoking
- Alcohol
- Diet and nutrition
- Exercise
- Weight
- General health
- Wellbeing

The questionnaire also recorded basic demographic information on participants, including gender, age, income level, sexuality, relationship status, employment status, qualification level, home ownership, place of birth. The questionnaire included a number of validated instruments for identifying and measuring health-related issues including:

The Alcohol Use Disorder Identification Tool (AUDIT)

The Alcohol Use Disorder Identification Tool (AUDIT) was developed by the World Health Organisation to identify harmful and hazardous alcohol consumption patterns [1]. It consists of ten questions measuring the frequency and quantity of alcohol consumption and problems related to alcohol use. Answers for each question are scored and summed to provide an overall score that indicates an individual's risk of harm from alcohol use. Drinking risk is categorised as:

Low risk	Scores 0 to 7
Increasing risk	Scores 8 to 15
Higher risk	Scores 16 to 19
Possible dependence	Scores 20 or more

EQ-5D

The EQ-5D is a measure of health status developed by the EuroQol Group which provides a measure of current general health [2]. The EQ VAS measure was used in the current report to determine the prevalence of poor general health. The EQ VAS is a measure of respondents' self-rated health on a vertical visual scale, where the end points are labelled 'the best health you can imagine' and the 'worst health you can imagine'. Scores are dichotomised to indicate poor general health as >1 standard deviation (18.2) below the mean (78.7) thus poor general health was operationalised as scores ≤60.

The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) is used as a measurement of mental wellbeing in adults [3]. WEMWBS consists of 14 questions about an individual's current mental wellbeing over the last two weeks. Responses are scored (none of the time=1, rarely=2, some of the time=3, all of the time=5) and summed to provide an overall WEMWBS score, ranging from 14 to 70. WEMWBS scores were grouped into three categories of low,

moderate and high mental wellbeing, where low/high represent scores of at least one standard deviation below/above the mean score for the weighted sample (mean 49.1, SD, 10.2):

Low mental wellbeing: Scores of 38 or lower
Moderate mental wellbeing: Scores of 39 to 58
High mental wellbeing: Scores of 59 or above

2.2 Sample design and response rate

For Phase 1 responses (those received between 6th and 18th March 2019)

The Cabinet Office holds a property database of all known addresses on the island and these addresses were shared with the Public Health Directorate. It should be noted that no information was shared about who might live at a particular address as no names of occupiers are contained within the property database. It was cleaned by the Public Health Directorate to remove non-residential addresses and nursing or residential homes.

It was decided that 7,000 addresses would be chosen from this database as has been for previous lifestyle surveys, with the assumption of obtaining a similar response rate of approximately 25%.

The addresses were split into 3-digit postcode areas and proportionally chose based on census data of population numbers for those areas. Within these postcode areas the addresses were chosen using a random sampling method[6].

Within the invitation letter another level of randomisation was added by requesting that it should be the person resident at the property whose birthday was next that answered the questionnaire.

For Phase 2 responses (those received between 18th March and 6th April 2019)

The questionnaire was promoted as 'open access' through media channels and anyone who wished to do so could complete.

Response Rate

Type of Response	Number returned
Phase 1 – Online	1,506
Phase 1 – Paper	115
Total Phase 1	1,621
Phase 2 – Online	1,441
Phase 2 – Paper	60
Total Phase 2	1,501
Total Responses	**3,122**

[6] Applying a random number to each record within Microsoft Excel (using RAND() function) and sorting twice to give a 'double shuffle' effect

As Phase 1 was an invited sample we are able to calculate that the response rate for this phase was 23.2% and represents 2.4% of the adult population.

In total, 3,122 responses were received which equates to 4.7% of the adult population.

2.3 Data analyses

Data from the online surveys was transferred to the Public Health Institute (via a secure Sharepoint) in Excel spreadsheets and transferred to the Statistical Package for Social Science (SPSS) v2 for data cleaning, recoding and analyses. Scanned copies of paper surveys were transferred to the Public Health Institute (via a secure Sharepoint) and entered into the online survey system and then downloaded and combined with the electronic surveys. Analyses presented in this report were undertaken using frequencies and cross-tabulations to examine findings by sociodemographic and other factors.

2.4 Data weighting

The characteristics of the participants who completed the survey did not correspond to the characteristics of the Isle of Man population (section 2.6). To account for these differences it was necessary to weight the sample by age and gender to align it with the Isle of Man population[7]. The weights were based on results from the Isle of Man census 2016. The demographic information used from this Census is listed below. All figures given in the report are based on weighted data, unless otherwise stated. Full data tables, including weighted and unweighted data, are available in the Data Annex.

Isle of Man census information 2016
Resident population: 83314
Number of residents over the age of 18: 67100
Age (years) and gender breakdown:

	18-24	25-34	35-44	45-54	55-64	65+	Total
Male	3225	4279	5086	6614	5501	8063	32768
Female	3118	4553	5399	6564	5556	9142	34332
Total	6343	8832	10485	13178	11057	17205	67100

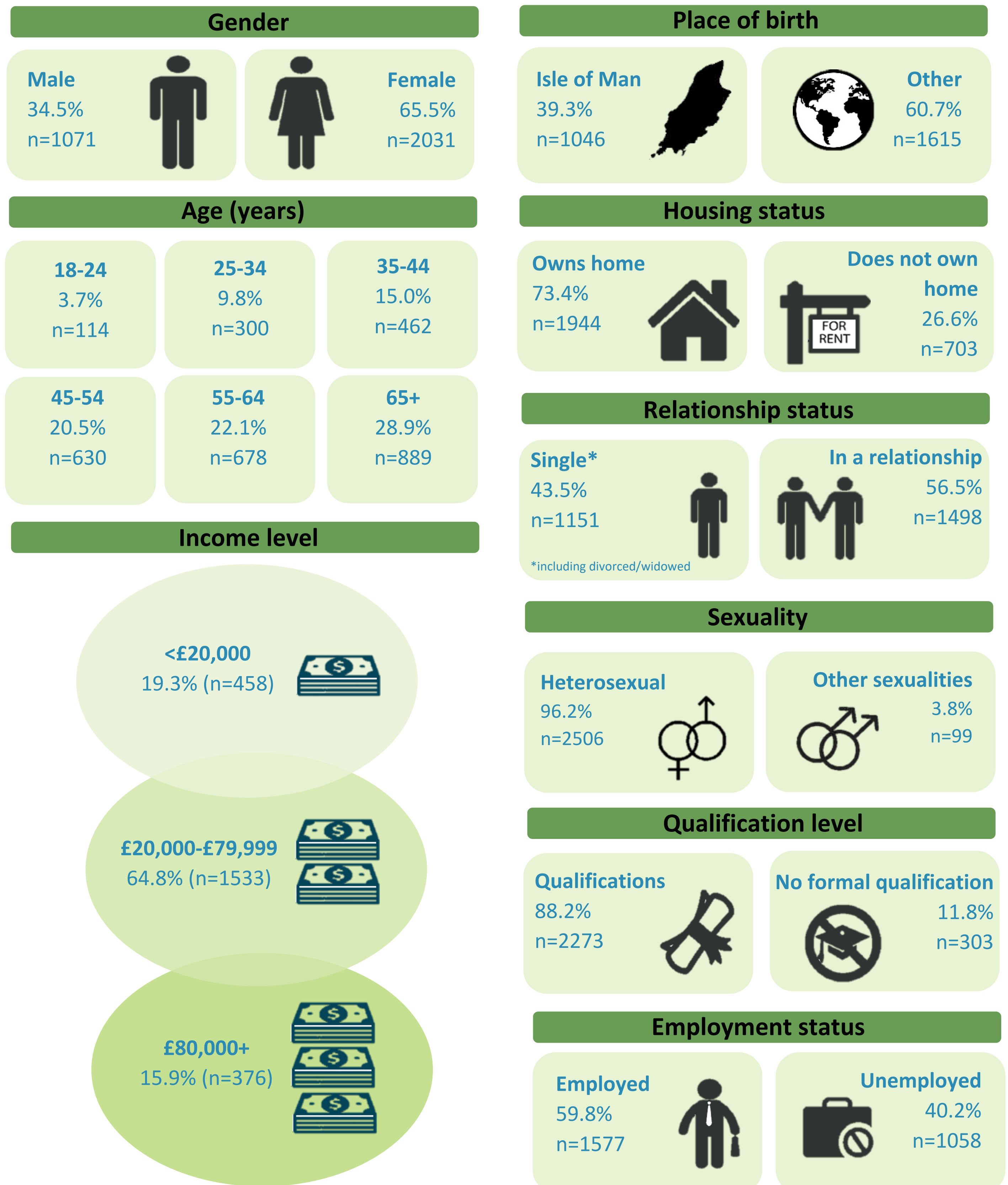
[7] The population may have differed from the sample on more than these two characteristics.

2.5 Reporting conventions

The following caveats and conventions should be considered when interpreting the findings in this report:

- The data is based on valid responses, with non-responses excluded from the reported figure, therefore bases may vary between analyses.
- Data should be interpreted with caution due to the small base sizes involved for some of the outcome measures. Sample base sizes can be found in the annex.
- Rows may not sum to 100% due to rounding.
- All figures presented in the main body of the report are weighted data, unless otherwise stated.
- Where significant differences are reported in bivariate analyses, these are based on unweighted data. Full data tables of weighted and unweighted data are presented in the Annex accompanying this report.
- Findings represent an association only and do not imply causation in any direction.

2.6 Sociodemographics of survey respondents[8]



[8] Unweighted data.

3. Findings

3.1 Smoking

The Isle of Man Health and Lifestyle Survey included a range of questions on smoking behaviours and attitudes, including exposure to second-hand smoke and intentions to quit smoking. Key finding from these questions are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.1.1 Tobacco smoking

12.0% of adults were current tobacco smokers

- Over half (56.3%) of adults had never smoked tobacco or only tried smoking once or twice, 31.8% of adults were ex-smokers, and 12.0% were current smokers (including daily (see Box 1) and occasional smokers; Figure 1; Table A1).
- The overall prevalence of current smoking was slightly higher for males (12.2%) than females (11.7%; Table A1). The prevalence of ex-smokers was also higher amongst males (33.2%) than females (30.4%; Table A1).
- The prevalence of current smoking decreased as age group increased and the prevalence of ex-smokers generally increased as age group increased (Figure 2; Table A1).
- The prevalence of current smoking was highest amongst the lowest income group and decreased as income level increased (<£20,000, 19.5%; £20,000-79,999, 11.0%; £80,000+, 8.0%; Table A1). The prevalence of ex-smokers also decreased as income level increased (<£20,000, 36.8%; £20,000-79,999, 32.9%; £80,000+, 27.8%; Table A1)

Figure 1: Smoking status

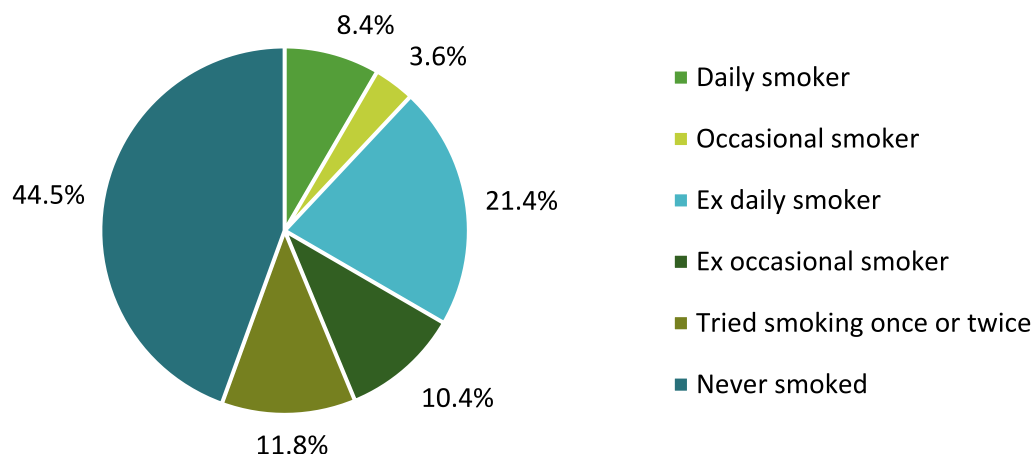
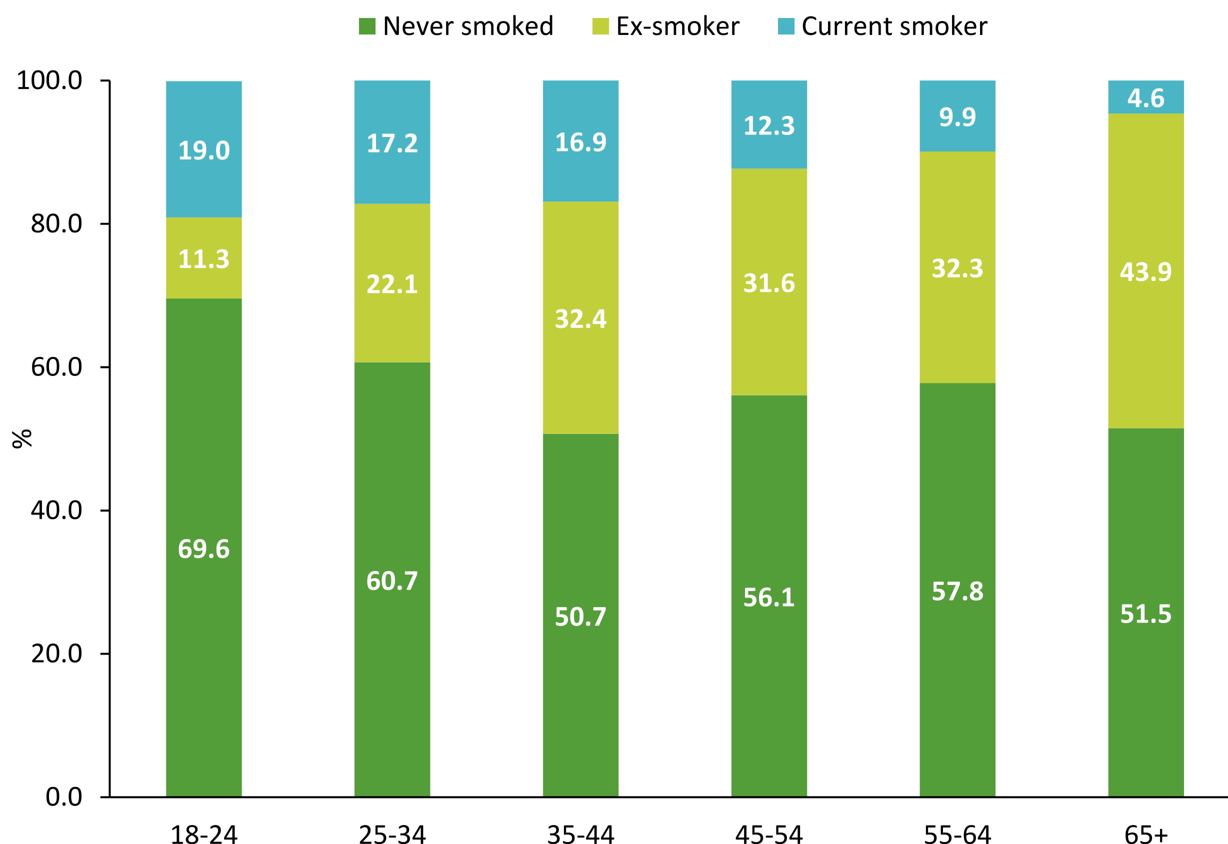


Figure 2: Smoking status by age group (years)



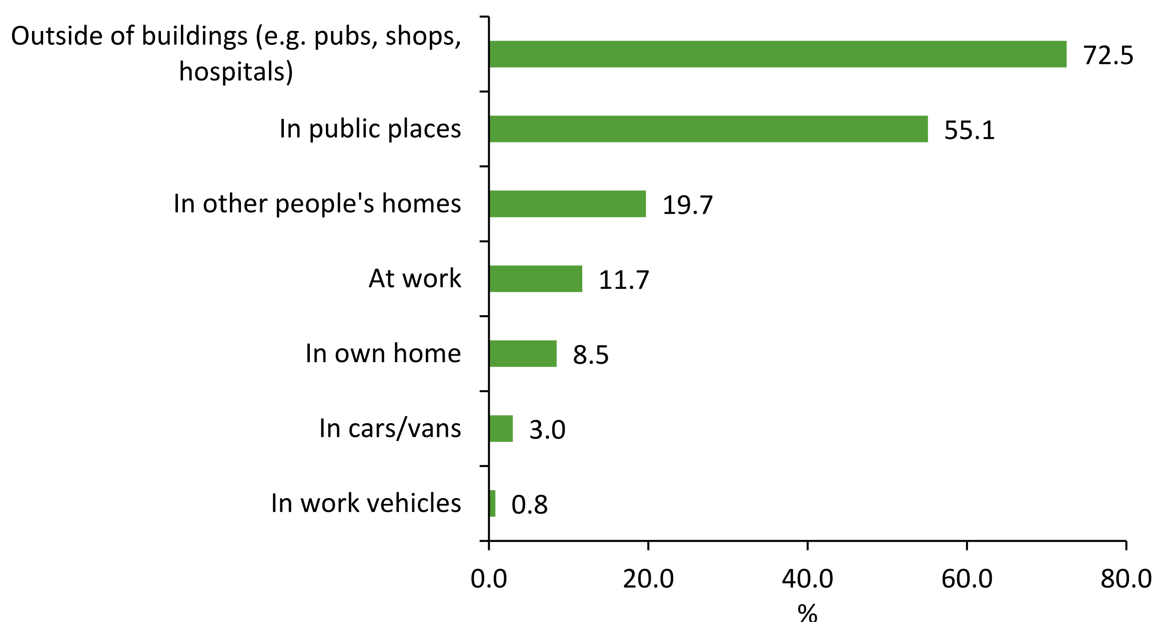
3.1.2 Exposure to second-hand smoke

42.4% of adults were regularly exposed to other people's tobacco smoking

- Of those who were regularly exposed, the most common place of exposure was outside of buildings such as pubs, shops or hospitals (72.5%; Figure 3).
- Survey participants were asked what best describes the rules about smoking in their household. The majority of adults did not allow smoking inside their house; 41.0% said that smoking was not allowed anywhere on their property, 47.4% reporting smoking was allowed outside (e.g. in the garden) only, and 3.9% said smoking was allowed outside in a doorway. Less than one in twenty adults allowed smoking anywhere in their house (2.3%) or in certain rooms in their house (3.2%)[9].

[9] 2.2% selected 'other'.

Figure 3: Prevalence of regular exposure to second-hand smoke by location

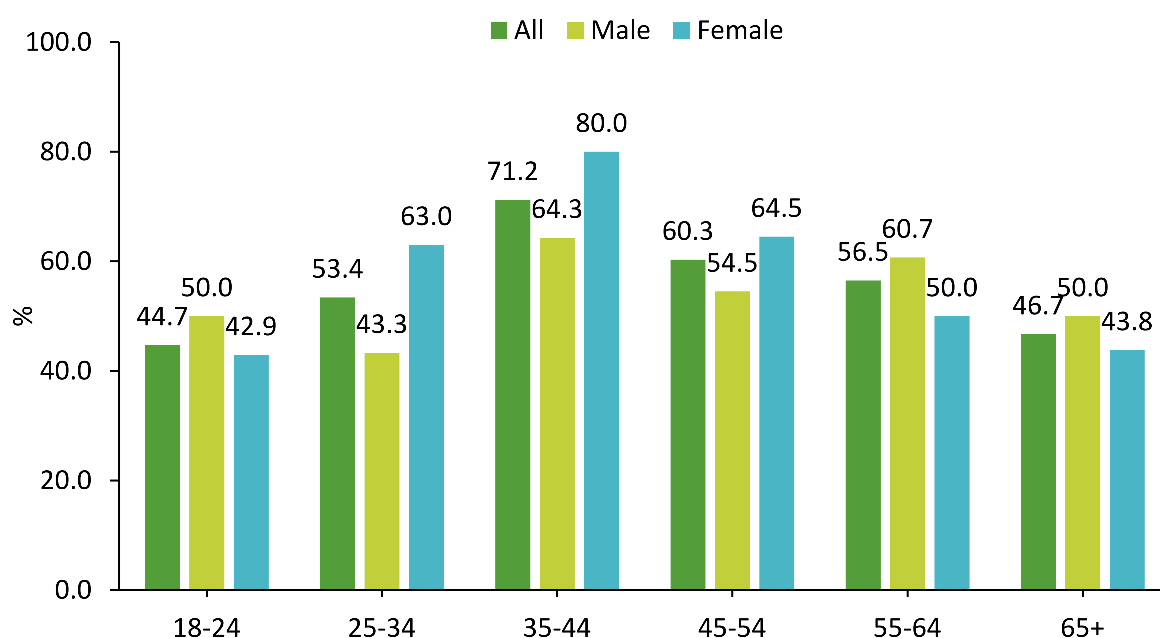


3.1.3 Intentions to stop smoking

57.4% of smokers were planning to stop smoking

- Over one third (33.1%) of smokers planned to stop smoking sometime in the future, 24.3% planned to stop soon, whilst 19.9% had no plans to quit and 22.7% were unsure if they were going to stop smoking.
- Approximately equal proportions of males (56.0%) and females (59.0%) were planning to stop smoking. The highest proportion of smokers who planned to stop smoking was amongst those aged 35-44 years (71.2%), whilst the lowest proportion was amongst those aged 18-24 years (44.7%; Figure 4).
- Approximately equal proportions of daily smokers (58.8%) and occasional smokers (54.5%) were planning to stop smoking.

Figure 4: Proportion of smokers planning to stop smoking by age group (years) and gender



3.1.4 Electronic cigarettes

3.7% of adults were current e-cigarette users

- The majority (91.4%) of adults had either never used e-cigarettes or heard of them, or only tried e-cigarettes once or twice (Figure 5). 4.6% of adults were ex-users, and 3.7% were current e-cigarette users (including daily [see Box 2] and occasional users; Figure 5).
- The overall prevalence of current e-cigarette use was slightly higher for females (3.8%) than males (3.6%; Table A2). The prevalence of ex-users was higher amongst males (5.1%) than females (4.7%; Table A2).
- The prevalence of current e-cigarette use was highest amongst those aged 25-34 years, whilst the prevalence of ex-users decreased as age group increased (Figure 6; Table A2).
- The prevalence of current e-cigarette use was highest amongst the lowest income group and decreased as income level increased (<£20,000, 4.4%; £20,000-79,999, 4.3%; £80,000+, 1.8%; Table A2). The prevalence of ex-users also decreased as income level increased (<£20,000, 7.1%; £20,000-79,999, 4.9%; £80,000+, 4.6%; Table A2).
- Over half (53.8%) of e-cigarette users were also current tobacco smokers, whilst 43.0% of current e-cigarette users were ex tobacco smokers, and 3.2% had never smoked tobacco.

Figure 5: E-cigarette use

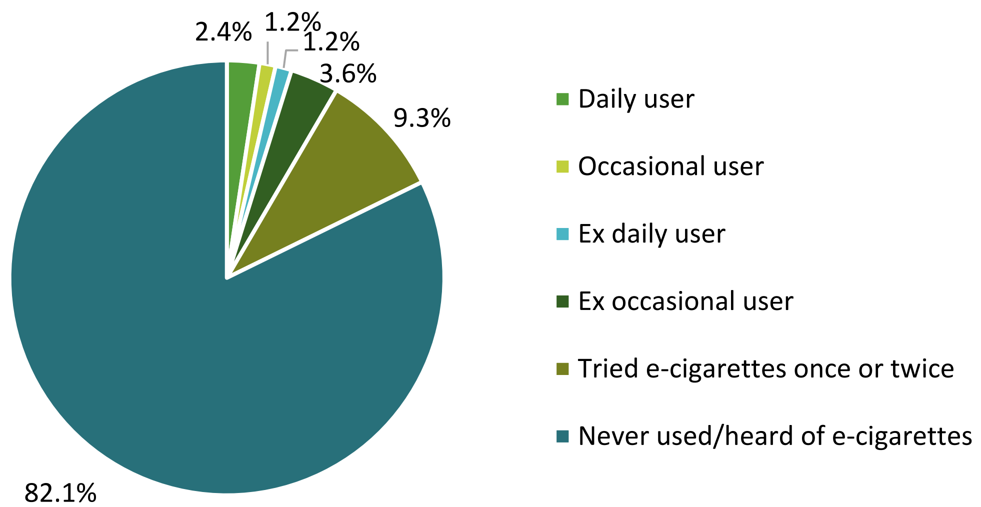
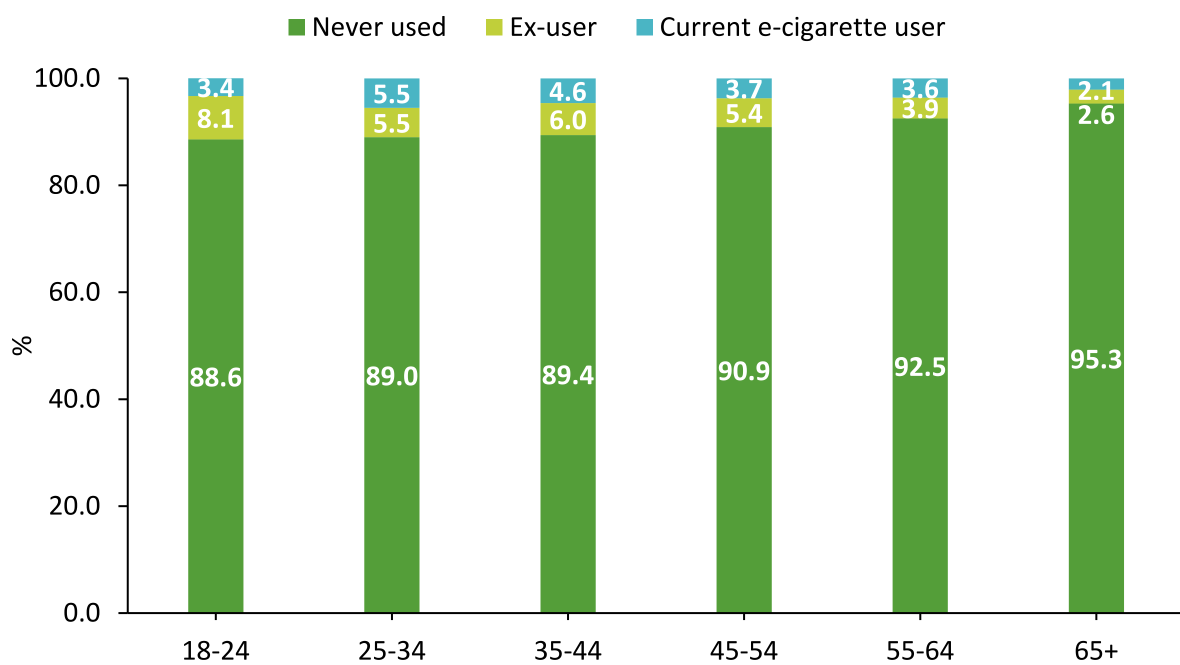


Figure 6: E-cigarette use by age group (years)



Box 1: Health in focus – Daily tobacco smoking

Daily tobacco smoking

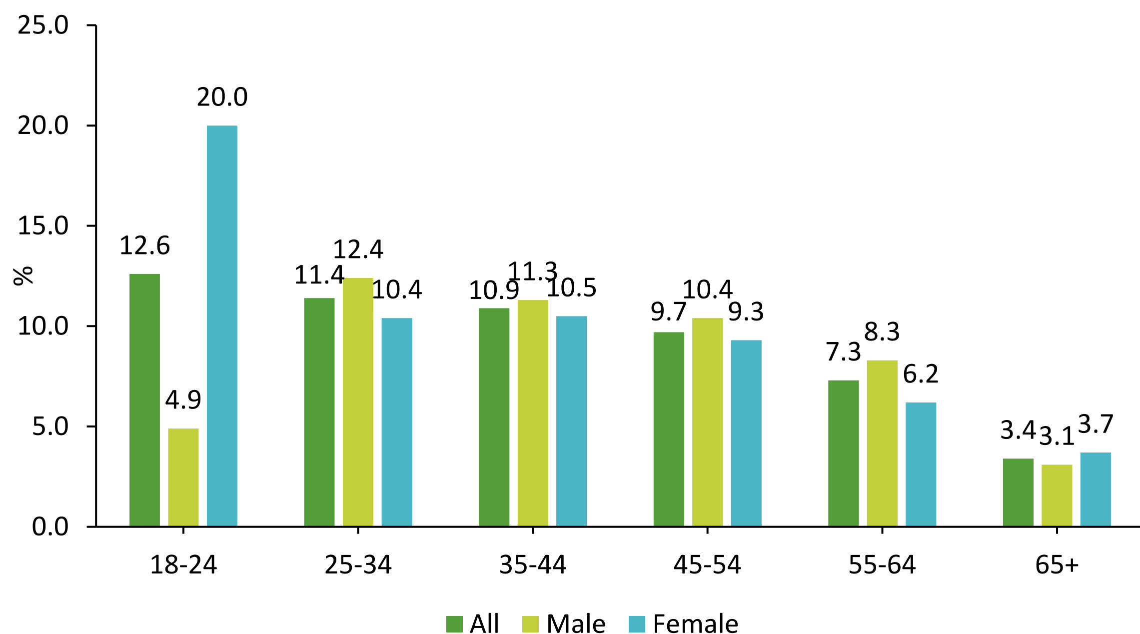
Current smoking of tobacco on a daily basis

8.4% of all adults

- A slightly higher proportion of females (8.6%) than males (8.2%) reported smoking tobacco on a daily basis. The prevalence of daily smoking reduced as age group increased, with the highest prevalence amongst those aged 18-24 years (12.6%) and the lowest amongst those aged 65+ (3.4%; Figure 7; Table A3).

- In sample (unweighted) analyses, daily tobacco smoking was significantly associated with age ($p<0.001$) but not gender (Table A3). Daily tobacco smoking was also significantly associated with: income level (<£20,000, 13.4%, £20,000-£79,999, 7.5%; £80,000+, 2.4%; $p<0.001$); home ownership status (does not own home, 16.0%; owns home, 4.9%; $p<0.001$); relationships status (single, 11.1%; in a relationship, 5.4%; $p<0.001$); qualification level (no qualifications, 15.7%; qualifications, 6.5%; $p<0.001$) and, employment status (employed, 8.8%; unemployed, 6.2%; $p<0.05$); Table A3).

Figure 7: Prevalence of daily tobacco smoking by age group (years) and gender



Box 2: Health in focus – Daily e-cigarette use

Daily e-cigarette use

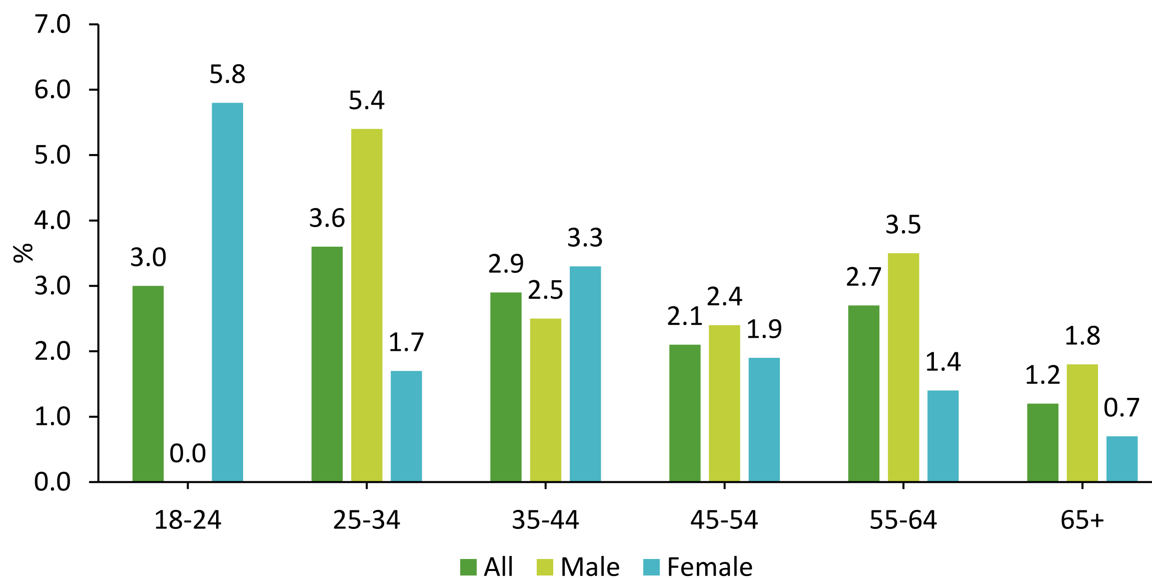
Current using of electronic cigarettes on a daily basis.

2.4% of all adults

- A slightly higher proportion of males (2.8%) than females (2.1%) reported using e-cigarettes on a daily basis. The prevalence of daily e-cigarette use was highest amongst those aged 25-34 years (3.6%) and lowest amongst those aged 65+ (1.2%; Figure 8; Table A3).

- In sample (unweighted) analyses, using e-cigarettes daily was not significantly associated with age or gender (Table A3). Daily e-cigarette smoking was significantly associated with: home ownership status (does not own home, 4.4%; owns home, 1.5%; p<0.001); relationship status (single, 3.1%; in a relationship, 1.7%; p<0.05); and, qualification level (no qualifications, 4.3%; qualifications, 2.0%; p<0.05); Table A3).

Figure 8: Prevalence of daily e-cigarette smoking by age group (years) and gender



3.2 Alcohol

The Isle of Man Health and Lifestyle Survey included a range of questions on alcohol use including frequency and quantity of alcohol consumption. It also included the Alcohol Use Disorder Test (AUDIT; see section 2) which includes questions on participants' frequency and quantity of alcohol consumption and the harms they have experienced from alcohol. Responses to the AUDIT are scored to give an overall measure of drinking risk. Questions were also included on family alcohol and drug use. Key finding from these questions are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.2.1 Frequency of alcohol consumption

65.2% of adults consumed alcohol in the past week

- The majority (85.9%) of adults drank alcohol at least occasionally, with four in ten (41.1%) drinking at least twice a week (Figure 9).
- A higher proportion of females (17.4%) than males (10.8%) had never drank alcohol. The overall prevalence of drinking at least twice a week was higher amongst males (47.3%) than females (33.2%; Table A4).
- The prevalence of never having consumed alcohol was highest amongst those aged 65+ years (21.2%), whilst the alcohol consumption at least twice weekly was lowest amongst those aged 18-24 years (Figure 10; Table A4).
- The prevalence of never having consumed alcohol was highest amongst the lowest income group and decreased as income level increased (<£20,000, 27.2%; £20,000-79,999, 11.0%; £80,000+, 8.2%; Table A4). The prevalence of alcohol consumption on at least two occasions a week decreased as income level increased (<£20,000, 28.1%; £20,000-79,999, 40.8%; £80,000+, 54.1%; Table A4).
- Over one third (34.8%) of adults hadn't drank in the past week, 7.0% of adults drank on every day in the past week, 2.1% on 6 days, 4.1% on 5 days, 7.6% on 4 days, 11.7% on 3 days, 14.4% on 2 days, and 18.2% on one day. The majority (83.3%) of adults reported that their past week's alcohol consumption represented a typical week of alcohol consumption.

Figure 9: Frequency of alcohol consumption

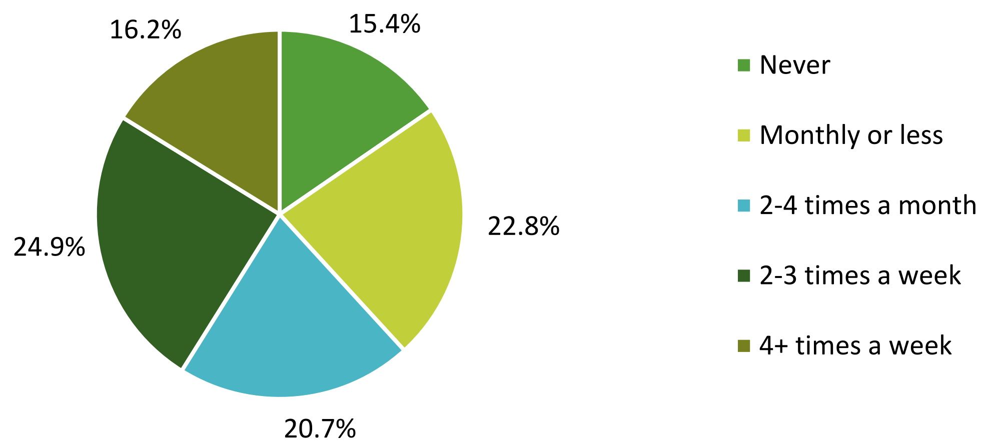
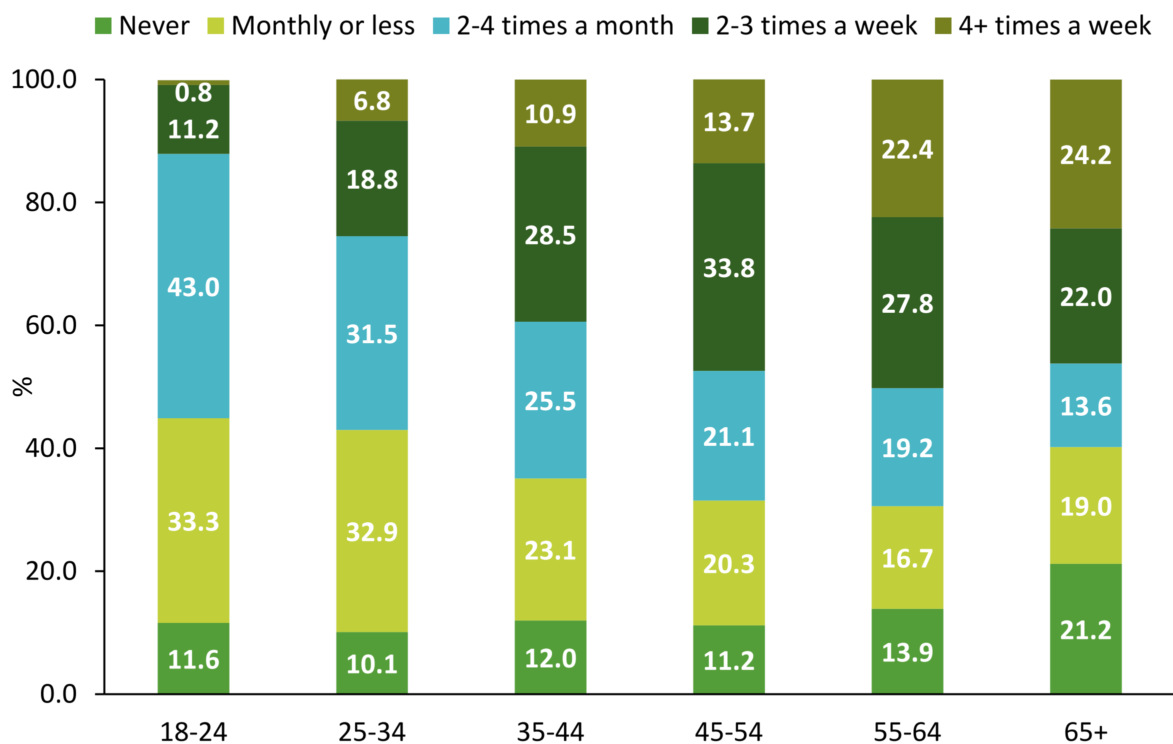


Figure 10: Frequency of alcohol consumption by age group (years)



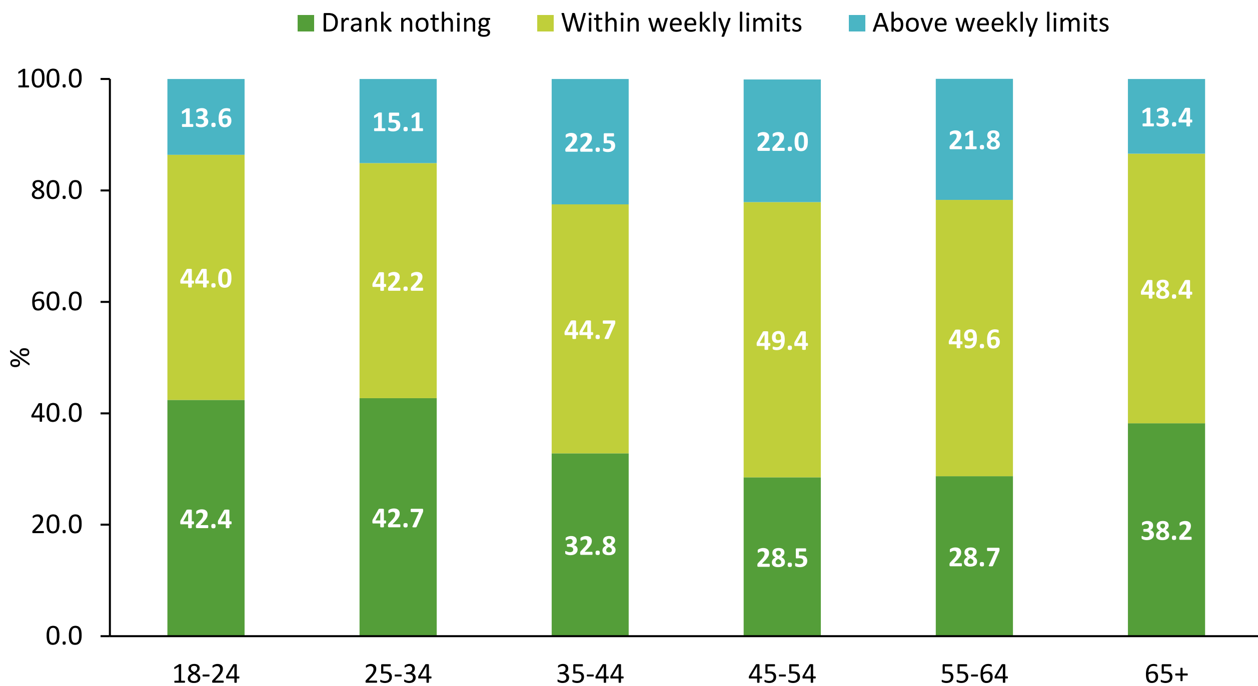
3.2.2 Quantity of alcohol consumption

18.2% of adults drank above the recommended weekly limit for alcohol

- Of adults who consumed alcohol, the average number of units consumed in the past week was 12.5 units, with the majority (83.3%) reporting their past week's number of units was typical of what they would normally drink in a week.

- Men and women are recommended to drink no more than 14 units of alcohol a week[10]. Almost one fifth (18.2%) of adults drank above the recommended weekly limit, whilst 47.0% drank within this limit and 34.8% of adults drank no alcohol in the previous week.
- A higher proportion of males (26.4%) than females (10.2%) drank above the recommended weekly limit in the past week (Table A5). A higher proportion of females (41.2%) than males (28.3%) did not drink alcohol in the past week (Table A5).
- Approximately one in five adults aged 35-64 years drank above the recommended weekly limit in the past week (Figure 11; Table A5). Drinking above the weekly limit was least common amongst adults in the youngest and oldest age groups (Figure 11; Table A5). The prevalence of drinking nothing in the past week was highest amongst younger adults (18-34 years; Figure 11; Table A5).
- The prevalence of drinking above the recommended weekly limit was highest amongst those with the highest income level (£80,000+, 27.0%) and decreased as income level decreased (£20,000-79,999, 18.7%; <£20,000, 13.0%; Table A5).

Figure 11: Past week alcohol consumption by age group (years)



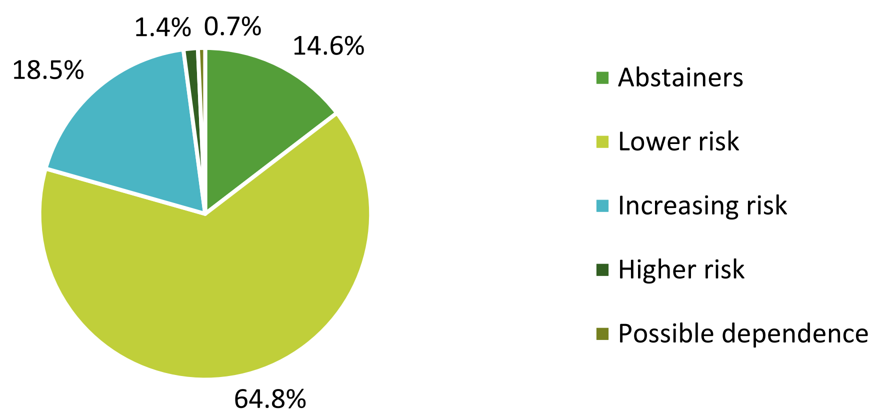
[10] See https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/

3.2.3 AUDIT drinking risk

Answers for each question on the AUDIT are scored and then summed to provide an overall score that indicates an individual's risk of harm from alcohol use. Drinking risk is categorised as: lower risk (scores of 0-7), increasing risk (scores of 8-15), higher risk (scores of 16-19) and possible dependence (scores of 20 or more)[11]. The AUDIT also includes a question which measures binge drinking frequency, defined as consuming six (if female) or eight (if male) units of alcohol on one occasion.

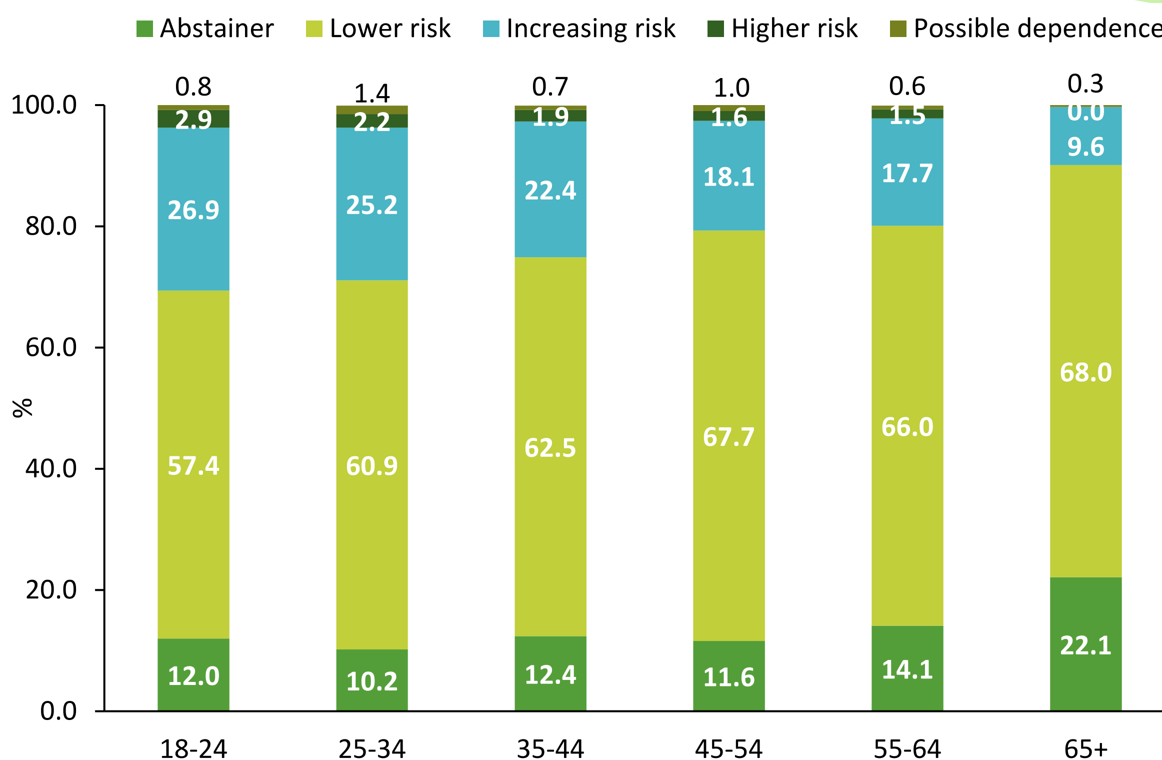
- Over three quarters (79.4%) of adults were classified as lower risk drinkers or abstainers, and 18.5% were categorised as increasing risk (Figure 12; Table A6). 2.1% were classified as higher risk or possible dependence (Figure 12; Table A6; Box 3).
- A higher proportion of females (17.9%) than males (11.1%) were categorised as abstainers, and lower risk drinkers (females, 68.1%; males, 61.5% Table A6). A higher proportion of males (25.1%) than females (11.9%) were categorised as increasing risk drinkers (Table A6). Whilst more males (1.8%) than females (1.1%) were higher risk drinkers, more females (0.9%) than males (0.5%) were categorised as possibly dependent drinkers (Table A6).
- The proportion of adults classified as increasing or higher risk drinkers decreased as age group increased (Figure 13; Table A6).
- The proportion of abstainers decreased as income level increased (Table A6). The proportion of increasing risk drinkers increased as income level increased (Table A6).
- Over one third (37.6%) of adults never binge drank, 31.4% binge drink less than monthly, 11.9% monthly, 16.8% weekly and 2.3% daily or almost daily (see Box 4).

Figure 12: AUDIT drinking risk



[11] When used as a screening tool, participants only complete questions 4 to 10 if they reach a certain score on questions 1 to 3. However, all participants in the IoM Survey were asked to complete all questions and thus AUDIT scores have been calculated based on all responses, regardless of the score obtained for the first three questions.

Figure 13: AUDIT drinking risk by age group (years)



3.2.4 Family alcohol and drug use

20.3% had been affected by someone in their family's use of alcohol and/or drugs

- Almost one in five (18.5%) adults had been affected by someone in their family's use of alcohol, whilst 6.5% had been affected by someone in their family's use of drugs.
- A higher proportion of females (22.6%) than males (17.9%) had been affected by someone in their family's use of alcohol and/or drugs than males (Table A7).
- The proportion of adults affected by family drug and/or alcohol use was highest amongst those aged 35-44 years (27.2%) and lowest amongst those aged 65+ years (Table A7).
- The proportion of adults affected by family drug and/or alcohol use increased as income level increased (<£20,000, 18.9%; £20,000-79,999, 20.8%; £80,000+, 21.3%; Table A7).

Box 3: Health in focus – High risk drinking

High risk drinking

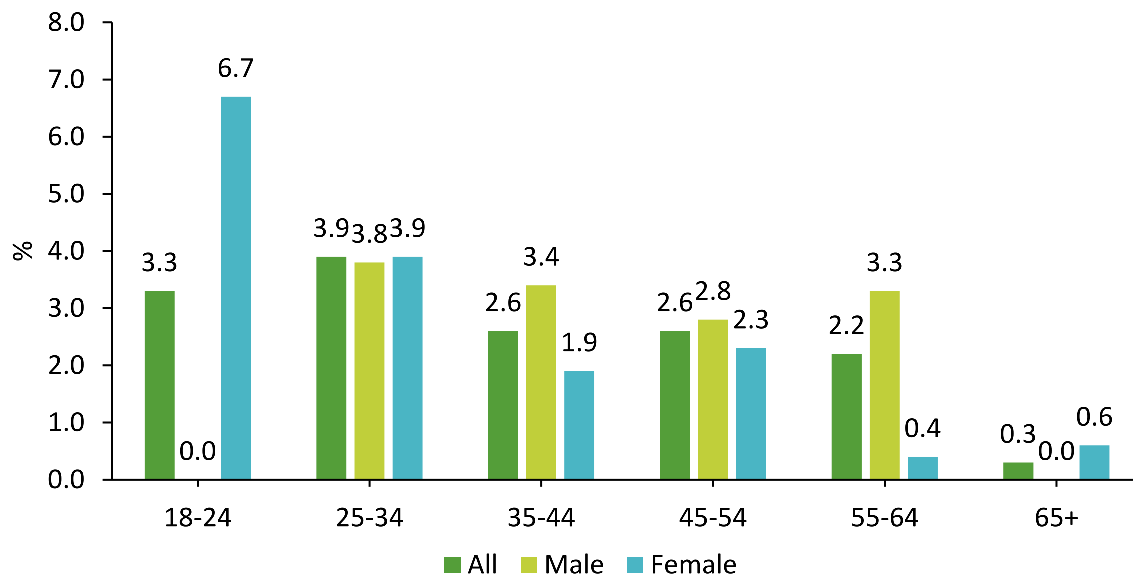
Individuals with a score of 16 or over on the Alcohol Use Disorder Identification Test (AUDIT).

2.2%* of all adults

- A higher prevalence of males (2.3%) were classified as a high risk drinker compared with females (2.0%; Table A8). The prevalence of high risk drinking generally decreased as age increased, with the lowest amongst those aged 65+ years (0.3%; Figure 15; Table A8).

- In sample (unweighted) analyses, high risk drinking was significantly associated with age (p<0.01) but not gender (Table A8). High risk drinking was significantly associated with: home ownership status (does not own home, 3.1%; owns home 1.4%; p<0.05) and, employment status (employed, 2.7%; unemployed, 0.7%; p<0.01; Table A8).

Figure 15: Prevalence of high risk drinking by age group (years) and gender



*differs from figure above due to rounding

Box 4: Health in focus – Binge drinking

Binge drinking

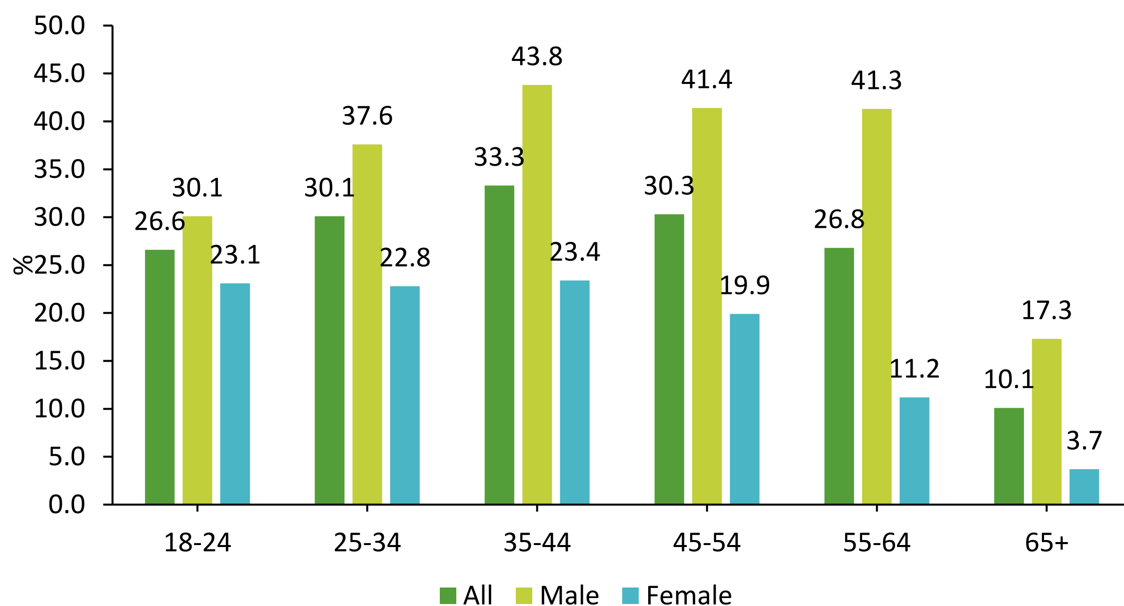
Consuming six (females)/eight (males) or more standard alcoholic drinks on one occasion, at least once a week.

24.8% of all adults

- A higher proportion of males (34.3%) than females (15.4%) reported binge drinking (Table A8). The lowest prevalence of binge drinking was amongst those aged 65+ years (10.1%), whilst those highest was amongst those aged 35-44 years (33.3%; Figure 14; Table A8).

- In sample (unweighted) analyses, binge drinking was significantly associated with age (p<0.001) and gender (p<0.001; Table A8). Binge drinking was also significantly associated with: income level (<£20,000, 13.8%; £20,000-£79,999, 23.6%; £80,000+, 28.5%; p<0.01); and, employment status (employed, 12.9%; unemployed, 27.1%; p<0.001; Table A8).

Figure 14: Prevalence of binge drinking by age group (years) and gender



3.3 Diet and nutrition

The Isle of Man Health and Lifestyle Survey included a range of questions on diet and nutrition including fruit and vegetable consumption, fluid intake, convenience food, fast food and soft drink consumption and reasons for not eating healthier foods. Key finding from these questions are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.3.1 Fruit and vegetable consumption

44.0% of adults had not consumed the recommended five or more pieces of fruit and vegetables on the previous day

- Over half (56.0%) of adults had consumed the recommended five or more pieces of fruit and vegetables on the previous day (Figure 16; Table A9), 15.3% had consumed four pieces, 11.7% three, 9.0% two. Less than one in ten (8.0%) adults had consumed one or no fruit and vegetables on the previous day (Figure 16; Table A9; see Box 5).
- A slightly higher proportion of females (59.3%) had consumed five or more pieces of fruit and/or vegetables a day than males (52.6%; Table A9).
- The proportion of adults consuming five or more pieces of fruit and vegetables on the previous day generally increased as age group increased, with the highest prevalence amongst those aged 65+ years (66.0%; Figure 17; Table A9).
- The proportion of adults consuming five or more pieces of fruit and vegetables on the previous day increased as income level increased (<£20,000, 52.5%; £20,000-79,999, 53.9%; £80,000+, 63.7%; Table A9).

Figure 16: Portions of fruit and vegetables consumed yesterday

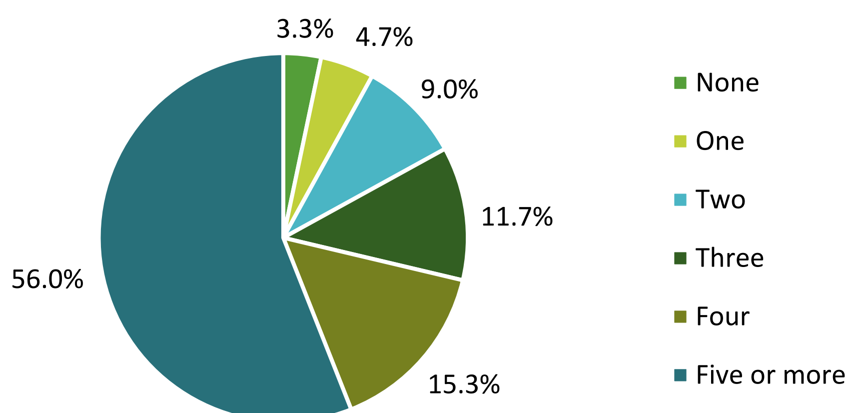
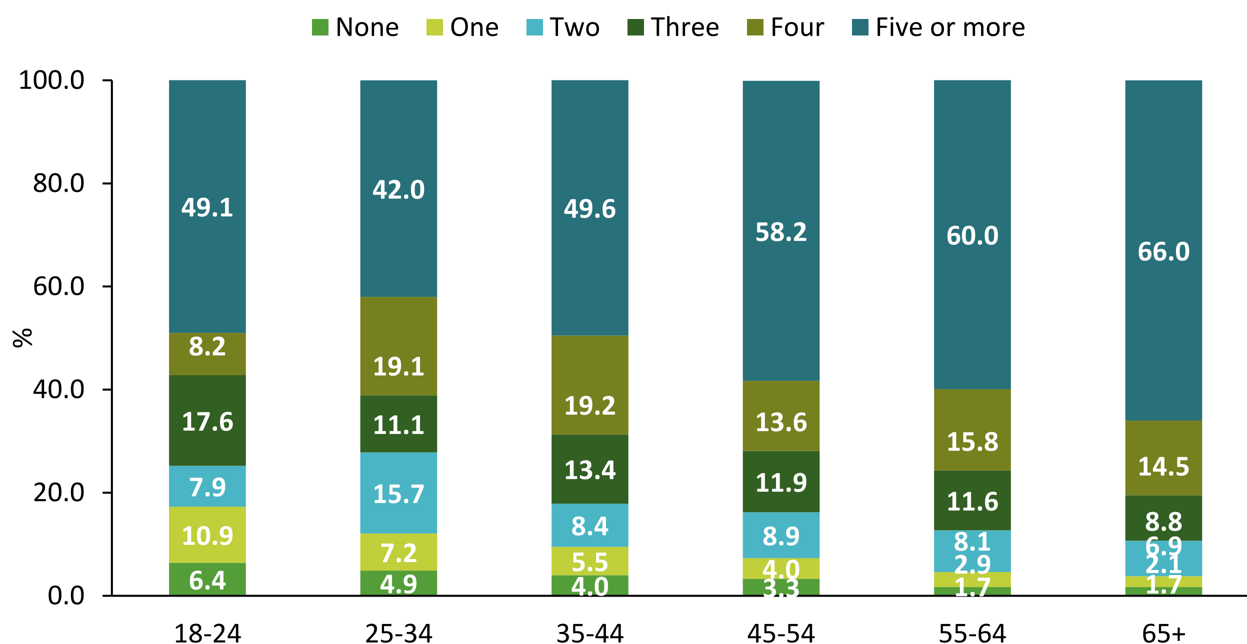


Figure 17: Portions of fruit and vegetables consumed yesterday by age group (years)



3.3.2 Unhealthy food consumption

13.2% of adults consumed convenience or fast food/takeaways twice a week or more

Convenience or fast food/takeaways

- Just over one in ten (13.2%) adults ate convenience or fast food/takeaways at least twice a week (Figure 18; Table A10).
- A higher proportion of males (15.6%) than females (10.8%) ate convenience or fast food/takeaways at least twice a week (Table A10).
- The proportion of adults eating convenience or fast food/takeaways at least twice a week was highest amongst the youngest age group and decreased as age increased (Figure 19; Table A10).
- The proportion of adults eating convenience or fast food/takeaways at least twice a week decreased as income level increased (<£20,000, 17.3%; £20,000-79,999, 11.6%; £80,000+, 12.0%; Table A10).

High calorie/high fat treats

- Almost two thirds (63.6%) of adults ate high calorie or high fat treats (e.g. cakes, sweets, crisps, ice creams, pudding, chocolates) at least twice a week (Figure 18; Table A10).
- A slightly higher proportion of females (64.7%) than males (62.5%) ate high calorie or high fat treats at least twice a week (Table A10).

- The proportion of adults eating high calorie or high fat treats at least twice a week was highest amongst those aged 25-34 years (74.9%) but generally decreased as age increased (Figure 19; Table A10).
- The proportion of adults eating high calorie or high fat treats at least twice a week was lowest amongst those with the lowest income level (<£20,000, 58.9%; £20,000-79,999, 66.4%; £80,000+, 65.3%; Table A10).

Figure 18: Frequency of unhealthy food consumption

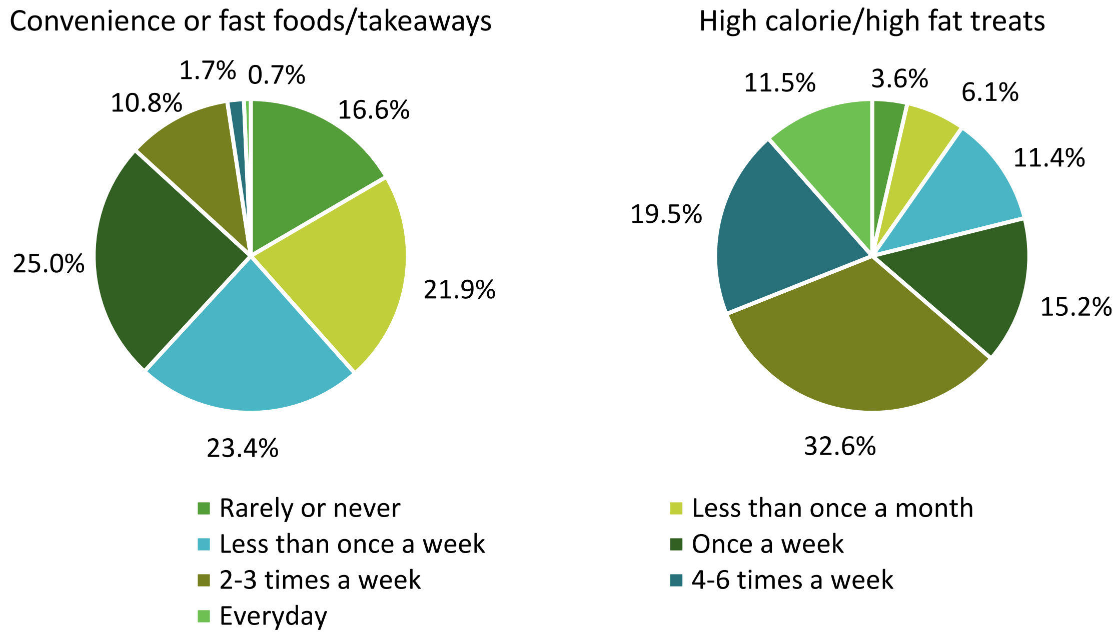
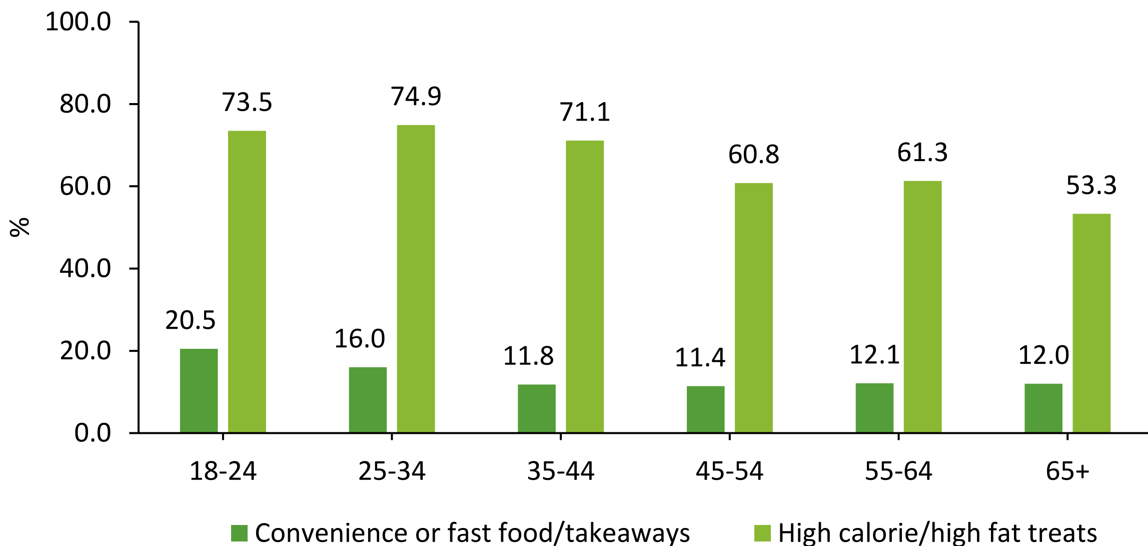


Figure 19: Consumption of unhealthy food at least twice a week by age group (years)

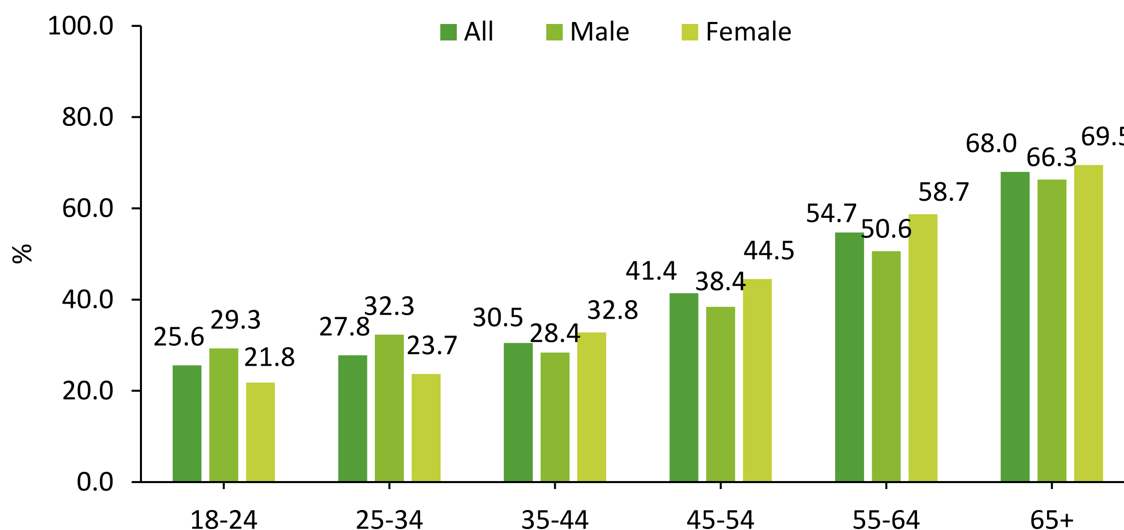


3.3.4 Healthy eating habits

45.5% of adults reported that they were currently eating as healthily as possible

- Four in ten (45.5%) adults reported that they were currently eating as healthily as possible (Table A10).
- A slightly higher proportion of females (46.8%) than males (44.1%) reported that they were currently eating as healthily as possible (Table A10).
- The proportion of adults reporting eating as healthily as possible increased as age group increased and was highest amongst those aged 65+ years (68.0%) (Figure 20; Table A10).
- The proportion of adults reporting eating as healthily as possible was highest amongst those in the lowest income group and decreased as income level increased (<£20,000, 54.3%; £20,000-79,999, 45.8%; £80,000+, 42.6%; Table A10).

Figure 20: Currently eating as healthily as possible by age group (years) and gender

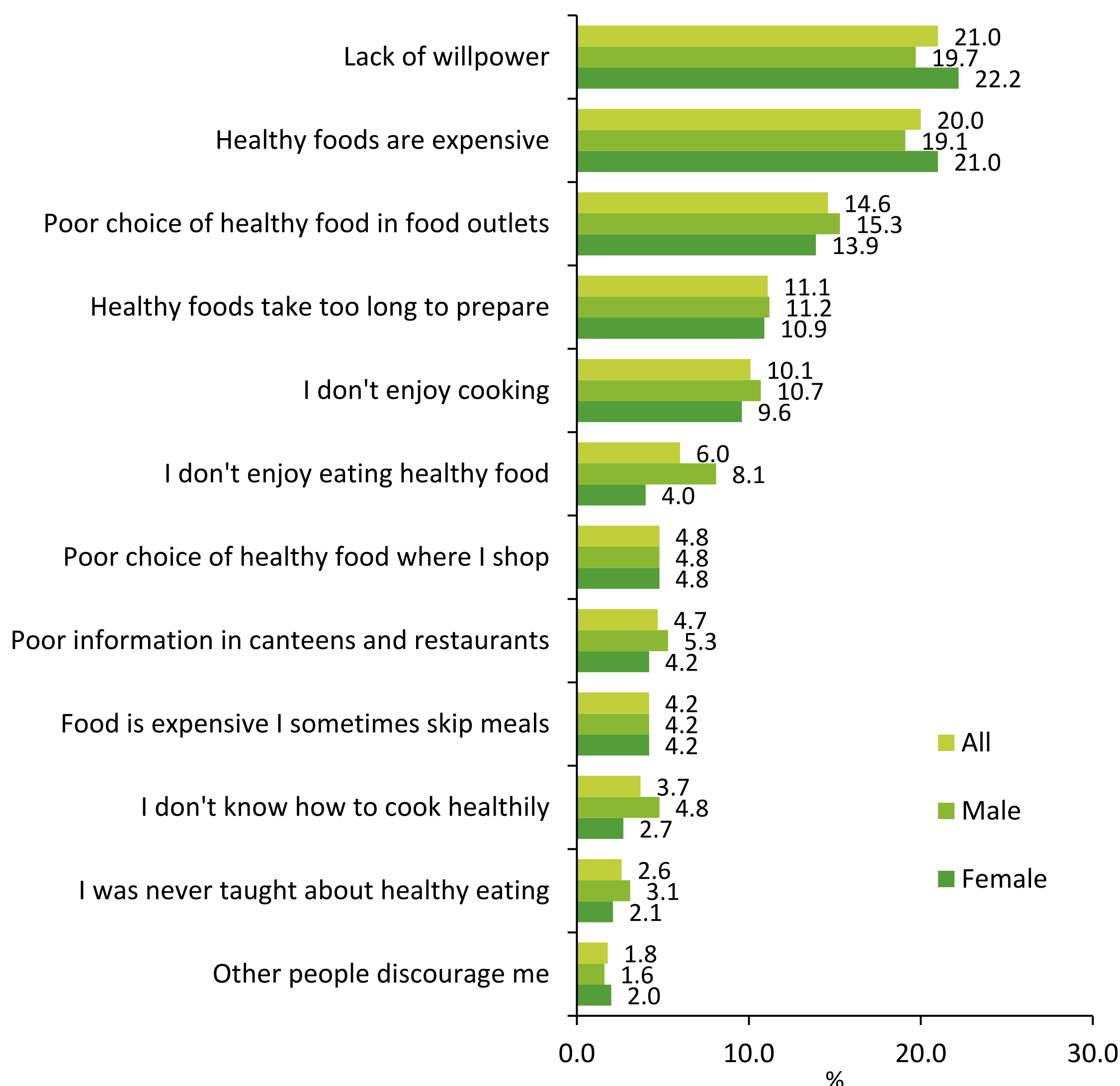


Reasons for not eating more healthy foods

- The most common reason adults gave for what prevented them from eating more healthy foods[12] was lack of will power (21.0%), followed by healthy foods are too expensive (20.0%) (Figure 21). Two thirds (66.4%) of adults would find it helpful if foods were labelled more clearly, with information about fat, sugar and salt content.
- More females than males cited lack of will power and healthy foods being expensive as reasons for not eating more healthy foods, whilst more males than females cited poor choice of healthy foods in food outlets, not enjoying cooking and not enjoying healthy foods as reasons for not eating healthier (Figure 21).

[12] Respondents were provided with a list of reasons and could tick as many as applicable.

Table 21: Reasons for not eating healthier foods by gender



Eating meals together with household members

43.6% of adults reported all or most of the people in their household eat a main meal together on 7 or more occasions a week

- Approximately one in four (43.6%) adults reported all or most of the people in their household eat a main meal together on 7 or more occasions a week, 35.9% consumed a main meal together 2-6 times a week, 4.7% once a week, 3.8% less than once a week, and 12.0% rarely or never ate a main meal with other household members (Figure 22; Table A10).
- A slightly higher proportion of females (44.9%) than males (42.3%) reported consuming a main meal with other household members on 7 or more occasions a week (Table A10).
- The proportion of adults consuming a main meal with other household members on 7 or more occasions a week was lowest amongst those aged 18-24 years (31.3%) and highest amongst those aged 65+ years (57.5%; Figure 23; Table A10).

- The proportion of adults consuming a main meal with other household members on 7 or more occasions a week was lowest amongst those with lowest income level (<£20,000, 39.5%; £20,000-79,999, 44.5%; £80,000+, 42.0%; Table A10).

Figure 22: Frequency of household members eating a main meal together

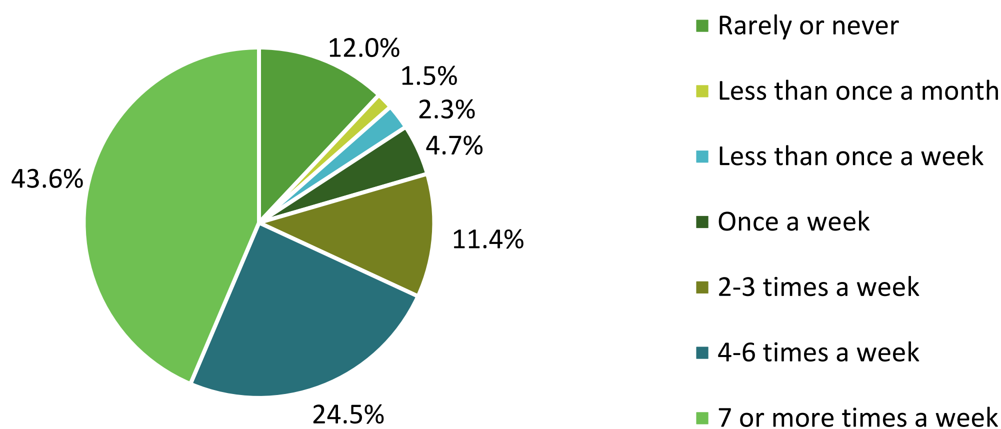
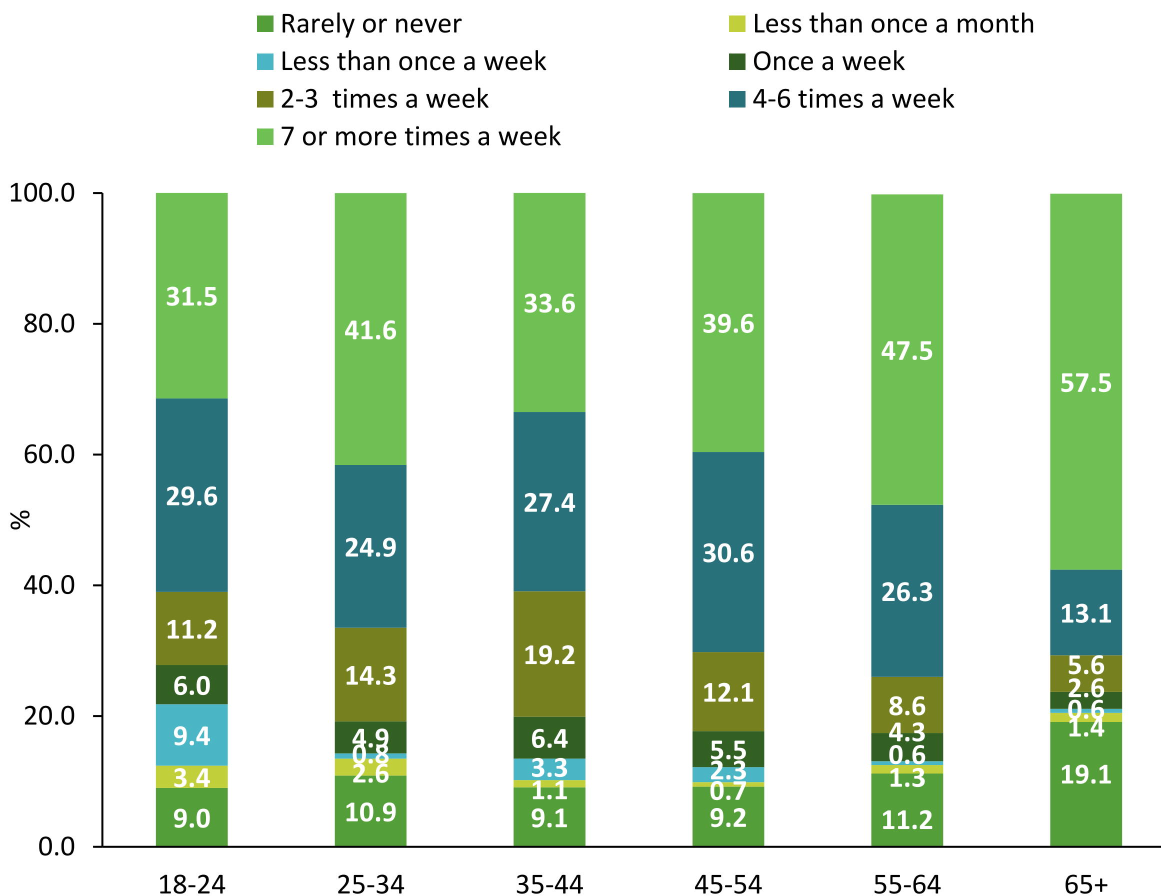


Figure 23: Frequency of household members eating a main meal together by age group (years)



3.3.3 Fluid consumption

61.6% of adults consumed the recommended six or more glasses (250ml) of fluid on an average day

All fluids

- The majority (96.6%) of adults consumed at least three glasses (250ml) of fluid on an average day, with 61.6% consuming the recommended daily intake of six or more glasses (Figure 24; Table A11).
- A higher proportion of females (65.0%) than males (58.1%) consumed the recommended daily intake of 6 or more glasses of fluid on an average day (Table A11).
- The proportion of adults consuming six or more glasses of fluid on an average day was slightly higher amongst those in older age groups (Figure 25; Table A11).
- The proportion of adults consuming six or more glasses of fluid on an average day did not vary much between income levels (<£20,000, 61.7%; £20,000-79,999, 60.2%; £80,000+, 62.8%; Table A11).

Plain drinking water

- 14.5% of adults consumed six or more glasses (250ml) of plain drinking water on an average day (Figure 24; Table A11). Over half of adults drank less than three glasses of plain drinking water on an average day (Figure 24; Table A11).
- A higher proportion of females (16.0%) than males (13.0%) consumed six or more glasses of plain drinking water on an average day (Table A11).
- The proportion of adults consuming six or more glasses of plain drinking water on an average day was higher amongst younger age groups and generally decreased as age increased (Figure 25; Table A11).
- The proportion of adults consuming six or more glasses of plain drinking water on an average day increased as income level increased (<£20,000, 10.5%; £20,000-79,999, 14.6%; £80,000+, 19.2%; Table A11).

Figure 24: Average daily fluid and plain drinking water consumption (250ml glass)

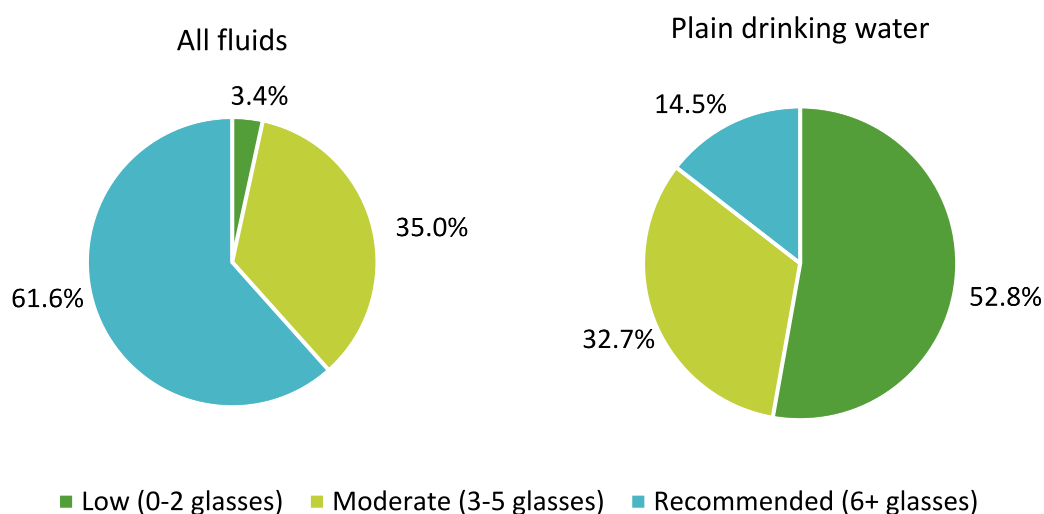
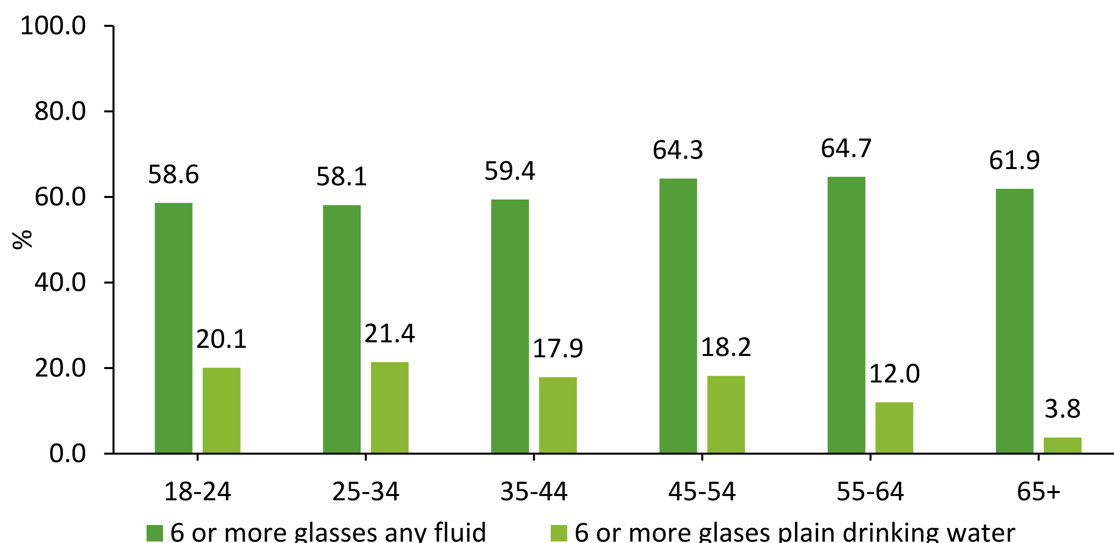


Figure 25: Fluid consumption on average day by age group (years)



Soft drinks (non-diet)

- Just over one in ten (11.3%) adults drank soft drinks (non-diet) at least twice a week[13] (Figure 26; Table A11).
- A higher proportion of males (13.9%) than females (8.7%) drank soft drinks (non-diet) at least twice a week (Table A11).
- The proportion of adults drinking soft drinks (non-diet) at least twice a week was highest amongst the youngest age group and decreased as age increased (Figure 27; Table A11).
- The proportion of adults drinking soft drinks (non-diet) at least twice a week decreased as income level increased (<£20,000, 15.1%; £20,000-79,999, 10.8%; £80,000+, 7.7%; Table A11).

Diet soft drinks

- One in five (20.3%) adults drank diet soft drinks at least twice a week[13] (Figure 26; Table A11).
- A higher proportion of males (21.7%) than females (19.1%) drank diet soft drinks at least twice a week (Table A11).
- The proportion of adults drinking diet soft drinks at least twice a week was highest amongst the youngest age group and generally decreased as age increased (Figure 27; Table A11).
- The proportion of adults drinking diet soft drinks at least twice a week was lowest amongst those in the lowest income group (<£20,000, 15.0%; £20,000-79,999, 22.0%; £80,000+, 22.0%; Table A11).

[13] Response options were dictomised into two categories: 2-3 times a week, 4-6 times a week, 7 or more times a week = twice a week or more; and, rarely or never, less than once a month, once a week = once a week or less.

Energy drinks

- Less than one in twenty (2.3%) adults drank high energy caffeine drinks (e.g. Red Bull, Relentless, Monster) at least twice a week[13] (Figure 26; Table A11).
- A higher proportion of males (3.5%) than females (1.2%) drank energy drinks at least twice a week (Table A11).
- The proportion of adults drinking energy drinks at least twice a week was highest amongst those aged 25-34 years but generally decreased as age increased (Figure 27; Table A11).
- The proportion of adults drinking energy drinks at least twice a week was highest amongst those in the lowest income group and decreased as income level increased (<£20,000, 3.6%; £20,000-79,999, 2.3%; £80,000+, 1.0%; Table A11).

Figure 26: Frequency of soft drink, diet soft drink and energy drink consumption

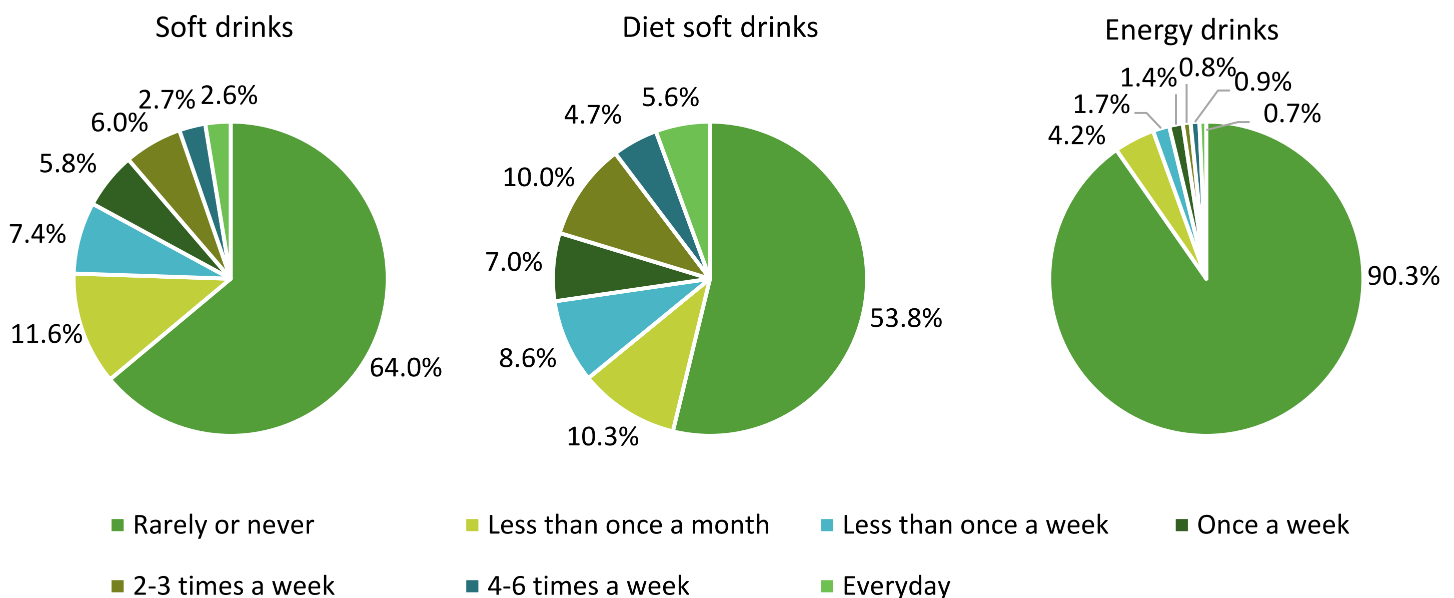
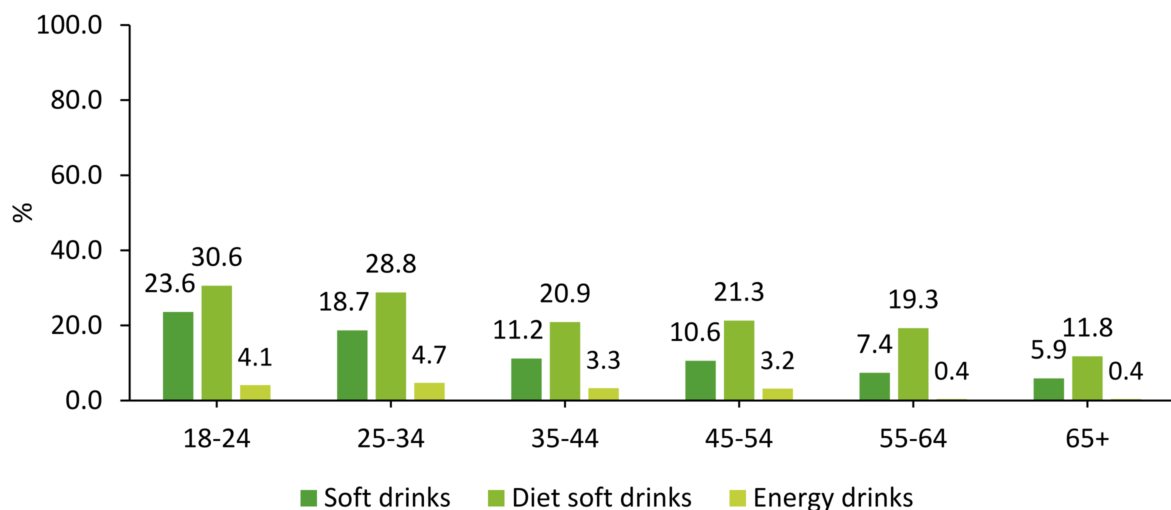


Figure 27: Consumption of soft drinks, diet soft drinks, and energy drinks at least twice a week by age group (years)



Box 5: Health in focus – Poor diet

Poor diet

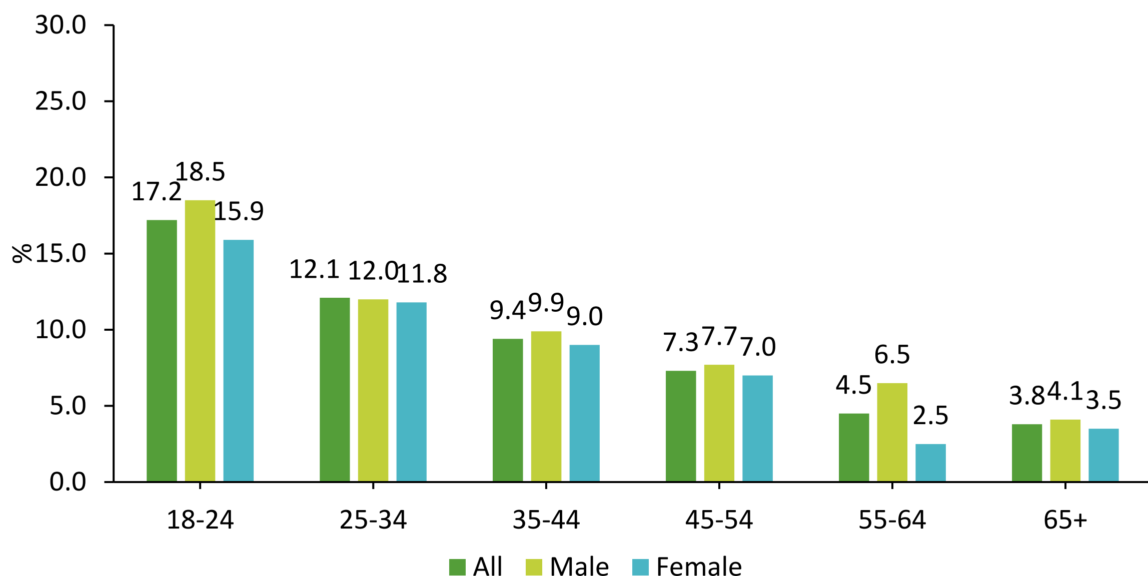
<2 pieces of fruit and/or vegetables a day

7.9% of all adults

- A higher proportion of males (8.6%) reported having a poor diet compared with females (7.2%; Table A12). There was also a decrease of reporting a poor diet with age, those in the youngest age group were most likely to report having a poor diet (17.2%) compared with those in the oldest age group 65+ (3.8%; Figure 28; Table A12).

- In sample (unweighted) analyses, having a poor diet was significantly associated with age ($p<0.001$) but not gender (Table A12). Poor diet was also significantly associated with: place of birth (IoM, 8.2%; other, 5.8%; $p<0.05$); home ownership status (does not own home, 11.2%; owns home, 5.1%; $p<0.001$); relationship status (single, 9.8%; in a relationship, 4.3%; $p<0.001$); sexuality (heterosexual, 6.5%; other, 12.6%; $p<0.05$) and, employment status (employed, 8.2%; unemployed, 4.5%; $p<0.001$; Table A12).

Figure 28: Prevalence of poor diet by age group (years) and gender



3.4 Exercise

The Isle of Man Health and Lifestyle Survey included a range of questions on physical exercise including daily activity level, sport or recreational activity, active travel and reasons for not exercising more. Key finding from these questions are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.4.1 Daily activity level

43.8% of adults were usually sitting down during the day and did not walk about much

- Almost one in four (39.1%) adults move quite a lot during the day, but do not lift or carry things very often (Figure 29; Table A13). Just over one in ten (13.1%) adults usually lift or carry light loads or have to climb stairs or hills often, whilst less than one in twenty adults (4.0%) often do heavy work or carry heavy loads (Figure 29; Table A13).
- A higher proportion of males (49.6%) than females (38.2%) reported usually sitting down during the day and not walking about much (Table A13).
- The proportion of adults usually sitting down during the day and not walking about much generally decreased as age increased (Figure 30; Table A13).
- The proportion of adults usually sitting down during the day and not walking about much increased as income level increased (<£20,000, 24.6%; £20,000-79,999, 45.5%; £80,000+, 68.8%; Table A13).

Figure 29: Daily activity level

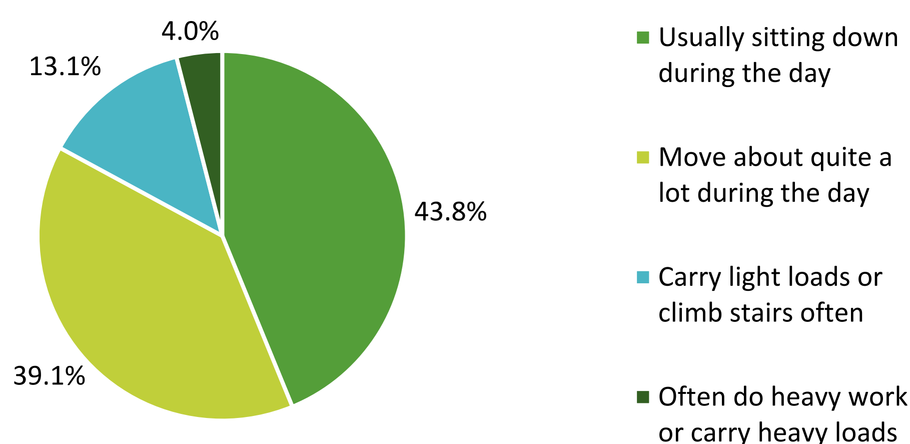
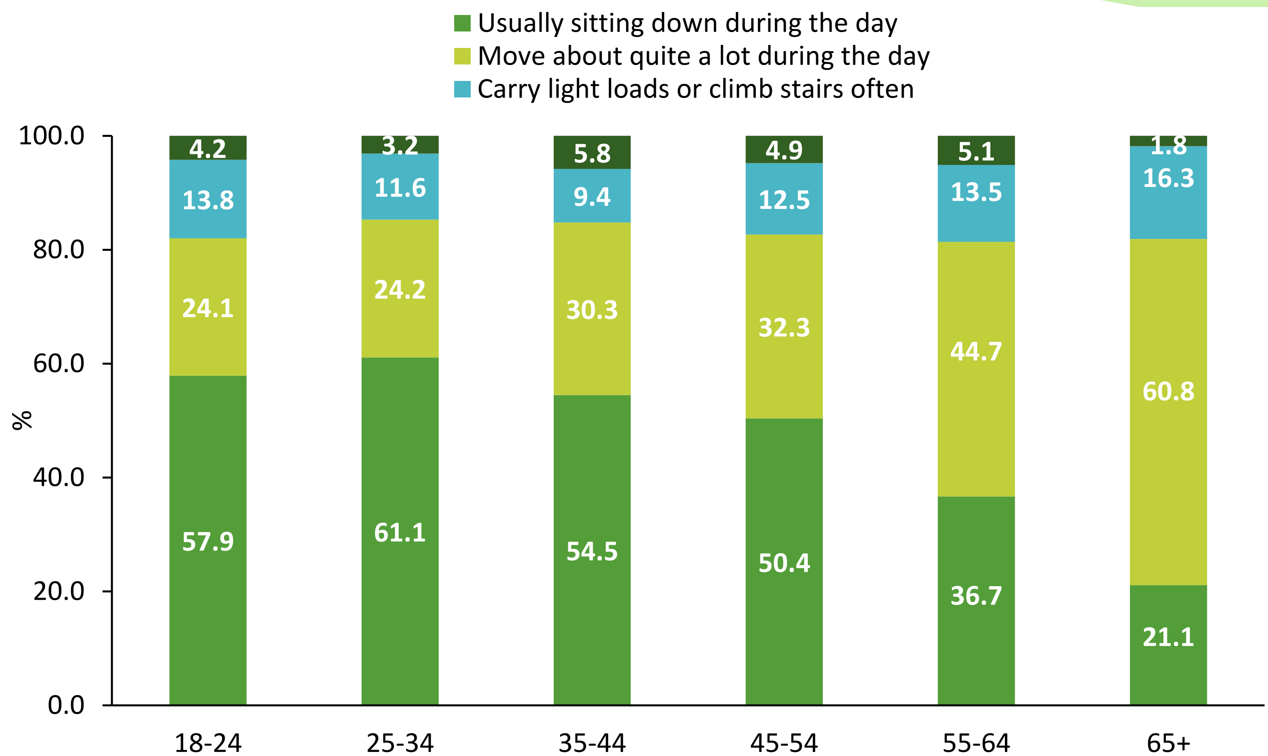


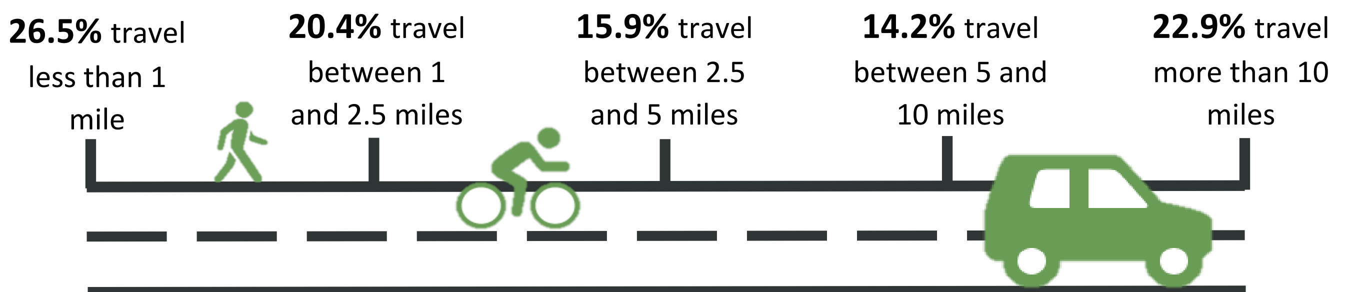
Figure 30: Daily activity level by age group (years)



3.4.2 Active travel

17.8% of adults use active forms of travel (i.e. walking or cycling) to and from work

Figure 31: Distance travelled to work[14]



- Almost seven in ten (67.3%) adults' primary mode of transport to and from work was by car (as a driver), 5.5% used public transport, and 4.6% went to and from work as a passenger in a car (Figure 32; Table A14). Almost one in five (17.8%) adults used active forms of travel to get to and from work, with 16.0% walking and 1.8% cycling (Figure 32; Table A14).

[14] Categories based on response options in the survey.

- Over one quarter (26.5%) of adults travelled less than 1 mile to work (Figure 31). The highest proportion of adults using active forms of travel to and from work was amongst those who travelled less than 1 mile to work (43.8%), decreasing to 24.5% of those who travelled between 1 and 2.5 miles, 6.2% of those who travelled between 2.5 and 5 miles, 3.8% of those who travelled between 5 and 10 miles, and 1.0% of those who travelled more than 10 miles.
- A higher proportion of males (19.8%) than females (15.8%) primarily used active forms of travel to get to and from work (Table A14).
- The proportion of adults using active forms of travel to and from work was highest amongst those aged 55-64 years and lowest amongst those aged 18-24 years (Figure 33; Table A14).
- The proportion of adults using active forms of travel to and from work was highest amongst the lowest income group and decreased as income group increased (<£20,000, 22.9%; £20,000-79,999, 17.7%; £80,000+, 15.7%; Table A14).

Figure 32: Primary mode of transport to and from work

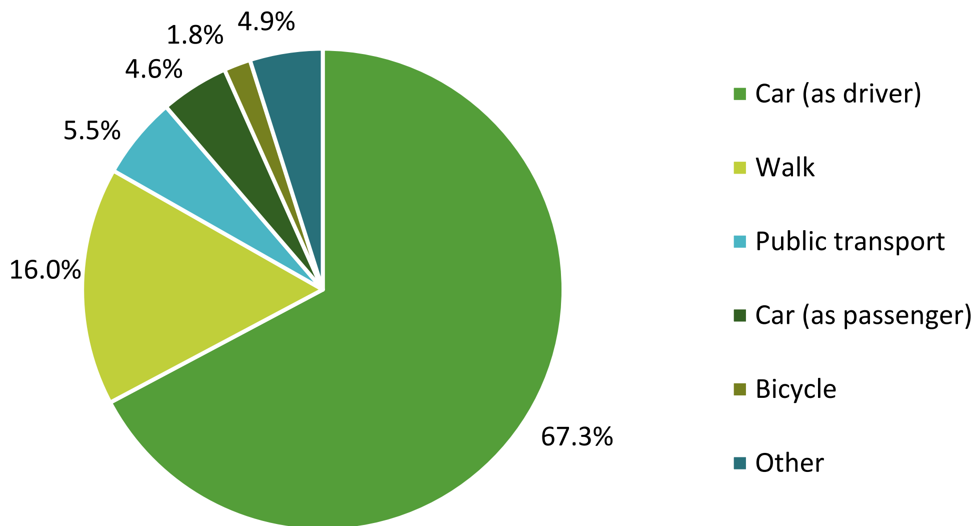
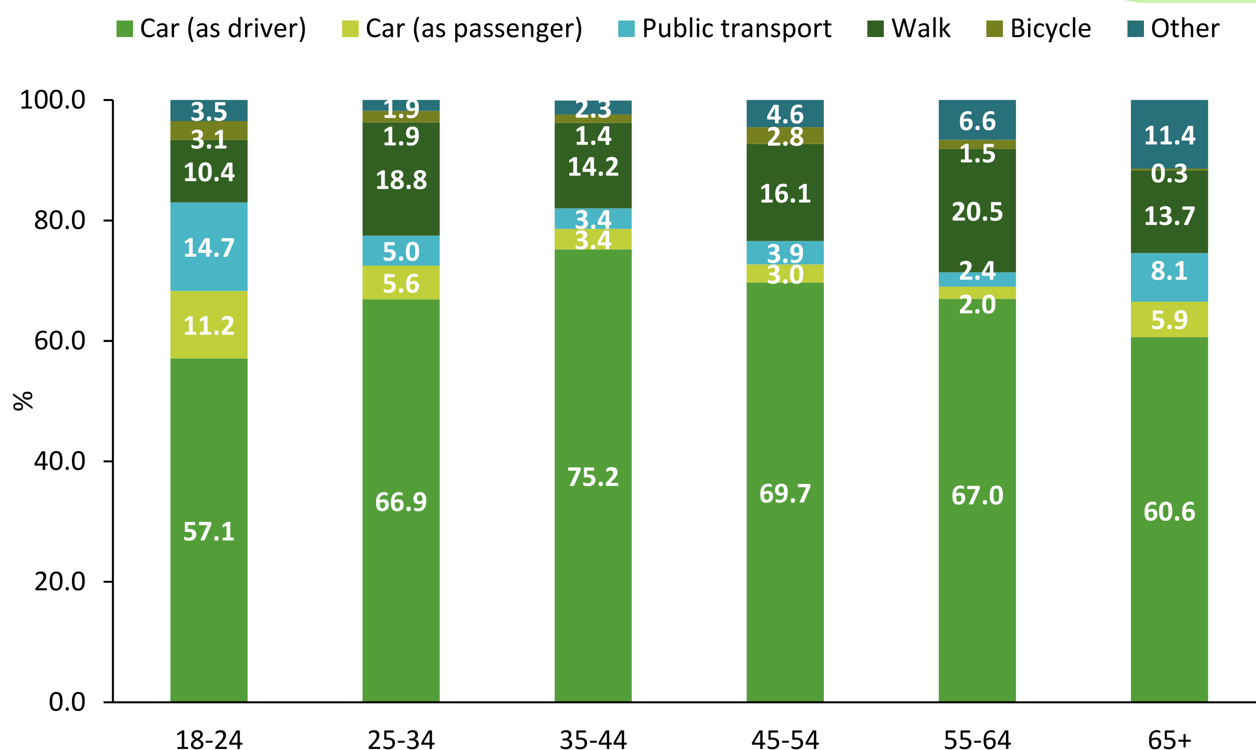


Figure 33: Primary mode of transport to and from work by age group (years)



3.4.3 Physical activity from sport or recreation

22.8% of adults spent 7 hours or more participating in sport or recreational activity in the past week

- One in five (22.8%) adults spent 7 or more hours in the past week taking part in sport or recreational activity that made them slightly breathless and warm, one quarter (25.6%) of adults spent 4:00-6:59 hours, and 34.6% spent 1:00-3:59 hours (Figure 34; Table A15). More than one in ten (16.9%) adults spent less than one hour in the past week taking part in sport or recreational activity (Figure 34; Table A15). Overall, six in ten adults took part in the recommended 2.5 hours or more of sport or recreational activity in the past week (see Box 6).
- A higher proportion of males (23.7%) than females (22.0%) spent 7 or more hours in the past week taking part in sport or recreational activity that made them slightly breathless and warm (Table A15).
- The proportion of adults spending 7 or more hours in the past week taking part in sport or recreational activity that made them slightly breathless and warm was highest amongst those aged 65+ years and lowest amongst those aged 25-34 years (Figure 35; Table A15).

- The proportion of adults spending 7 or more hours in the past week taking part in sport or recreational activity that made them slightly breathless and warm was lowest amongst the middle income group (<£20,000, 26.1%; £20,000-79,999, 21.1%; £80,000+, 26.2%; Table A15).

Figure 34: Physical activity from sport or recreation in the past week (hours, minutes)

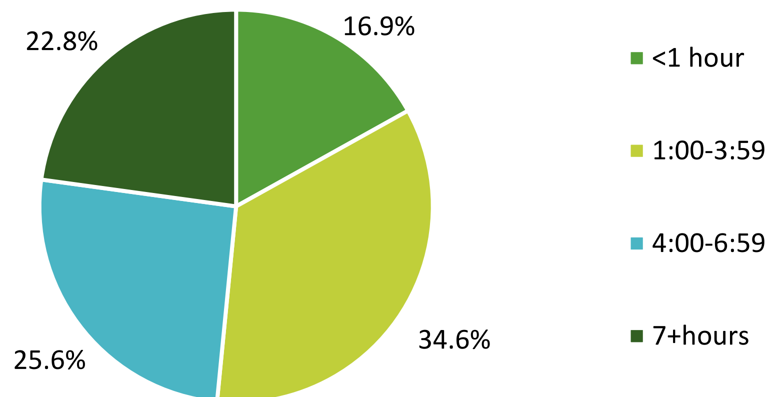
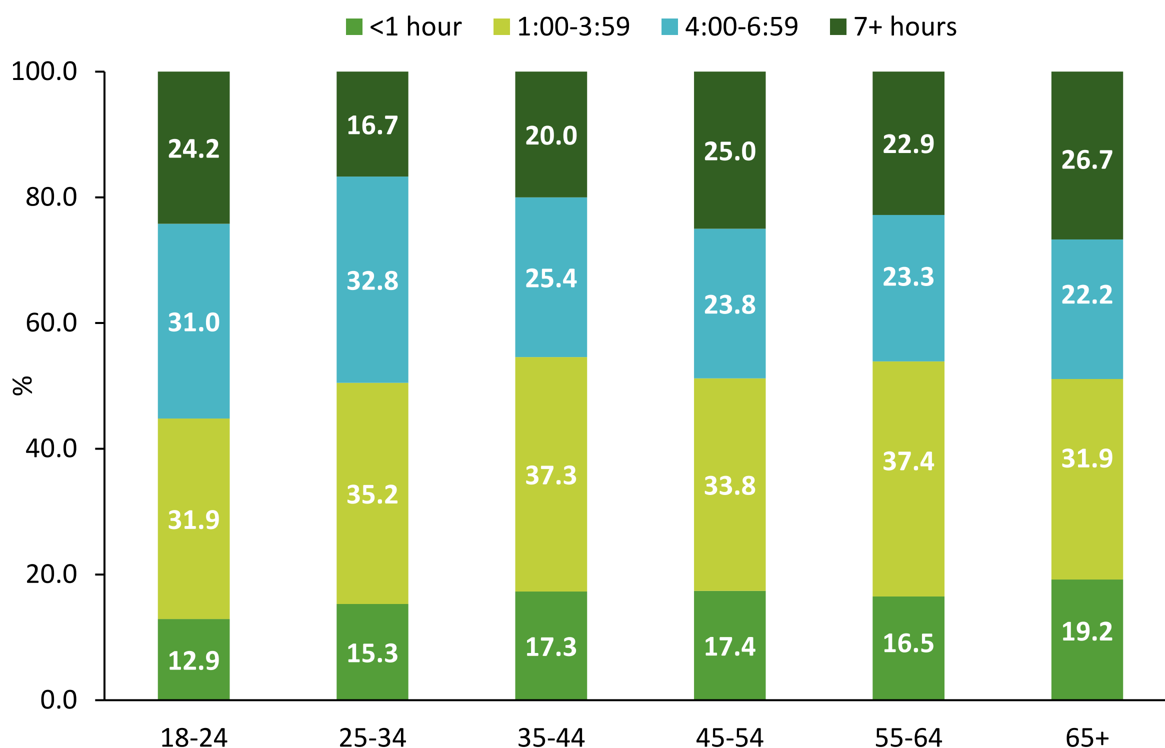


Figure 35: Physical activity from sport or recreation in the past week (hours, minutes) by age group (years)

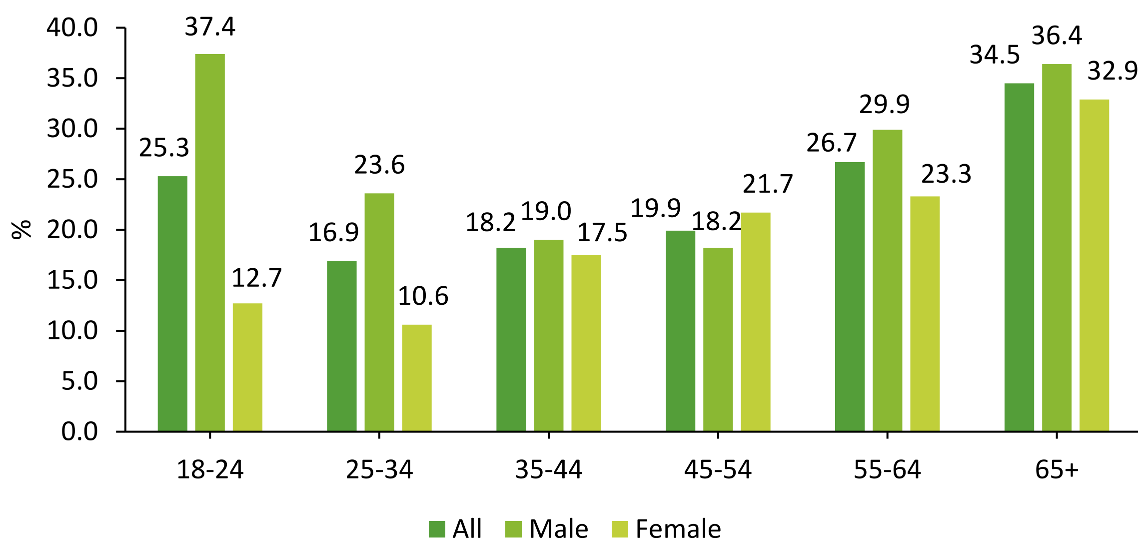


3.4.4 Perceived level of physical exercise

24.6% of adults felt they were currently doing enough exercise

- Almost one quarter (24.6%) of adults felt they were currently doing enough exercise. One third (33.9%) of adults wear a fitness tracker/step counter or use an activity app to track their exercise.
- A slightly higher proportion of males (27.4%) than females (21.9%) felt they were currently doing enough exercise. The proportion of adults who felt they were currently doing enough exercise was highest amongst those aged 65+ years (34.5%; Figure 36).

Figure 36: Currently doing enough exercise by gender and age group



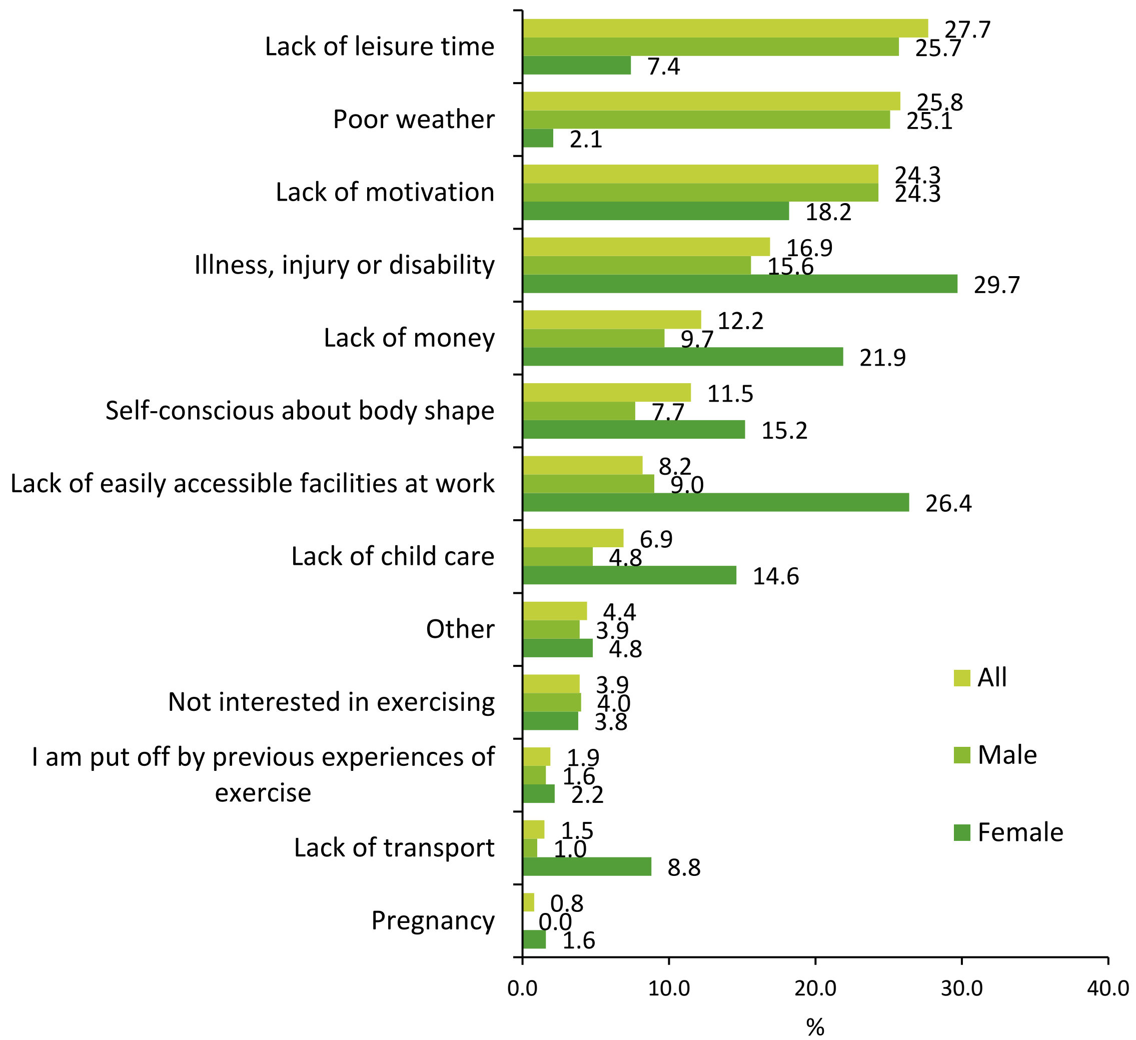
3.4.5 Reasons for not exercising more

27.7% of adults reported that the reason they did not exercise more was due to a lack of leisure time

- The most common reason adults gave for what prevented them from doing more physical activity[15] was lack of leisure time (27.7%), followed by poor weather (25.8%) and lack of motivation (24.3%; Figure 37).
- More females than males cited illness, injury or disability and lack of easily accessible facilities at work as reasons for not exercising more, whilst more males than females cited lack of leisure time, poor weather and lack of motivation as reasons for not exercising more (Figure 37).

[15] Respondents were provided with a list of reasons and could tick as many as applicable.

Table 37: Reasons for not exercising by gender



Box 6: Health in focus – Low physical exercise

Low physical exercise

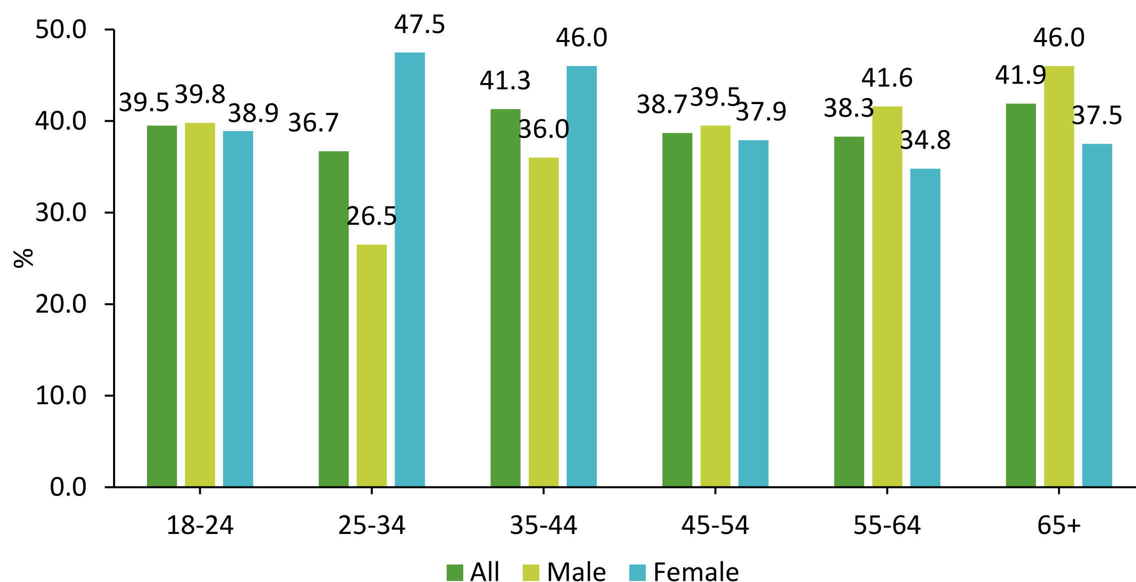
Taking part in less than 2.5 hours of physical activity (e.g. walking quickly, cycling, sports or exercise) in the past week.

39.6% of all adults

- A slightly higher proportion of females (40.2%) reported having lower physical activity compared with males (38.9%). Participants aged 25-34 were least likely to report low physical activity (36.7%) whilst participants aged 65+ reported the highest prevalence of low physical activity (41.9%; Figure 38; Table A16).

- In sample (unweighted) analyses, low physical activity was not significantly associated with age or gender. The prevalence of low physical activity was significantly associated with: income level (<£20,000, 43.6%, £20,000-£79000, 40.1%; £80,000+, 33.7%; p<0.05); home ownership status (does not own home, 45.4%; owns home, 37.9%; p<0.01); and, qualification level (no qualifications, 48.9%; qualifications, 39.0%; p<0.01; Table A16).

Figure 38: Prevalence of low physical exercise by age group (years) and gender (weighted data)



3.5 Weight

The Isle of Man Health and Lifestyle Survey included questions on height and weight enabling a calculation of individuals' Body Mass Index (BMI), in addition to self-perception of weight and health professional's perception of individual's weight. Key finding from these questions are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.5.1 Body Mass Index (BMI)

34.6% of adults were classified as normal weight

- Using World Health Organisation classifications of BMI [4], just over one third (34.6%) of adults were classified as normal weight, with a BMI of 18.5-24.9 (Figure 39; Table A17). Just over one in one hundred (1.2%) adults were classified as underweight (BMI <18.5; Figure 39; Table A17). Overall, almost two thirds (64.3%) of adults were overweight or obese (see Box 7). Over one third (36.6%) of adults were overweight (BMI 25.0-29.9). Over one quarter (27.7%) of adults were obese: with 18.1% class 1 obesity (BMI 30.0-34.9), 6.5% class 2 obesity (BMI 35.0-39.9) and 3.1% class 3 obesity (BMI ≥40) (Figure 39; Table A17).
- A higher proportion of females (36.7%) than males (32.3%) had a BMI in the normal weight range (Table A17).
- The proportion of adults with a BMI in the normal weight range was highest amongst those in the youngest age group and showed an approximate decrease as age group increased (Figure 40; Table A17).
- The proportion of adults with a BMI in the normal weight range was highest amongst those in the highest income group and decreased as income group decreased (<£20,000, 28.7%; £20,000-79,999, 33.7%; £80,000+, 41.3%; Table A17).

Figure 39: BMI classifications

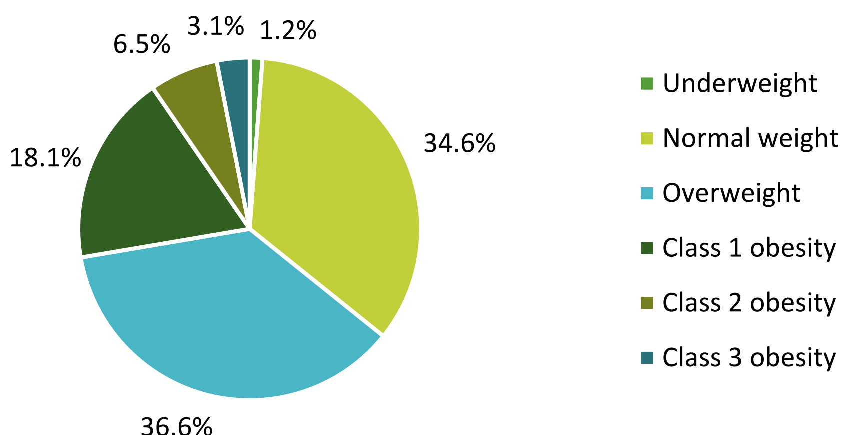
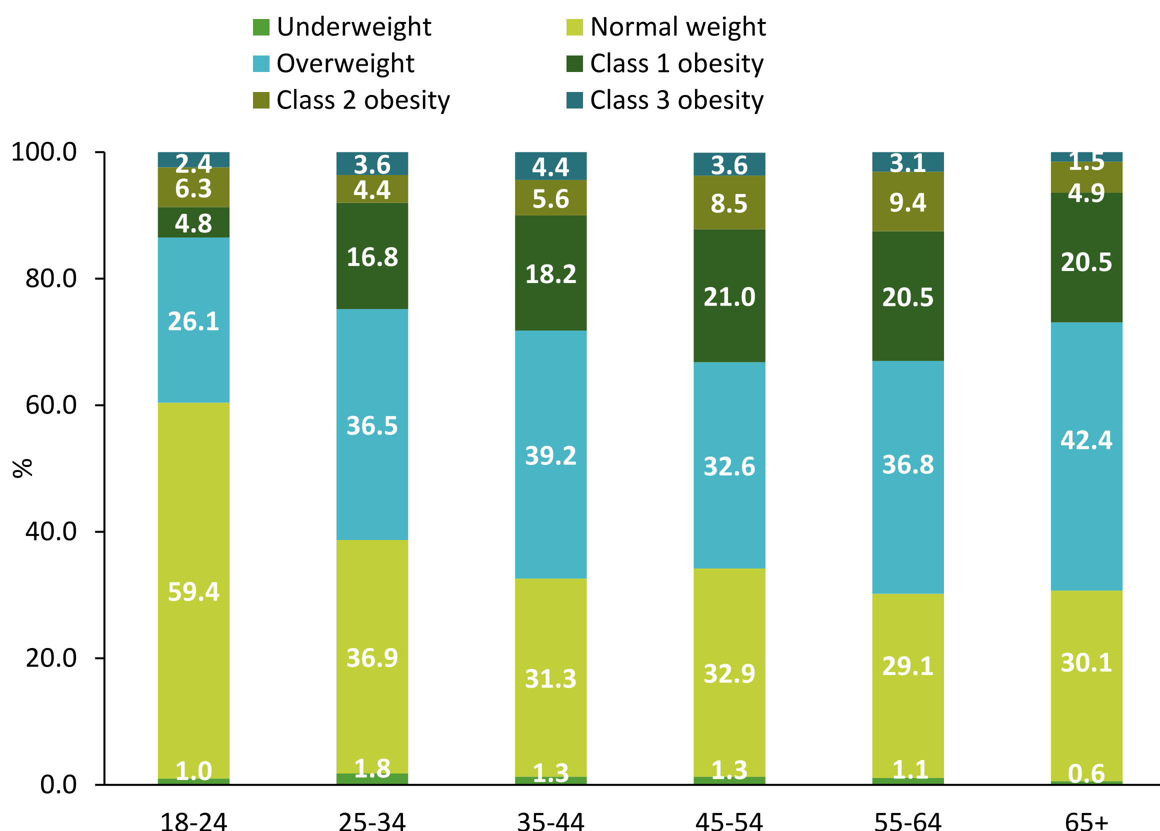


Figure 40: BMI classification by age group (years)



3.5.2 Self-reported weight classification and BMI comparison

31.2% of adults underestimated their weight classification compared to their BMI classification

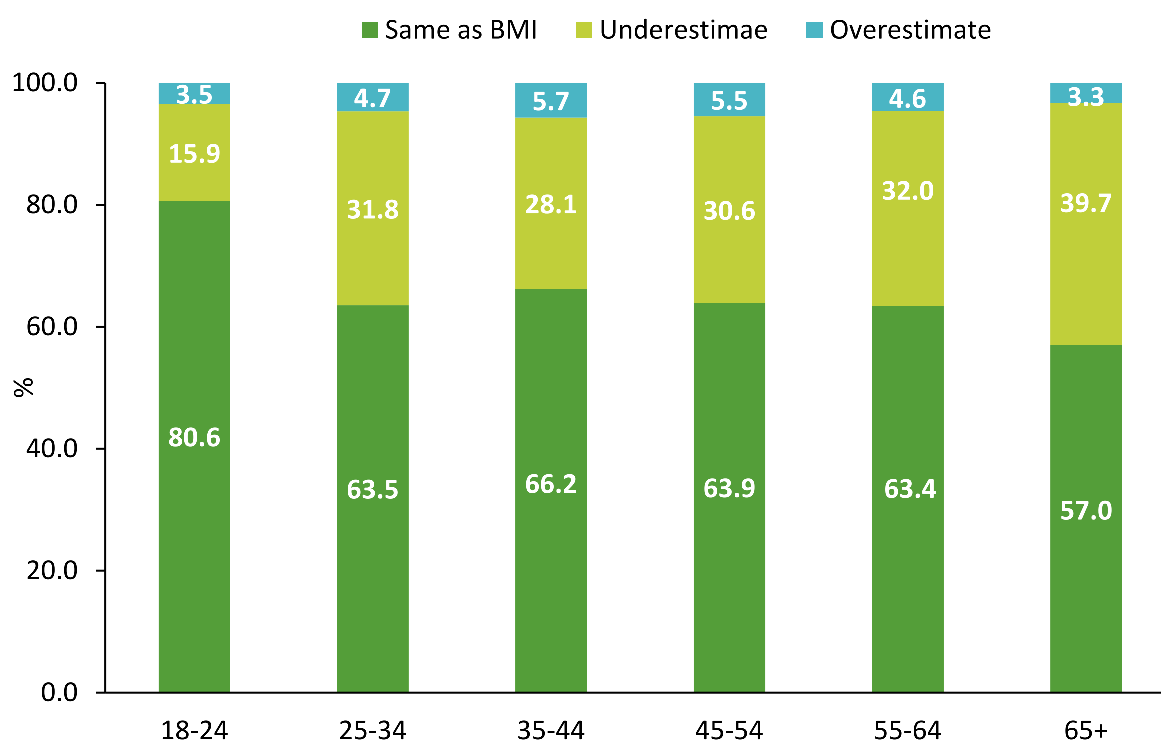
- Four in ten (40.2%) adults believed that they were a healthy weight, whilst 43.7% said they were overweight, 11.7% said they were very overweight, 2.7% reported being underweight and 1.7% were unsure about their weight.
- Three in ten (29.8%) adults had been told by a health professional that they were overweight. Of those who believed they were very overweight, the majority (84.2%) had also been told by a health professional they were overweight. Of those who believed they were overweight, 41.4% had also been told they were by a health professional. Less than one in twenty adults who reported they were about healthy weight (3.6%), underweight (4.2%) or unsure about their weight (4.3%) had been told by a health professional they were overweight.
- Adults self-reported weight category was compared to their BMI category[16] to estimate the proportion of adults who correctly knew they weight, underestimated their weight or overestimated their weight. Almost two thirds (64.2%) self-reported their weight as the same as their BMI classification, 31.2% of adults underestimated

[16] Self-reported 'very overweight' was coded as correct for BMI's Class 1 obesity, Class 2 obesity, and Class 3 obesity.

their weight classification (i.e. reported a lower weight classification than their BMI classification), and 4.5% overestimated their weight (i.e. placed their weight in a higher classification than their BMI classification).

- A higher proportion of females (70.0%) than males (58.0%) self-reported their weight classification as the same as their BMI classification. A higher proportion of females (6.5%) than males (2.4%) overestimated their weight classification, whilst a higher proportion of males (39.6%) than females (23.4%) underestimated their weight classification (Table A18).
- The proportion of adults who self-reported their weight classification as the same as their BMI weight classification was highest amongst those aged 18-24 years and lowest amongst those aged 65+ years (Figure 41; Table A18).
- The proportion of adults who self-reported their weight classification as the same as their BMI weight classification was highest amongst the highest income group and decreased as income group decreased (<£20,000, 56.0%; £20,000-79,999, 63.3%; £80,000+, 75.0%; Table A18).

Figure 41: Accuracy of self-reported weight classification by age group (years)



Box 7: Health in focus – Overweight or obese

Overweight or obese

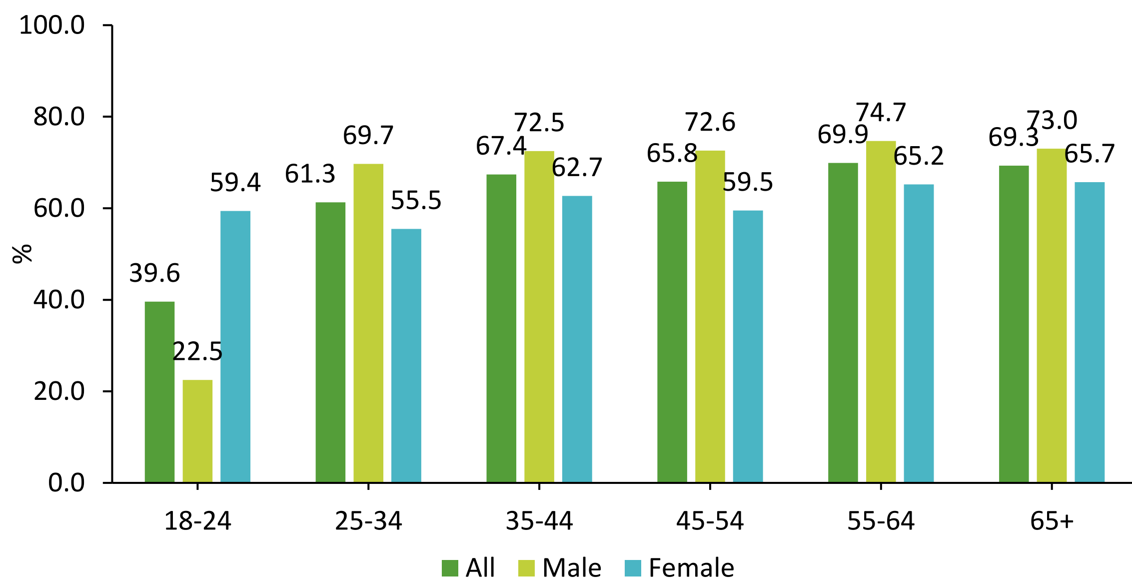
Body Mass Index (BMI) of 25 or more

64.3% of all adults

- A slightly higher proportion of males (67.0%) than females (61.7%) were classified as overweight or obese. The highest prevalence of overweight or obese individuals was amongst those aged 55-64 years (69.9%), whilst the lowest was amongst those aged 18-24 years (39.6%; Figure; 42; Table A19).

- In sample (unweighted) analyses, being overweight or obese was significantly associated with age (p<0.01) and gender (p<0.001; Table A19). The prevalence of being overweight or obese was also associated with: income status (<£20,000, 71.7%; £20,000-79,999, 65.9%; £80,000+, 61.8%; p<0.05); relationship status (single, 62.9%; in a relationship, 67.4%; p<0.05); and, qualification level (no qualifications, 76.3%; qualifications, 64.4%; p<0.01; Table A19).

Figure 42: Prevalence of overweight or obese adults by age group (years) and gender



3.6 General health

The Isle of Man Health and Lifestyle Survey included a range of questions on general health including self-reported general health, health conditions and attending health checks. Key findings from these questions are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.6.1 Self-reported general health

72.3% of adults had very good/good self-reported general health

- The majority (72.3%) of adults had very good or good self-reported general health, 22.3% reported having fair general health and 5.5% reported very bad or bad general health (Figure 43; Table A20). Adults were also asked to rate their health on the day of participation in the survey on a scale from 0-100 (where 100 is the best heath you can imagine). The average score was 78.7 (see Box 8).
- A slightly higher proportion of females (73.1%) than males (71.5%) had very good or good self-reported general health, approximately the same proportion of males (22.5%) and females (22.0%) reported fair general health, and more males (6.1%) than females (4.9%) reported very bad or bad general health (Table A20).
- The proportion of adults with good or very good general health was highest amongst those aged 35-44 years and lowest amongst those aged 65+ years (Figure 44; Table A20).
- The proportion of adults with good or very good general health was highest amongst the highest income group and decreased as income group decreased (<£20,000, 57.8%; £20,000-79,999, 74.4%; £80,000+, 86.8%; Table A20).

Figure 43: Self-reported general health

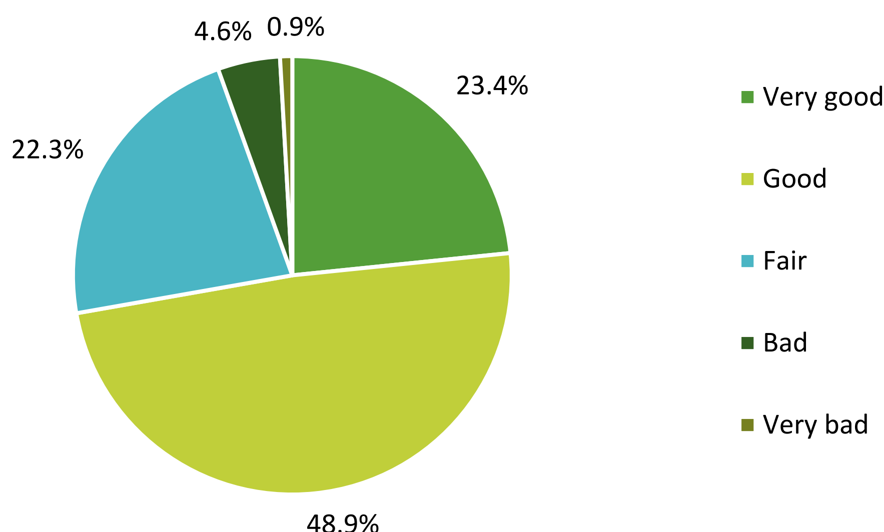
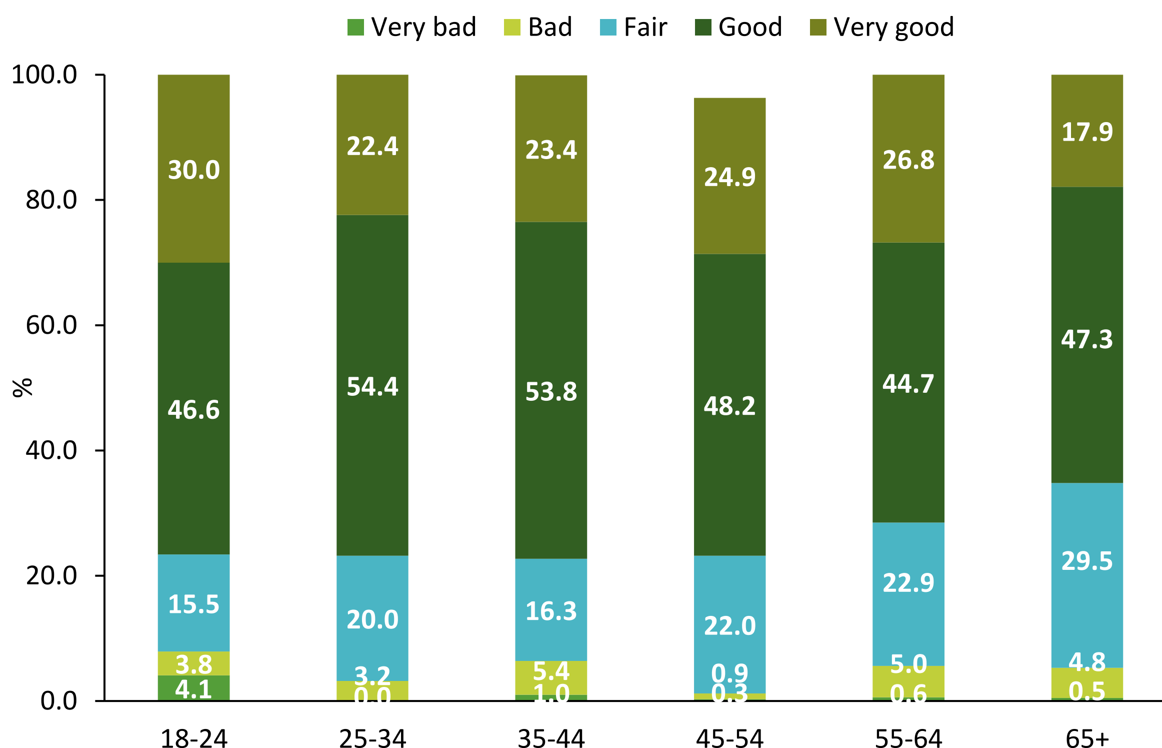


Figure 44: Self-reported general health by age group (years)



3.6.2 Health conditions

42.8% of adults had a physical or mental health condition or illness lasting or expected to last 12 months or more

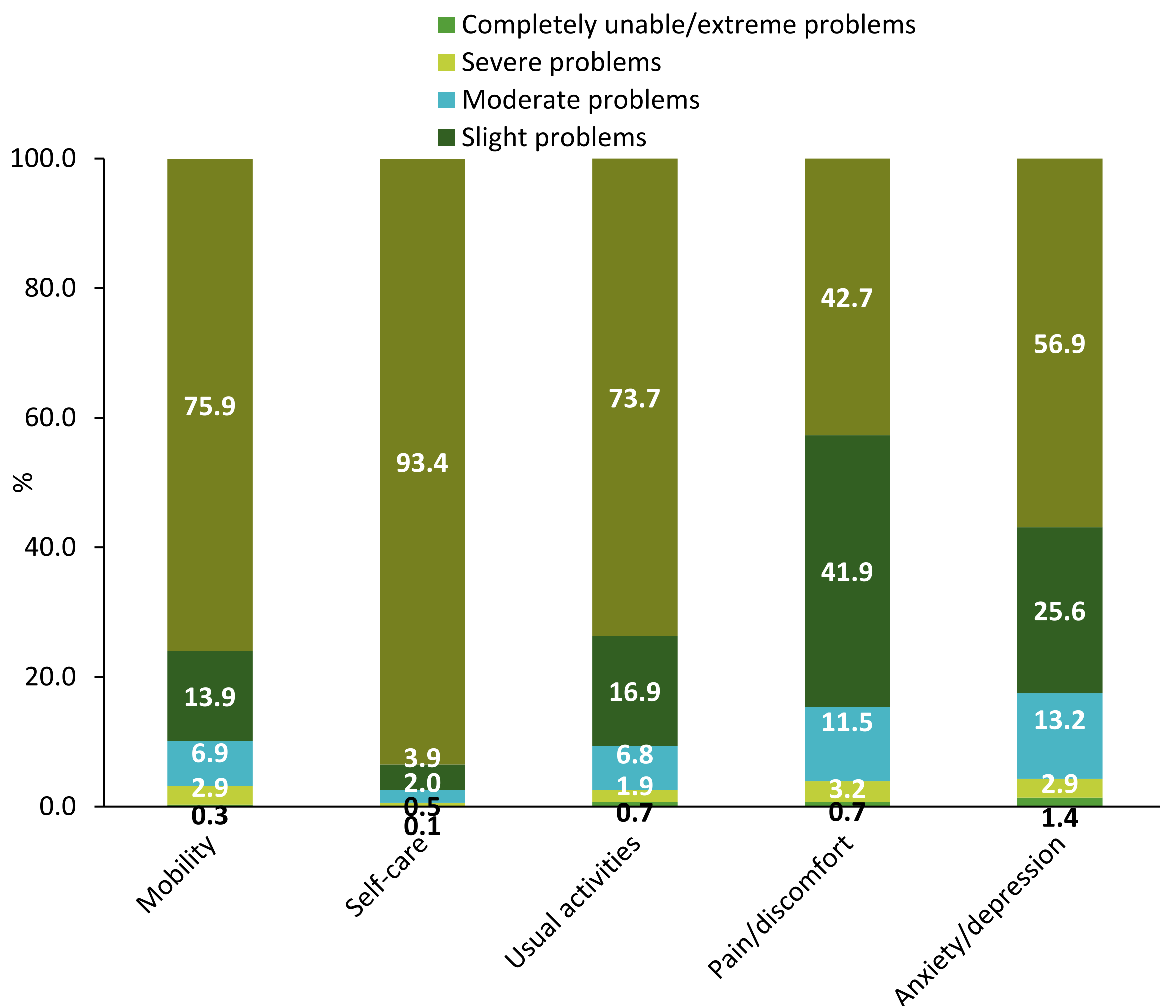
Long-term health conditions

- One in four (42.8%) adults had a physical or mental health condition or illness lasting or expected to last 12 months or more. Of those adults who had a condition, over half (57.1%) reported their illness limited their activities a little, 21.0% reported the condition limited their activities a lot, and 21.9% reported the condition did not limit their activities at all.
- A slightly higher proportion of females (44.2%) reported having a health condition compared with males (41.3%; Table A21).
- The proportion of adults with a long-term health condition increased as age group increased, with the lowest prevalence amongst those aged 18-24 and the highest amongst those aged 65+ years (18-24, 29.1%; 25-34, 30.4%; 35-44, 36.1%; 45-54, 40.1%; 55-64, 50.2%; 65+, 55.7%; Table A21).
- The proportion of adults with a long-term health condition was highest amongst the lowest income group and decreased as income group increased (<£20,000, 57.2%; £20,000-79,999, 65.1%; £80,000+, 30.7%; Table A21).

Activities of daily living, pain and mental health problems

- Three quarters (75.9%) of adults had no problems with their mobility (e.g. walking about), whilst 3.2% of adults were unable to walk or had severe mobility problems (Figure 45).
- The majority (93.4%) of adults had no problems with self-care (e.g. washing or dressing themselves), whilst 0.6% of adults were unable to wash or dress themselves or had severe problems doing so (Figure 45).
- Over seven in ten (73.7%) adults had no problems doing their usual activities (e.g. work, study, housework, family or leisure activities), whilst 2.6% of adults were unable to do their usual activities or had severe problems doing so (Figure 45).
- Approximately four in ten adults (42.7%) had no pain or discomfort, whilst 3.9% of adults had extreme or severe pain or discomfort (Figure 45).
- Over half (56.9%) of adults were not anxious or depressed, whilst 4.3% of adults had extreme or severe anxiety or depression (Figure 45).

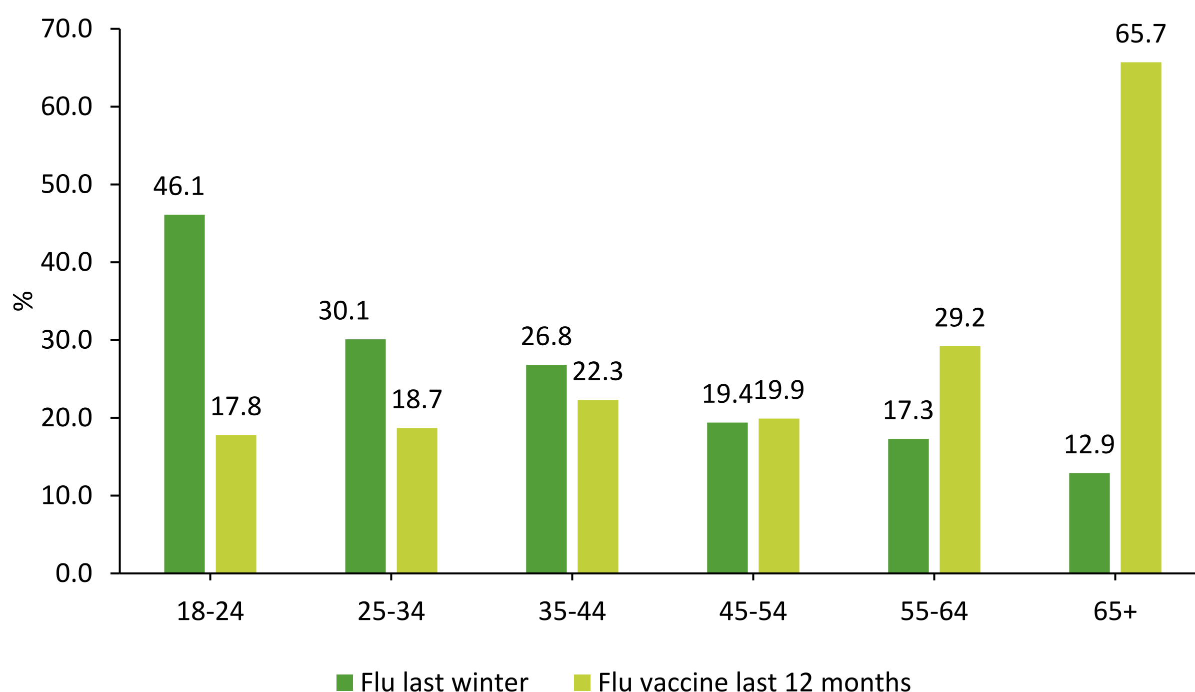
Figure 45: Activities of daily living, pain and mental health problems



Flu

- Just over one in five (22.0%) had the flu last winter[17]. Approximately two thirds (65.6%) of all adults had not had the flu vaccine in the past 12 months. Of those who had the flu vaccine, the majority (91.1%) received it for free. Of those who had the flu vaccine, 18.5% had the flu last winter, compared to 23.8% of those who did not have the flu vaccine.
- A slightly higher proportion of males (22.1%) than females (21.8%) had the flu last winter, whilst a slightly higher proportion of females (37.9%) than males (30.8%) had the flu jab in the last 12 months (Table A21).
- The prevalence of flu last winter was highest amongst the youngest age group (18-24 years, 46.1%) and decreased as age group increased (Figure 46; Table A20). The highest proportion of adults receiving the flu vaccine in the past 12 months was amongst those aged 65+ years and there was an approximate decrease as age group decreased (Figure 46; Table A21).
- The prevalence of flu last winter was highest amongst those in the lowest income group and decreased as income group increased (<£20,000, 23.7%; £20,000-79,999, 21.5%; £80,000+, 19.2%; Table A21). The proportion of adults who had the flu vaccine last winter was highest amongst the lowest income group and decreased as income group increased (<£20,000, 46.0%; £20,000-79,999, 32.0%; £80,000+, 23.9%; Table A21).

Figure 46: Prevalence of flu and flu vaccine by age group (years)



[17] Defined as a sudden fever, a temperature of 38ºC or above, an aching body, feeling tired or exhausted, a dry cough, a sore throat, and/or a headache.

3.6.3 Health checks and screening

81.3% of adults had attended a dental check within the past five years

- The majority (81.3%) of adults had attended a dental check in the last five years. Among those who had not, 21.7% said they had not because the cost was too high, whilst 20.3% said they didn't feel they needed it.
- Over one fifth (77.0%) of adults had attended an eye test in the last five years. Among those who had not, 42.9% said they didn't feel they needed it, whilst 21.3% said they did not receive an invite.
- Over one in ten (14.7%) adults had attended a hearing test in the last five years. Among those who had not, 41.9% said they didn't feel they needed it, whilst 27.7% said it wasn't applicable to them.
- Just over one in twenty (5.7%) adults had attended a sexual health check-up (sexually transmitted diseases) in the last five years. Among those who had not, 56.4% said it wasn't applicable to them, whilst 32.5% said they didn't feel they needed it.
- Over six in ten (61.9%) adults aged 60+ years had attended colorectal (bowel cancer) screening in the last five years[18]. Of those adults aged 60+ years who had not attended, 33.5% said they did not receive an invite, whilst 20.0% said they didn't feel they needed it.
- Over seven in ten (73.5%) women aged 50+ years had attended breast mammography (breast cancer screening) in the last five years[19]. Of those women aged 50+ years who had not attended, 39.9% said they did not receive an invite, whilst 13.6% said it wasn't applicable to them.
- Over seven in ten (73.5%) women aged 25-64 years had attended cervical smear testing in the last five years[20]. Of those women aged 25-64 years who had not attended, 39.9% said they did not receive an invite, whilst 13.6% said it wasn't applicable to them.

[18] Bowel cancer screening is available on the Isle of Man for men and women aged 60-75, and adults over the age of 75 years by request.
[19] Breast cancer screening is available on the Isle of Man for women aged 50-70, and women over the age of 70 years by request.
[20] Cervical screening is available on the Isle of Man for women aged 25-64 and is done every three years for women aged 25-49 and every five years for women aged 50-64.

Box 8: Health in focus – Poor general health

Poor general health

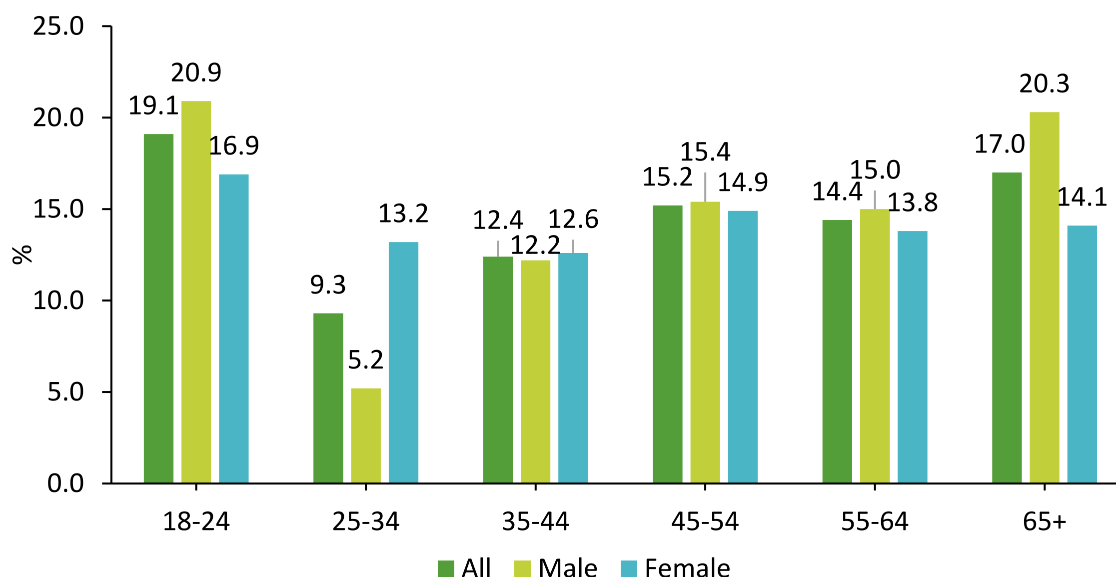
One standard deviation (18.2) below the mean score (78.7) on the self-reported health measure (EQ VAS).

14.7% of all adults

- A higher proportion of males (15.3%) had poor health compared with females (14.0%). Participants aged 25-34 were least likely to have poor health (9.3%) whilst participants aged 18-24 years old had the highest prevalence of poor general health (19.1%; Figure 47; Table A22).

- In sample (unweighted) analyses, having poor general health was not significantly associated with age or gender (Table A22). Poor general health was significantly associated with: income level (<£20,000, 7.8%; £20,000-£79,999, 12.1%; £80,000+, 25.7%; p<0.001); home ownership status (does not own home, 21.0%; owns home, 12.1%; p<0.001); relationship status (single, 17.0%; in a relationship, 12.4%; p<0.01); qualification level (no qualifications, 24.7%; qualifications, 12.9%; p<0.001); and, employment status (unemployed, 20.7%; employed, 10.2%; p<0.001; Table A22).

Figure 47: Prevalence of poor health by age group (years) and gender (weighted data)



3.8 Wellbeing

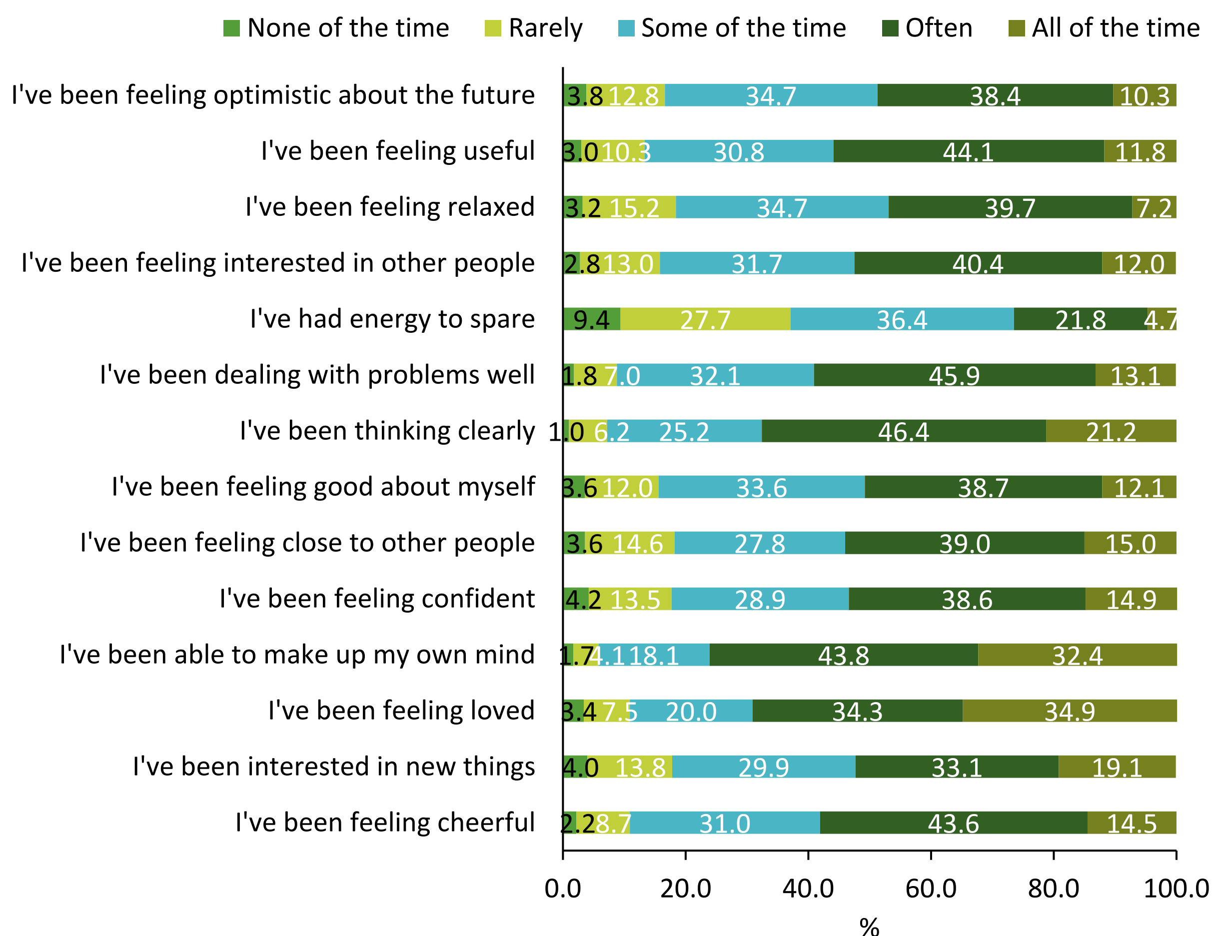
The Isle of Man Health and Lifestyle Survey included a range of questions on wellbeing including mental wellbeing, anxiety, stress, sleep quality, life satisfaction, happiness, feeling life is unworthwhile and social relationships. Key findings from these questions are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.8.1 Mental wellbeing

28.2% of adults had high mental wellbeing

- Mental wellbeing was measured using the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS; see section 2). Figure 48 shows the responses to the 14 questions included in the scale and the proportion of adults who gave each response option.

Figure 48: Responses to the 14 WEMWBS items



- Responses to each WEMWBS question are scored and summed into a total WEWMBS score (see section 2). WEWMBS scores were categorised into high (scores of 59 or more), moderate (39-58) or low (38 or lower) mental wellbeing.
- Almost three in ten (28.2%) adults had high mental wellbeing, 59.6% had moderate mental wellbeing (Figure 49; Table A22). More than one in ten (12.3%) adults had low mental wellbeing (see Box 9).
- A higher proportion of females (29.3%) than males (27.0%) had high mental wellbeing (Table A23).
- The proportion of adults with high mental wellbeing was highest amongst the youngest (34.1%) and oldest (35.9%) age groups (Figure 50; Table A23).
- The proportion of adults with high mental wellbeing was highest amongst the highest income group (<£20,000, 18.6%; £20,000-79,999, 14.3%; £80,000+, 20.4%; Table A23).

Figure 49: Mental wellbeing

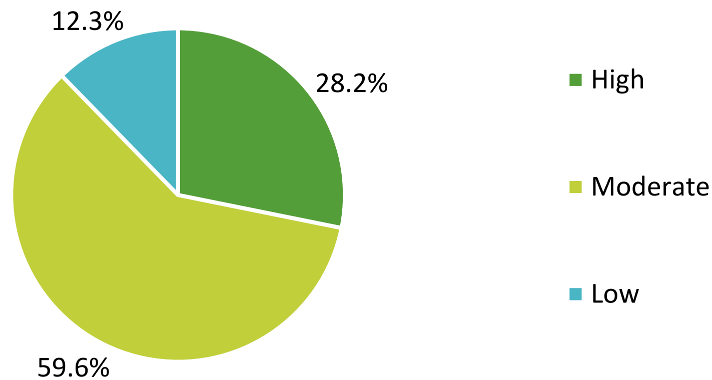
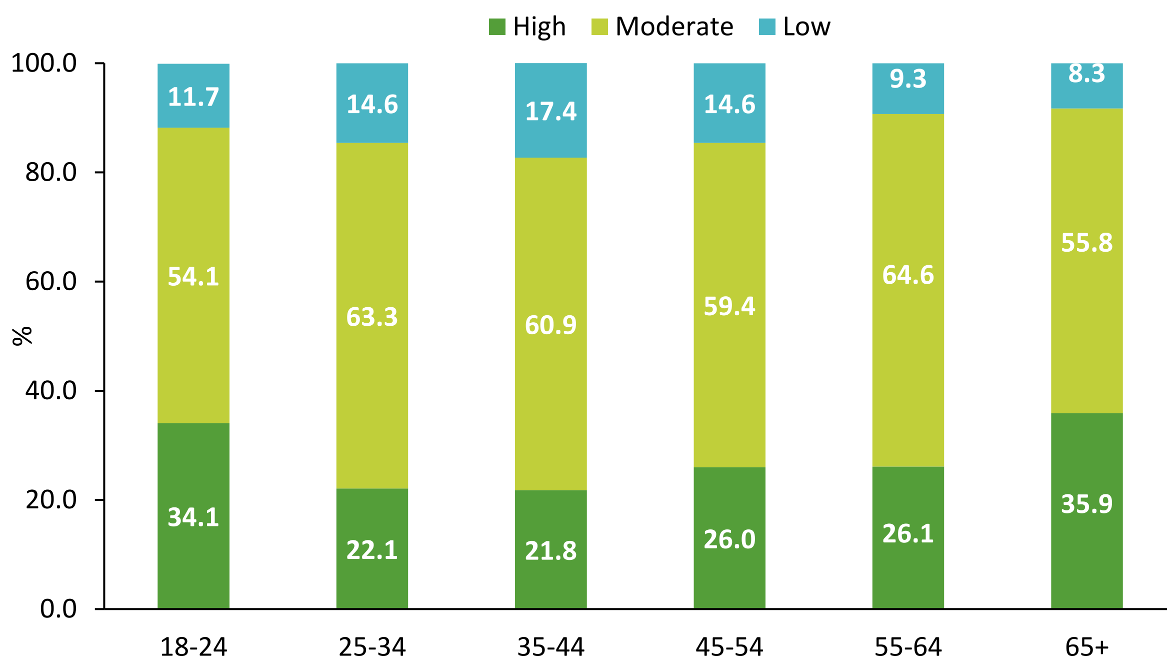


Figure 50: Mental wellbeing by age group (years)



3.8.2 Stress

11.6% of adults experienced a large amount of stress

Level of stress

- More than half (54.3%) of adults were completely free of stress or experienced a small amount of stress, whilst 45.7% experienced moderate or large amounts of stress (Figure 51; Table A24).
- A higher proportion of females (49.0%) than males (42.3%) experienced a moderate or large amount of stress (Table A24).
- The proportion of adults experiencing a moderate or large amount of stress was lowest amongst older age groups (Figure 52; Table A24).
- The proportion of adults experiencing a moderate or large amount of stress was highest amongst the lowest income group (<£20,000, 49.5%; £20,000-79,999, 44.2%; £80,000+, 46.8%; Table A24).

Figure 51: Level of stress

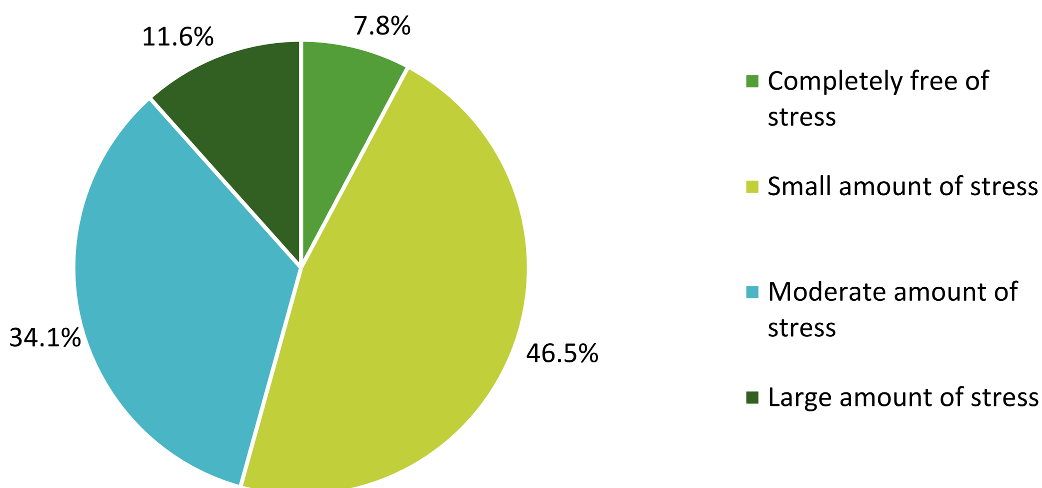


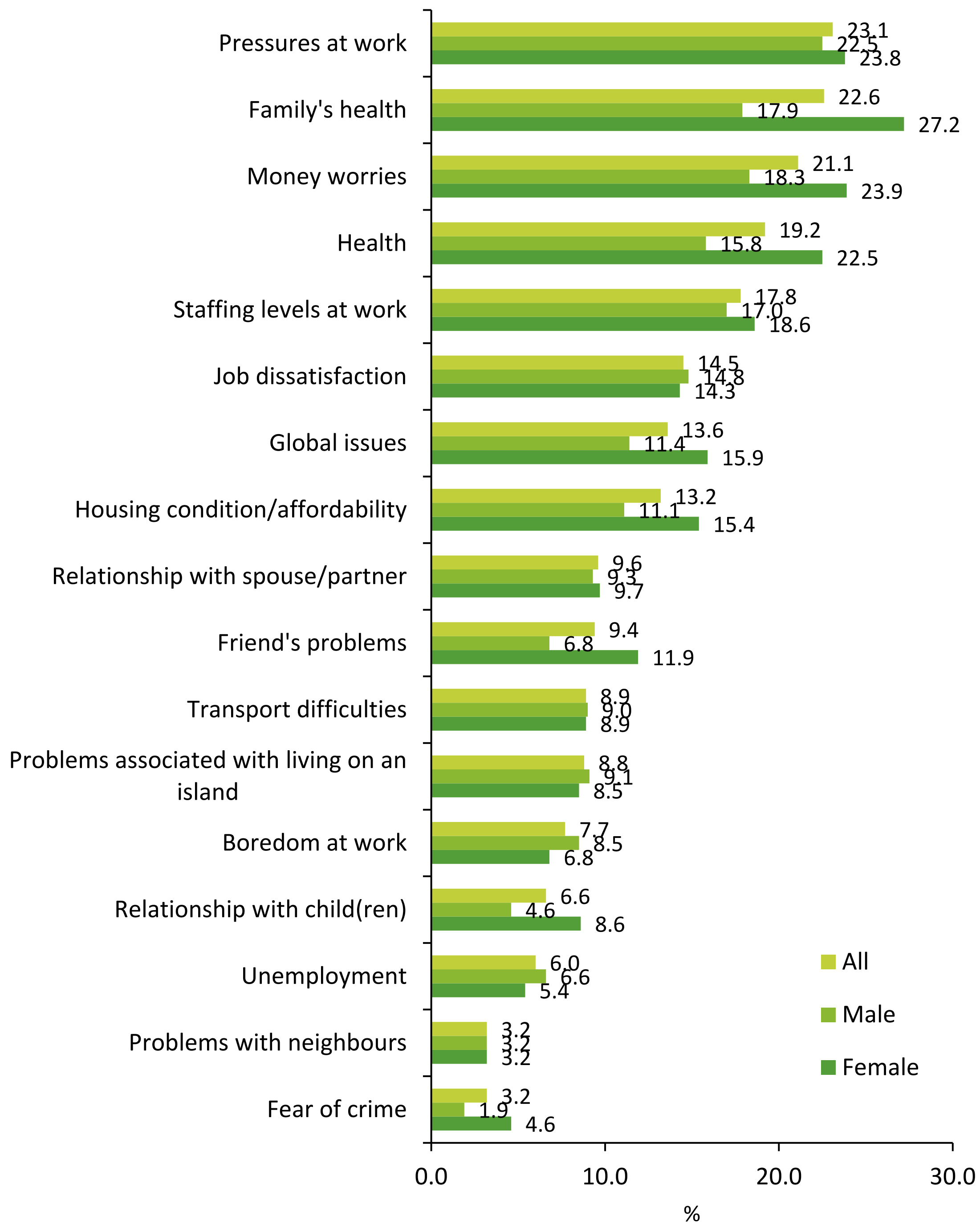
Figure 52: Level of stress by age group (years)

Causes of stress

- Participants were asked about how often a range of different issues caused them stress or anxiety[21]. Pressures at work was the top reason for stress or anxiety, with 23.1% of adults reporting that it caused them stress or anxiety always or frequently (Figure 53). Other factors which participants reported as always or frequently causing them stress or anxiety were: family's health (22.6%); money worries (21.1%); own health (19.2%); staffing levels at work (17.8%); job dissatisfaction (14.5%); global issues (13.6%); housing condition/affordability (13.2%); relationship with spouse/partner (9.6%); friend's problems (9.4%); transport difficulties (8.9%); problems associated with living on an island (8.8%); boredom at work (7.7%); relationship with child(ren) (6.6%); unemployment (6.0%); problems with neighbours (3.2%); and fear of crime (3.2%; Figure 53).
- The most common reason for stress or anxiety for females was family's health (27.2%), whilst for males the most common reason was pressures at work (22.5%; Figure 53).

[21] Respondents were provided with a list of reasons and could tick as many as applicable.

Table 53: Causes of stress by gender



3.8.3 Sleep quality

18.5% of adults had bad/very bad sleep quality

- Over four in ten (42.5%) adults rated their overall sleep quality as very good or good, 39.0% reported their sleep quality was fair, whilst 18.5% reported their sleep quality as bad or very bad (Figure 54; Table A25).
- A higher proportion of females (20.2%) than males (16.9%) rated their overall sleep quality as bad or very bad (Table A25).
- The proportion of adults reporting their overall sleep quality as bad or very bad was highest amongst those in middle age groups compared to those in the youngest and oldest age groups (Figure 55; Table A25).
- The proportion of adults reporting their overall sleep quality as bad or very bad was highest amongst the lowest income group (<£20,000, 22.3%; £20,000-79,999, 18.2%; £80,000+, 14.6%; Table A25).

Figure 54: Sleep quality

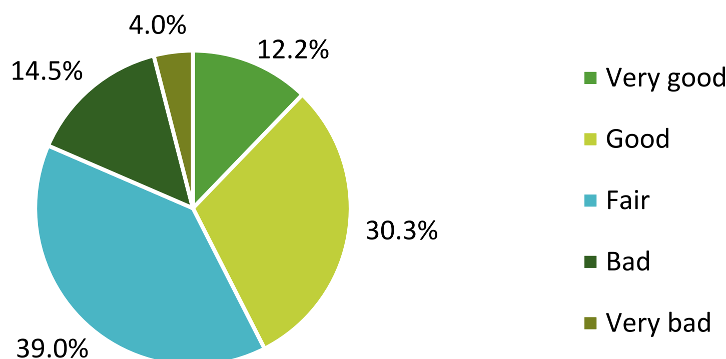
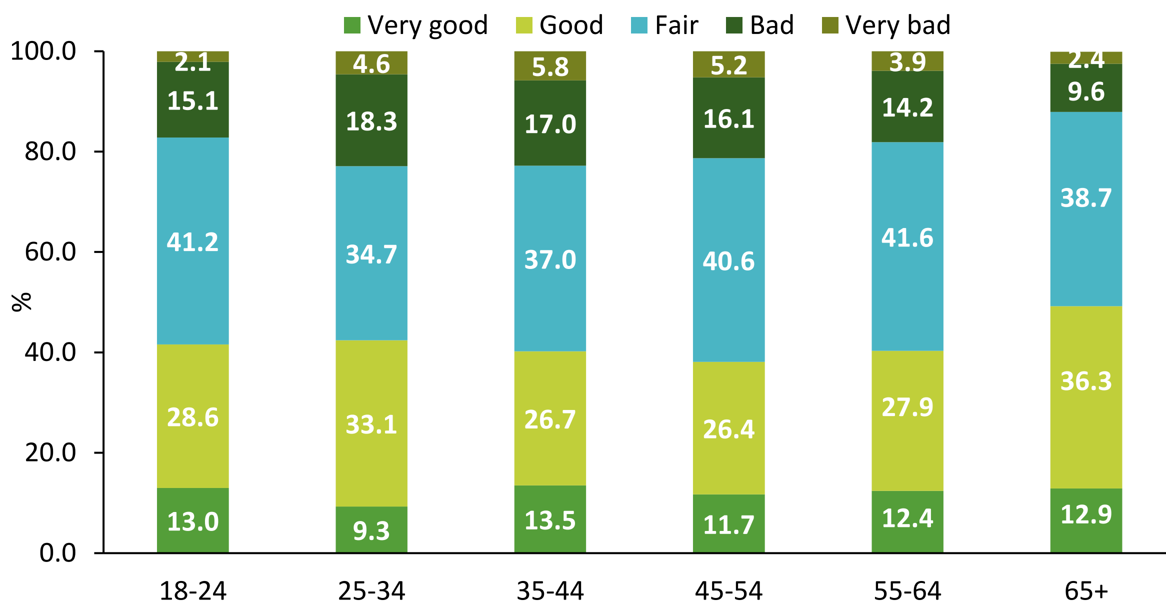


Figure 55: Sleep quality by age group (years)



3.8.4 Anxiety

26.8% of adults were highly anxious[22]

- A higher proportion of females (31.4%) than males (22.0%) were highly anxious on the day prior to survey participation (Table A26).
- The proportion of adults who were highly anxious was highest amongst those 35-44 (18-24, 32.1%; 25-34, 24.3%; 35-44, 33.1%; 45-54, 28.3%; 55-64, 23.6%; 65+, 23.0%; Table A26).
- The proportion of adults reporting being highly anxious was highest amongst the lowest income group and decreased as income group increased (<£20,000, 30.1%; £20,000-79,999, 27.1%; £80,000+, 22.6%; Table A26).

3.8.5 Life satisfaction

19.2% of adults had low life satisfaction[23]

- A higher proportion of females (20.4%) than males (18.0%) had current low life satisfaction (Table A26).
- The proportion of adults with low life satisfaction was highest amongst those 45-54 (18-24, 21.8%; 25-34, 17.5%; 35-44, 22.4%; 45-54, 22.6%; 55-64, 17.5%; 65+, 15.7%; Table A26).
- The proportion of adults reporting low life satisfaction was highest amongst the lowest income group and decreased as income group increased (<£20,000, 31.7%; £20,000-79,999, 17.8%; £80,000+, 11.3%; Table A26).

3.8.6 Happiness

22.1% of adults had low happiness[23]

- A higher proportion of females (24.6%) than males (19.6%) had low happiness on the day prior to survey participation (Table A26).
- The proportion of adults reporting low happiness was highest amongst those 35-44 (18-24, 26.1%; 25-34, 21.4%; 35-44, 27.2%; 45-54, 24.6%; 55-64, 20.1%; 65+, 17.2%; Table A26).
- The proportion of adults reporting low happiness was highest amongst the lowest income group and decreased as income group increased (<£20,000, 32.0%; £20,000-79,999, 20.9%; £80,000+, 15.0%; Table A26).

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[22] Scores ≥6 on a scale of 0 (not at all) to 10 (completely).
[23] Scores <6 on scale from 0 (not at all) to 10 (completely).

3.8.7 Feeling life is unworthwhile

22.8% of adults felt the things they do in life are unworthwhile[23]

- A higher proportion of females (23.5%) than males (22.1%) reported feeling life is unworthwhile (Table A26).
- The proportion of adults feeling life is unworthwhile was highest amongst those 35-44 (18-24, 22.6%; 25-34, 22.8%; 35-44, 26.2%; 45-54, 25.2%; 55-64, 19.9%; 65+, 20.9%; Table A26).
- The proportion of adults feeling life is unworthwhile was highest amongst the lowest income group and decreased as income group increased (<£20,000, 31.5%; £20,000-79,999, 22.9%; £80,000+, 12.8%; Table A26).

3.8.8 Social interaction

29.6% of adults have low social interaction[24]

Level of social interaction

- Almost three in ten (29.6%) adults did not have enough social contact or felt socially isolated (i.e. low social interaction), whilst 41.1% had adequate social contact and 29.3% had as much social contact as they wanted (Figure 56; Table A27). Just over four in ten (42.1%) adults met with friends on a weekly basis, whilst approximately three in ten (29.4%) met with family on a weekly basis. The majority (91.5%) of adults reported having friends and family they could count on.
- A higher proportion of males (33.2%) than females (26.2%) had low social interaction (Table A27).
- The proportion of adults reporting low social interaction was highest amongst those in the youngest age group and lowest amongst those in the oldest age group, decreasing as age group increased (Figure 57; Table A27).
- The proportion of adults reporting low social interaction was highest amongst the lowest income group (<£20,000, 31.7%; £20,000-79,999, 29.6%; £80,000+, 28.7%; Table A27).

[24] Had some but not enough social contact with people they like or had little social contact with people and felt socially isolated.

Figure 56: Level of social interaction

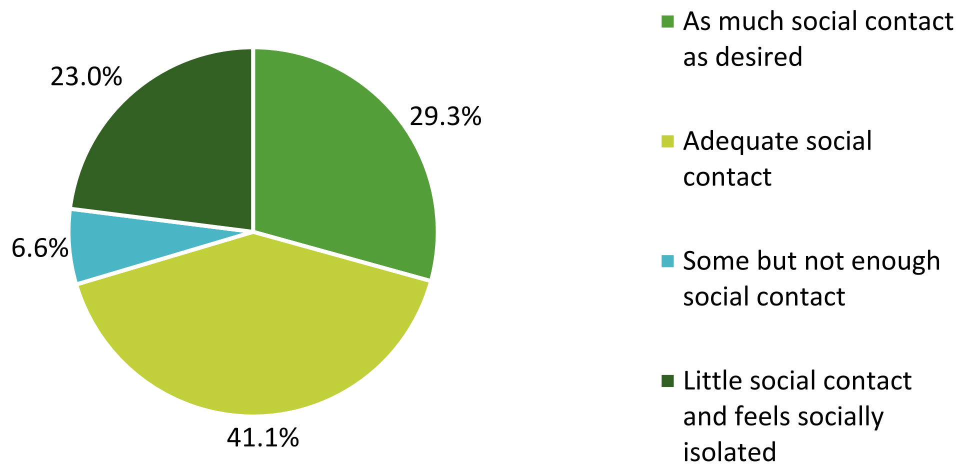
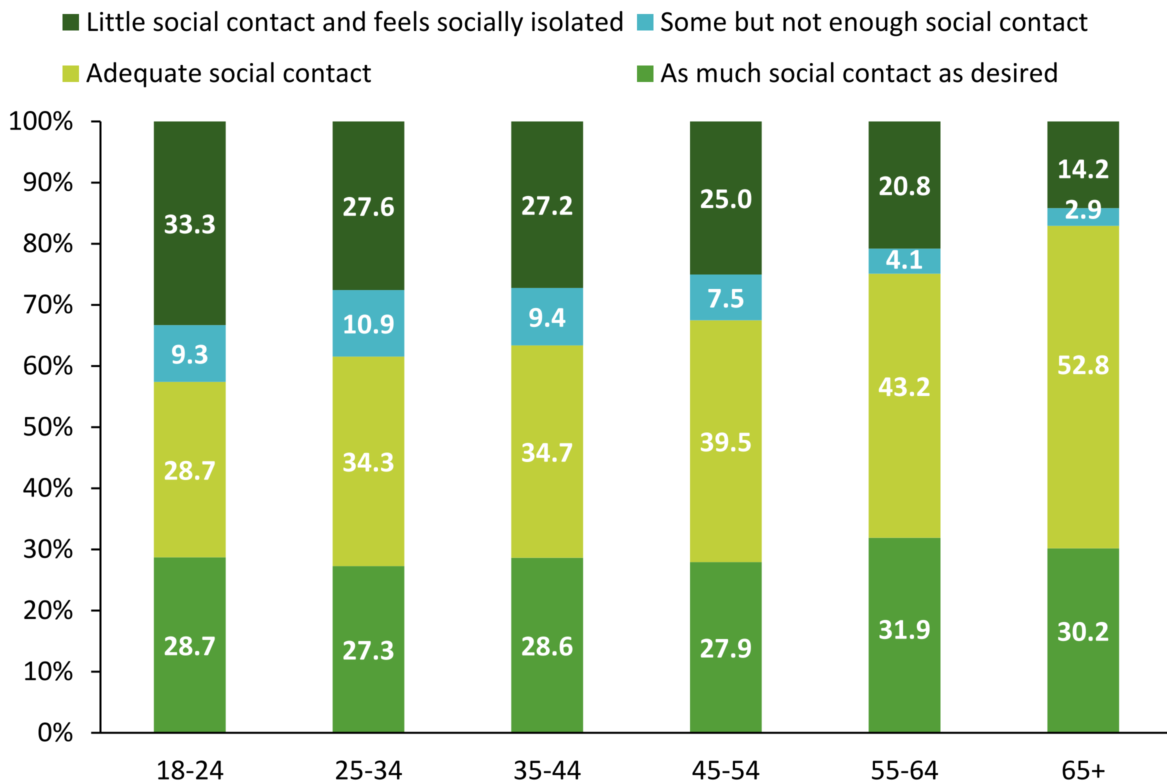


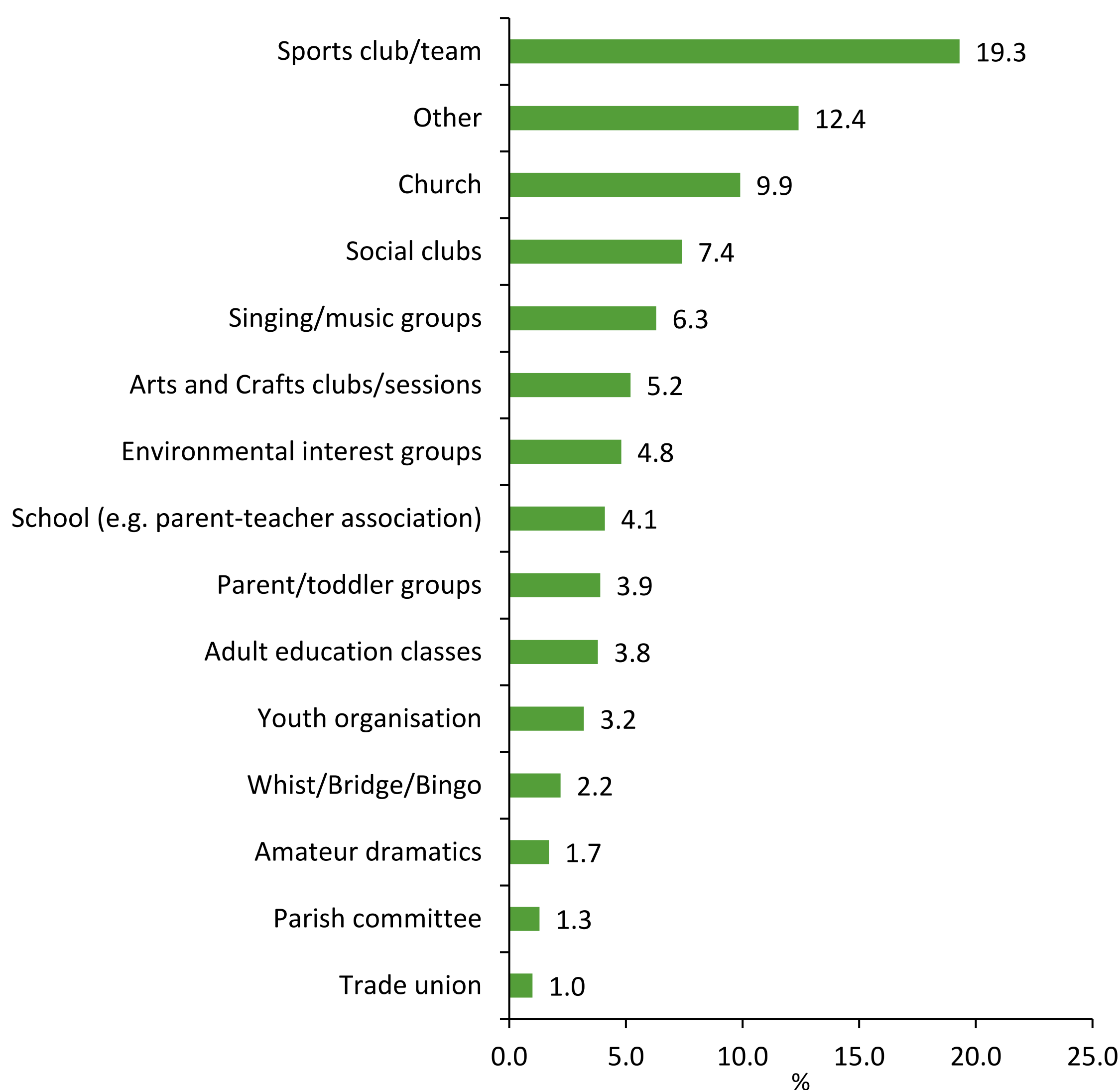
Figure 57: Level of social contact by age group (years)



Engagement in social activities

- Almost two thirds (64.9%) of adults regularly took part in at least one activity with a group or organisation. The most common social activity was engagement in sports clubs or teams[25] (19.3%; Figure 58). Almost one quarter (24.9%) of adults regularly volunteered their time for a registered charity or organisation (e.g. a youth or community group).

Table 58: Social activities



[25] Respondents were provided with a list of reasons and could tick as many as applicable.

Box 9: Health in focus – Low mental wellbeing

Low mental wellbeing

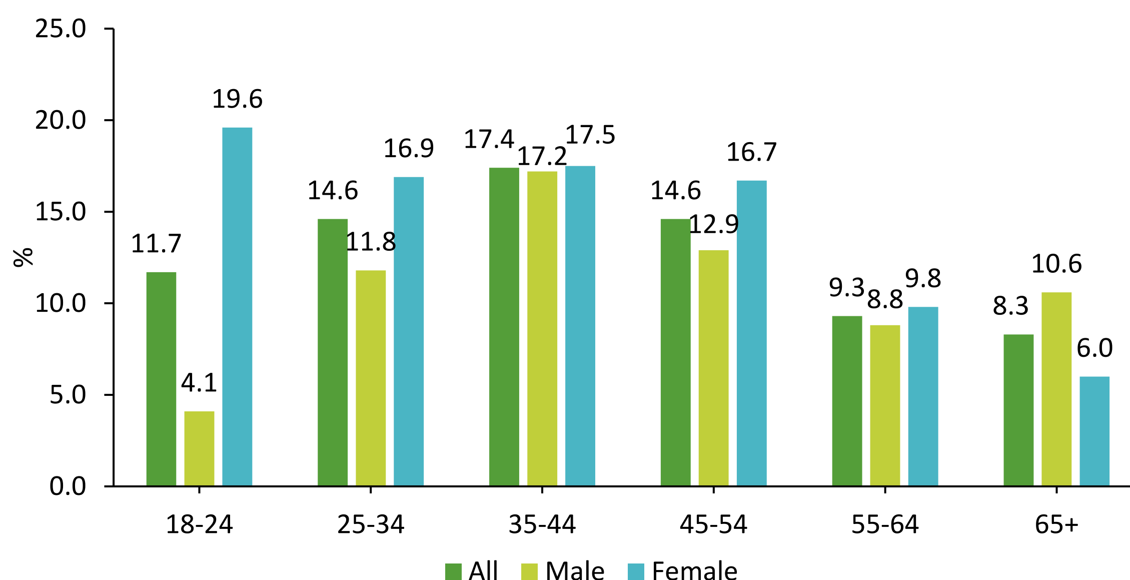
One standard deviation (10.2) below the average score (49.1) on WEMWBS

12.3% of all adults

- A higher proportion of females (13.1%) had low mental wellbeing than males (11.4%). The highest prevalence of low mental wellbeing was amongst adults aged 35-44 years (17.4%; Figure 59; Table A28).

- In sample (unweighted) analyses, low mental wellbeing was significantly associated with age (p<0.001) but not gender (Table A28). Low mental wellbeing was also significantly associated with: income level (<£20,000, 21.2%; £20,000-£79,999, 14.7%; £80,000+, 6.6%; p<0.001); place of birth (Isle of Man, 16.7%; other, 13.1%; p<0.05); home ownership status (does not own home, 23.3%; owns home, 11.3%; p<0.001); relationship status (single, 17.9%; in a relationship, 11.9%; p<0.001); and, sexuality (heterosexual, 13.8%; other, 29.3%; p<0.001; Table A28).

Figure 59: Prevalence of low mental wellbeing by age group (years) and gender (weighted data)



Box 10: Health in focus – High loneliness

High loneliness

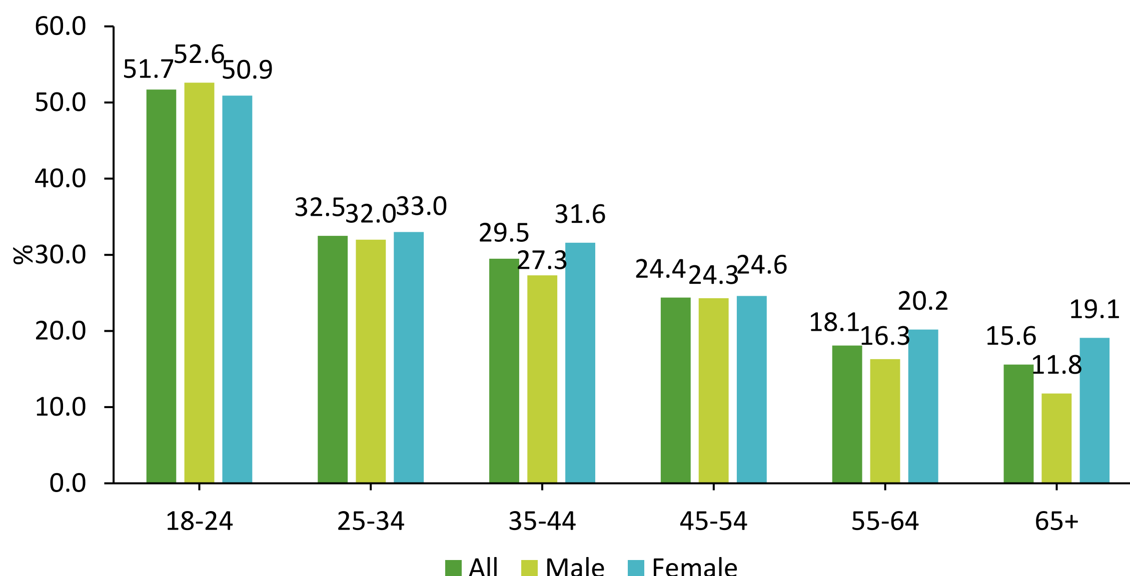
Always, often, or sometimes feeling lonely.

25.4% of all adults

- A higher proportion of females (27.0%) had high loneliness compared with males (23.9%). The highest proportion of adults who had high loneliness was amongst those aged 18-24 years (51.7%), and decreased as age group increased, with the lowest prevalence amongst those aged 65+ years (15.6%; Figure 60; Table A28).

- In sample (unweighted) analyses, high loneliness was significantly associated with age ($p<0.001$) and gender ($p<0.001$; Table A28). High loneliness was also significantly associated with: income level (<£20,000, 29.1%; £20,000-£79,999, 22.9%; £80,000+, 16.3%; $p<0.001$); place of birth (Isle of Man, 26.0%; other, 21.9%; $p<0.05$); home ownership status (does not own home, 34.4%; owns home, 19.6%; $p<0.001$); relationship status (single, 31.8%; in a relationship, 17.0%; $p<0.001$); and, sexuality (heterosexual, 22.7%; other, 39.8%; $p<0.001$; Table A28).

Figure 60: Prevalence of high loneliness by age group (years) and gender (weighted data)



3.9 Clustering of unhealthy behaviours

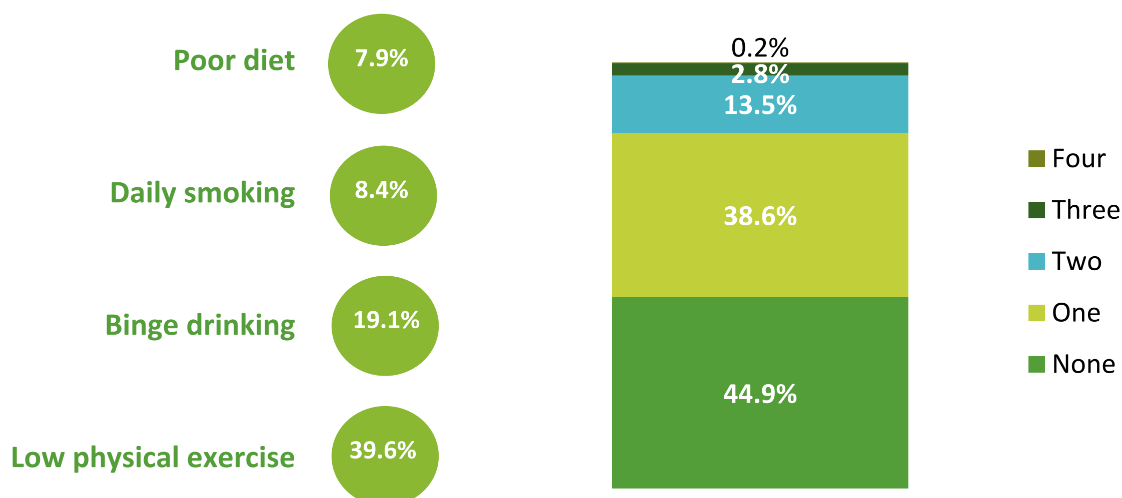
Derived variables created from questions on smoking, alcohol consumption, diet and physical exercise were used to examine the clustering of unhealthy behaviours amongst adults on the Isle of Man. For the purposes of this analysis: smoking was defined as daily tobacco smoking (see Box 1); alcohol consumption was defined as binge drinking (see Box 4); poor diet was defined as <2 pieces of fruit and/or vegetables a day (see Box 5); and low physical exercise was less than 2.5 hours of physical activity in the past week (see Box 6). Key findings on clustering of unhealthy behaviours and their relationship with health outcomes are presented in this section, with full data tables included in the Data Annex. All data in this section are adjusted to match the Isle of Man population demographics of adults (on age and sex), unless otherwise stated.

3.9.1 Types and extent of clustering

55.1% of adults had at least one unhealthy behaviour

- The most prevalent unhealthy behaviour was low physical exercise (39.6% of adults), followed by binge drinking (19.1% of adults), daily tobacco smoking (8.4% of adults) and poor diet (7.9% of adults; Figure 61).
- Over four in ten (44.9%) adults had none of the four unhealthy behaviours, 38.6% had one unhealthy behaviour, 13.5% had two, 2.8% had three, and 0.2% had all four unhealthy behaviours (Figure 61).

Figure 61: Clustering of unhealthy behaviours



- Amongst adults who had a poor diet, almost three quarters (74.3%) had at least one other unhealthy behaviour (Table 1). Amongst adults who had a poor diet: 62.2% also had low physical exercise; 20.7% were also daily smokers; and, 14.3% were binge drinkers (Table 1).
- Amongst adults who smoked daily, almost three quarters (73.5%) had at least one other unhealthy behaviour (Table 1). Amongst adults who smoked daily: 54.1% also had low physical exercise; 29.5% were also binge drinkers; and, 19.8% had a poor diet (Table 1).
- Amongst adults who were binge drinkers, almost half (48.8%) had at least one other unhealthy behaviour (Table 1). Amongst adults who were binge drinkers: 41.3% also had low physical exercise; 13.2% were also daily smokers; and, 5.9% had a poor diet (Table 1).
- Amongst adults who had low physical exercise, more than one third (37.2%) had at least one other unhealthy behaviour (Table 1). Amongst adults who had low physical exercise: 20.6% were binge drinkers; 12.4% had a poor diet; and, 11.5% smoked daily (Table 1).

Table 1: Combinations of unhealthy behaviours

	Poor diet	Daily smoking	Binge drinking	Low physical exercise
% with at least one other unhealthy behaviour	74.3	73.5	48.8	37.2
Type of unhealthy behaviour				
% Poor diet	-	19.8	5.9	12.4
% Daily smoking	20.7	-	13.2	11.5
% Binge drinking	14.3	29.5	-	20.6
% Low physical exercise	62.2	54.1	41.3	-

3.9.2 Clustering of unhealthy behaviours and sociodemographics

- A higher proportion of males (58.0%) than females (52.0%) had at least one unhealthy behaviour (Figure 62; Table A29).
- The proportion of adults who had at least one unhealthy behaviour was highest amongst aged 35-44 years (Figure 63; Table A29).
- The proportion of adults who had at least one unhealthy behaviour was highest amongst the lowest income group and decreased as income group increased (<£20,000, 59.8%; £20,000-79,999, 55.8%; £80,000+, 45.7%; Figure 64; Table A29).

Figure 62: Clustering of unhealthy behaviours by gender

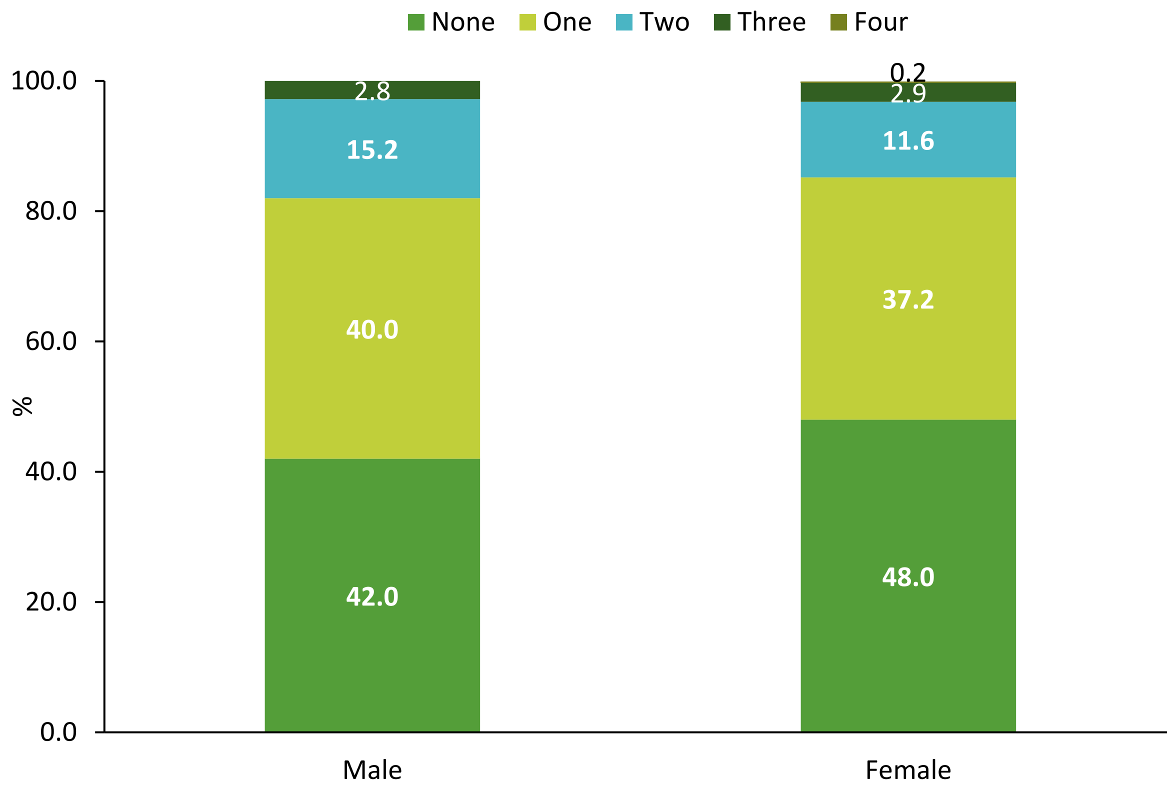


Figure 63: Clustering of unhealthy behaviours by age group (years)

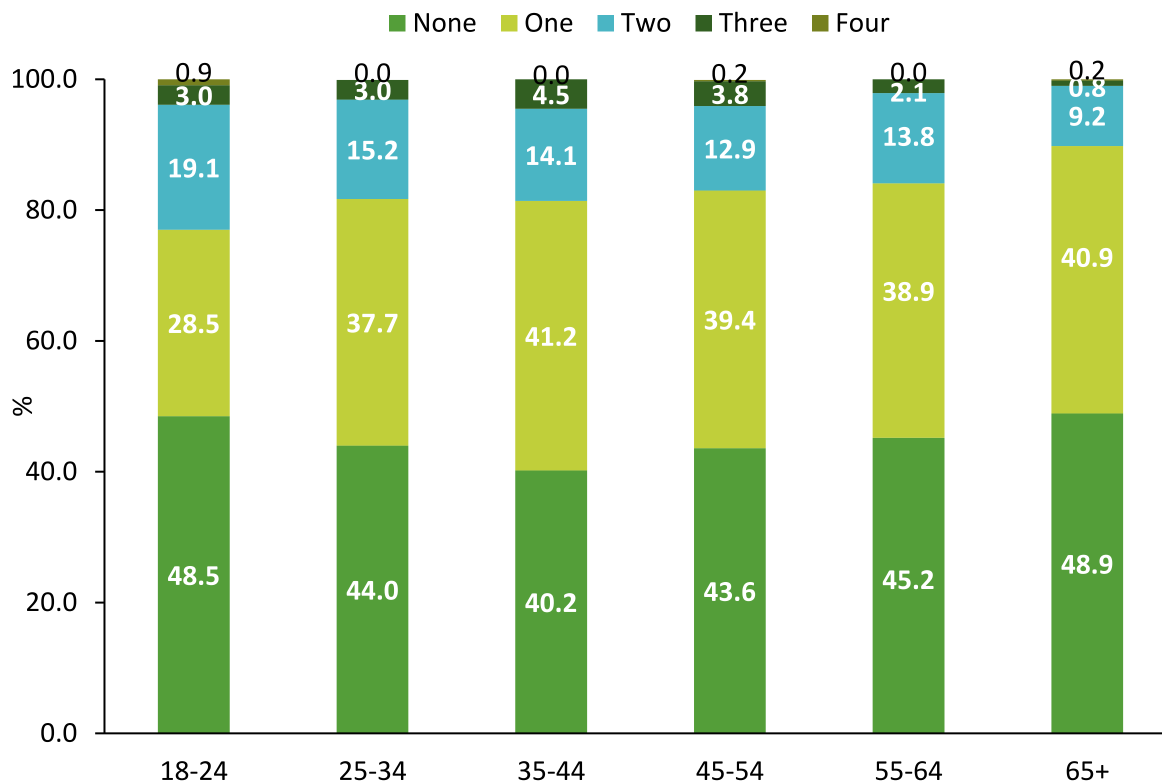
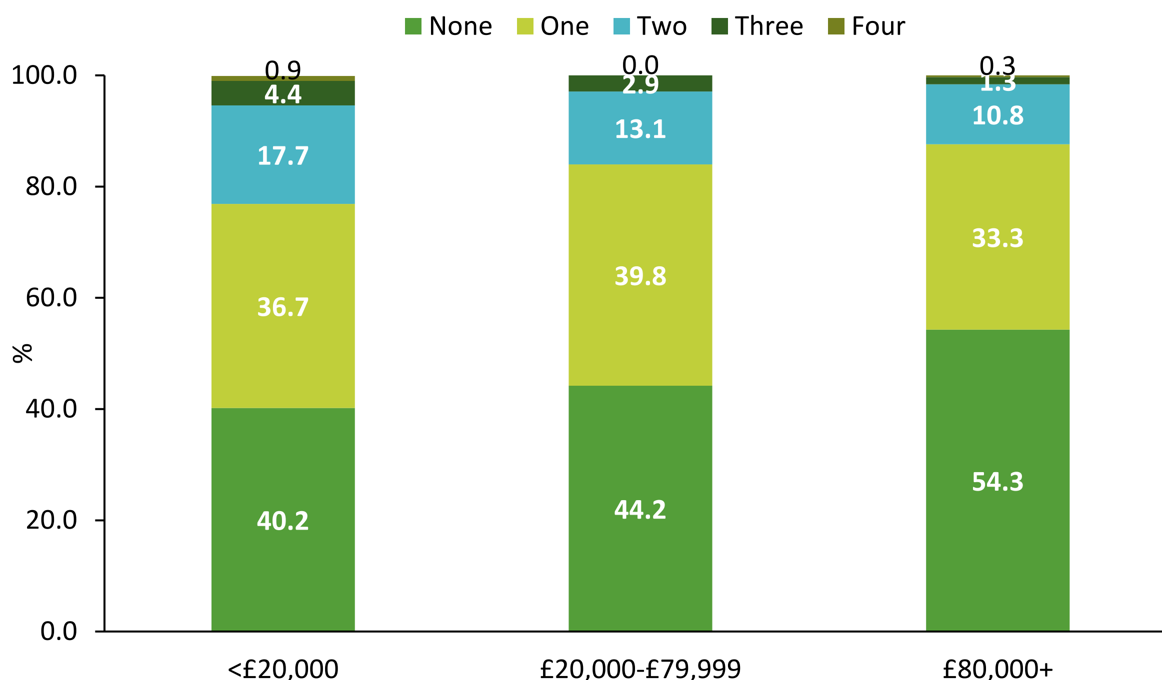


Figure 64: Clustering of unhealthy behaviours by income level



3.9.3 Clustering of unhealthy behaviours and health outcomes

Poor general health

- In sample (unweighted analysis) there was a significant association between number of unhealthy behaviours and poor general health. There was a graded relationship between the number of unhealthy behaviours and poor general health, with the prevalence of poor general health increasing as the number of unhealthy behaviours increased (none, 8.4%; one, 15.4%; two or more[26], 21.7%; $p<0.001$).

Overweight or obese

- In sample (unweighted analysis) there was a significant association between number of unhealthy behaviours and being overweight or obese. There was a graded relationship between the number of unhealthy behaviours and being overweight or obese, with the prevalence increasing as the number of unhealthy behaviours increased (none, 58.0%; one, 70.3%; two or more[26], 72.2%; $p<0.001$).

Low mental wellbeing

- In sample (unweighted analysis) there was a significant association between number of unhealthy behaviours and low mental wellbeing. There was a graded relationship between the number of unhealthy behaviours and low mental wellbeing, with the prevalence of low mental wellbeing increasing as the number of unhealthy behaviours increased (none, 9.0%; one, 15.6%; two or more[26], 21.4%; $p<0.001$).

[26] Categories of two, three and four unhealthy behaviours were collapsed for bivariate analyses to ensure adequate sample size for statistical testing.

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