HEALTHY IRELAND SURVEY 2018

Summary of Findings

Acknowledgment

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HEALTHY IRELAND SURVEY 2018

Executive Summary

Introduction

- This report provides an overview of results from the fourth wave of the Healthy Ireland Survey, an annual interviewer administered face-to-face survey commissioned by the Department of Health

- Survey data play a number of roles, including supporting the Department in ongoing engagement and awareness-raising activities in the various policy areas, as well as supporting better understanding of policy priorities

- The fourth wave consists of 7,701 interviews conducted with a representative sample of the population aged 15 and older living in Ireland

- Survey fieldwork was conducted by Ipsos MRBI between September 2017 and June 2018. Respondents were selected using a probability-based methodology and interviewed in their homes

Smoking

- 20% are current smokers. 17% smoke daily and 3% smoke occasionally

- Prevalence of smoking has declined from 23% in 2015 to 20% in 2018

- 44% of all who have smoked in the past 12 months have made an attempt to quit during that period

- Over half of smokers (57%) are at least thinking about quitting, and 40% of current smokers have made an attempt to quit in the past 12 months

- Most of those who have made an attempt to quit smoking in the past 12 months did so due to concerns about their health

Tobacco packaging

- Standardised packaging of tobacco, also known as generic or plain packaging, has been introduced in Ireland. All retail tobacco packaging must be in standardised form from 30 September 2018

- 71% of the general population and 62% of smokers approve of this plain packaging legislation

- 23% of smokers report that the health warnings on tobacco packaging have made them at least somewhat more likely to quit smoking during the past month

Alcohol

- Three-quarters have drunk alcohol in the past year, with over half (55%) of drinkers drinking at least once a week

- 37% of drinkers report that they drink six or more standard drinks (binge drinking) on a typical drinking occasion

- 54% of drinkers who also smoke binge drink on a typical drinking occasion, compared with 33% of non-smokers who drink

- 8% of drinkers have failed to do what was normally expected from them in the past 12 months because of drinking

Diet and Nutrition

- Of the five types of unhealthy foods measured by the survey, 34% consume at least one of them on a daily basis

- 9% drink sugar-sweetened drinks on a daily basis. This is highest amongst those aged 15-24 (15%)

- Over a third (37%) report that they consume at least five portions of fruit and vegetables daily (including juices)

General Health

- 85% perceive their health to be very good or good. 3% perceive it to be very bad or bad

- A notable gender gap in self-reported good health exists among those aged 55 to 64. 81% of women in this age group perceive their health to be good or very good, compared with 73% of men

- 29% have a long-standing illness or health problem

- 25% reported receiving the flu vaccine during the previous winter. This is highest among those aged 75 and older (78%)

- 66% have had their blood pressure measured during the past 12 months

Oral Health

- 79% describe their oral health as good or very good

- Women are more likely than men (82% and 76% respectively) to describe their oral health as good or very good

- 68% of smokers describe their oral health as good or very good, compared with 85% of those who have never smoked

- 46% say that they have all their own teeth. This declines with age from 88% of those aged 15 to 24, to 4% of those aged 75 and older

- 47% have visited a dentist during the past 12 months, with 65% of those visiting doing so for a check-up

Health Service Utilisation

- 74% have visited a GP in the past 12 months, with an average of 3.8 visits per person among all aged 15 and older

- 35% have consulted a nurse in a GP surgery in the past 12 months with an average of 1.4 visits per person among all aged 15 and older

- 8% have used a GP Out of Hours service during the past 12 months. 2% have used this service on multiple occasions during the past 12 months

- During the past 12 months, 12% have been admitted to hospital as an in-patient and 16% have been admitted to hospital as a day patient

Health Behaviours and Inequalities

- Those in more deprived areas are less likely to rate their health as good or very good, and more likely to have a long-term health problem

- Similarly, those in more deprived areas are more likely to smoke and binge drink

- Self-rated good health declines earlier for men in deprived areas (around the age of 55 to 64) than it does for both men in affluent areas and women in deprived areas

- Women living in more deprived areas are more likely than those in affluent areas to continue smoking and binge drinking into their 50s

Introduction

The Healthy Ireland Survey is an annual interviewer-administered face-to-face survey commissioned by the Department of Health. It is part of the Healthy Ireland Framework to improve the health and wellbeing of people living in Ireland.

The objectives of this survey are to:

- Provide and report on current and credible data in order to enhance the monitoring and assessment of the various policy initiatives under the Framework

- Support and enhance Ireland's ability to meet many of its international reporting obligations

- Feed into the Outcomes Framework for Healthy Ireland and contribute to assessing, monitoring and realising the benefits of the overall health reform strategy

- Allow targeted monitoring where necessary, with an outcomes-focussed approach, leading to enhanced responsiveness and agility from a policy-making perspective

- Support the Department of Health in ongoing engagement and awareness-raising activities in the various policy areas and support better understanding of policy priorities

This report provides an overview of results from the fourth wave of this survey. The fourth wave consists of 7,701 interviews conducted with a representative sample of the population aged 15 and older living in Ireland. Respondents were selected using a probability-based methodology and interviewed in their homes. Survey fieldwork was conducted by Ipsos MRBI between September 2017 and June 2018.

This wave of the Healthy Ireland Survey covers a variety of topics including:

- Smoking

- Tobacco packaging

- Alcohol

- Diet and nutrition

- General health

- Health service utilisation

- Oral health

Where appropriate, survey results are compared to results of the initial three waves of this survey conducted in 2014/15, 2015/16 and 2016/17. Reports on these waves of the survey have been published separately.[1]

In addition to providing an overview of survey results, this report also provides a more in-depth analysis of differences in health behaviours between men and women, with a particular focus on the differences related to the degree of deprivation or affluence in where an individual lives.

At the time of publication, survey fieldwork on the fifth wave of the Healthy Ireland Survey is already underway and publication of results is expected in autumn 2019.

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[1] http://www.healthyireland.ie/about/research/healthy-ireland-survey/

03 Survey Methods and Technical Overview

The Healthy Ireland Survey uses an interviewer-administered questionnaire with interviews conducted on a face-to-face basis with individuals aged 15 and over. This is the fourth wave of the survey conducted between September 2018 and June 2019. It involves 7,701 interviews with a representative sample of those living in Ireland. It follows the first three waves conducted between 2014 and 2017.

Topics covered by this wave include:

- Smoking
- Tobacco packaging
- Alcohol
- Diet and nutrition
- General health
- Health service utilisation
- Oral health

Approval to conduct the study was provided by the Research Ethics Committee at the Royal College of Physicians of Ireland.

Questionnaire design

In order to ensure accurate monitoring and to build a trend series of data the core of this questionnaire is the same as used in the initial wave of this survey. However, a number of amendments are made each year to other parts of the survey questionnaire in order to provide data on additional areas of interest and to provide further context on the health behaviours of the Irish population.

In designing and revising the questionnaire consideration is given to aligning survey topics with key objectives of the Healthy Ireland Framework as well as ensuring comparability with other relevant data sources, both nationally and internationally.

Sample design

In order to ensure a representative sample of those living in Ireland aged 15 and over a multi-stage probability sampling process was undertaken. Interviewers visited pre-selected addresses and sought to interview a randomly selected individual at each selected address.

The use of a probability sampling approach ensures that the survey sample comprehensively represents the defined population (in this case, those aged 15 and over). In adopting this approach every member of the defined population has a calculable chance of being included in the sample.

The initial stage of the sampling process was to select a representative distribution of sampling points around the country. In order to do so, all electoral divisions were stratified by region and socio-demographic factors, and 686 sampling points were selected using a random start point and systematic skip. As some of the electoral divisions were larger than the systematic skip these were selected more than once and multiple sampling points were utilised within these areas.

On this basis, 654 electoral divisions (or combinations thereof) contained one sampling point, 11 contained two sampling points, 2 contained three sampling points and 1 contained 4 sampling points.

GeoDirectory (a listing of all addresses in the state that is maintained by An Post) was used to select specific addresses to be contacted to seek an interview. Using the full list of addresses within each selected electoral division, a random start point and systematic skip was used to select 20 addresses in each sampling point. This provided a total sample of 13,720 addresses throughout Ireland.

Each of these addresses was visited by an Ipsos MRBI interviewer. To ensure that the correct address was visited, interviewers were provided with a GPS device with preloaded co-ordinates for selected households. As a high proportion of addresses are shared across multiple households this ensured that the integrity of the sampling process was maintained.

In the cases where there was no response when the interviewer contacted the address, further contacts were attempted on different days and at different times of day. If the interviewer had still not received a response following five separate visits, then this address was considered unsuccessful.

When establishing contact with the household the interviewer was required to list all individuals aged 15 and over ordinarily resident at that address. One individual was then selected randomly (using a KISH Grid approach) to take part in the survey and this was the only individual that could be interviewed at that address.

Interviewer briefing and training

All interviewers received extensive training before commencing fieldwork. The training sessions were led by the Project Director at Ipsos MRBI and provided comprehensive instructions on all aspects of the project. Topics covered by the training sessions included:

- Background to the study
- Questionnaire coverage
- Social class coding
- Sampling and contact sheets
- Ethical considerations
- Maximising survey response
- Project administration

In addition to the in-person training received, all interviewers were also provided with detailed written instructions on all aspects of the project. Interviewers also had ongoing access to telephone support from field management staff throughout the fieldwork period.

Survey fieldwork and response rate

All selected households were visited between September 2017 and June 2018. In advance of an interviewer contacting the household, the householder received two letters. One letter was on Department of Health headed paper indicating that the household had been selected to participate and provided background to the study. The other letter was on Ipsos MRBI headed paper and provided further detail on the study and what was required when participating.

A total of 35,722 visits were made to the 13,720 selected addresses. 9,017 (66% of all addresses) received multiple visits, with an average of 2.6 visits made to each selected address.

The first task when establishing contact with a household was to identify the survey respondent. Before commencing an interview, each respondent provided informed consent to participate in the survey.

In order to facilitate a measurement of survey response and non-response interviewers recorded details of each visit on a contact sheet. Analysis of the data generated from these contact sheets shows that the survey achieved a response rate of 62.0%.

Data cleaning and validation

As the survey was conducted through CAPI (Computer Assisted Personal Interviewing), the survey routing and many of the survey logic checks were automated and completed during fieldwork. This minimised the extent of data cleaning that was required post-fieldwork. However, extensive data checking was conducted following data collection and appropriate editing and data coding were conducted to ensure the accuracy of the final dataset.

Additionally, 100 sampling points were randomly selected for survey validation. Households in these sampling points were re-contacted to verify the interview process and to assess the quality of interview. Included in this process were households that had participated in the interview as well as those which had refused.

Data weighting

Whilst the sampling process is designed to deliver a representative sample of households and individuals throughout the country, differential response levels means that the survey sample is not a fully accurate representation of the population. As such, the aim of survey weighting is to bring the profile of respondents in line with the population profile.

Survey non-response can cause bias if the individuals who do not participate are systematically different to the individuals who take part. For example, it is often the case that young men are the most reluctant participants in social research, hence most weighting schemes include an adjustment for age and sex. By adjusting on known factors (i.e. characteristics for which population data are known, such as age, sex, etc.) potential biases in survey measurements can be reduced.

On this survey, the weighting scheme involves both selection weights and non-response adjustments. A selection weight overcomes any biases that may arise due to individuals from larger households being under-represented in the sample (these individuals had a lower chance of selection than those in smaller households). Non-response adjustments were made using known population statistics published by the Central Statistics Office. The variables used in this respect were: age by gender, education, work status of the respondent, and region.

Data analysis and reporting

This report presents an overview of the results emerging from the study. At this stage the analysis focuses on presenting key figures at population level as well as sub-group analysis across gender, age, social class and deprivation index. It also compares results to those collected in the earlier waves of the survey.
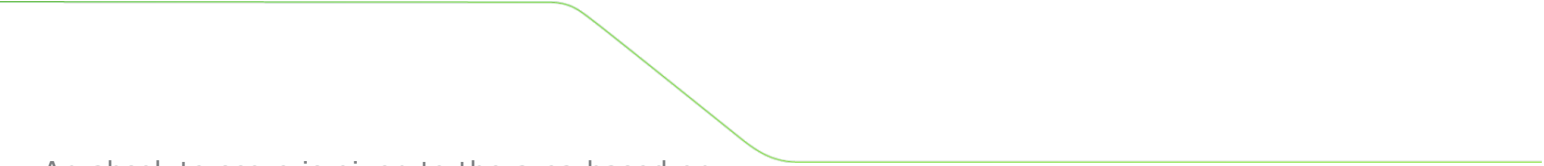
Please note, due to rounding, there may be occasions throughout this report where percentages displayed within any given table or chart may not sum to 100% exactly.

Deprivation index

The deprivation index used throughout the report is that designed by Haase and Pratschke (2016).

The index is a method of measuring the relative affluence or disadvantage of a particular geographical area using data compiled from the 2016 census. Three dimensions of affluence/ disadvantage are identified: Demographic Profile, Social Class Composition and Labour Market Situation.

An absolute score is given to the area based on a national average of zero. Data for this report are presented in terms of deciles.

For ease of understanding, deciles are referred to as "areas" throughout this report. All references to the most deprived areas refer to a combination of the most deprived deciles, and all references to the least deprived or most affluent areas refer to a combination of the three least deprived and three least deprived deciles.

Survey representation

This survey is designed to be representative of the population of Ireland aged 15 and older. Extensive efforts are made to maximise response rates across population groups and minimise any non-response bias. Additionally, the application of population weights to the survey data ensures that the survey sample is aligned with the profile of the general population.

For this reason, it is possible to refer to the survey results as relating to the population generally, and any references to the population in this report are derived from survey results.

Smoking

- 20% of the population are current smokers. 17% smoke daily and 3% smoke occasionally

- Men are more likely to smoke than women. 22% of men are current smokers, compared to 17% of women

- Smoking rates are highest among those aged 25 to 34. 28% of this age group are current smokers

- Those who currently smoke daily smoke on average 13 tobacco products each day

- Smoking rates are higher in more disadvantaged areas (26%) than in more affluent areas (16%)

- Those categorised as non-manual/skilled workers (21%) are more likely to smoke than those categorised as professional /managerial & technical workers (11%)

- 26% of the population are ex-smokers. This is highest among men aged 65 and older, 48% of whom are ex-smokers (compared to 12% who currently smoke)

Quitting

- Of all those who have smoked in the past 12 months, 9% have successfully quit during this time.

- 40% of current smokers have made an attempt to quit in the past 12 months

- 12% of current smokers who attempted to quit in the past 12 months stopped smoking for at least 6 months. 24% re-commenced smoking within one week of quitting

- 8% of current smokers are currently trying to quit, and 57% are at least thinking about quitting

Motivations for quitting and help used

- Most of those who have made an attempt to quit smoking did so due to concerns about their health (65%), with 10% quitting due to concerns about the cost of smoking and 6% quitting due to advice from a health professional

- Women (10%) are more likely than men (2%) to have made an attempt to quit smoking due to advice from a health professional

- Almost half (42%) of those who have successfully quit smoking in the past 12 months did so through willpower alone, and 41% used e-cigarettes

- 40% of smokers who saw their GP in the past 12 months discussed ways of quitting smoking

E-cigarettes

- 4% currently use e-cigarettes and a further 12% of the population have tried them at some point

- Almost half (49%) of all current smokers have tried e-cigarettes at some point, compared with 19% of ex-smokers

- 9% of current smokers use e-cigarettes, with 10% of ex-smokers using them

- 17% of those who have tried to quit smoking in the past year, and 30% of those who have successfully quit smoking, are current users of e-cigarettes

SMOKING

SMOKING PREVALENCE 2018

Prevalence by Gender

20% TOTAL

22% MEN

17% WOMEN

Prevalence by Age

19%	28%	22%	19%	19%	13%	8%
15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
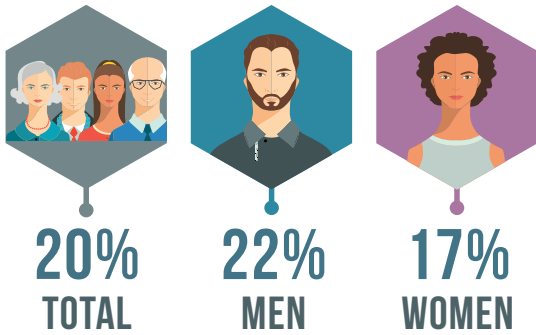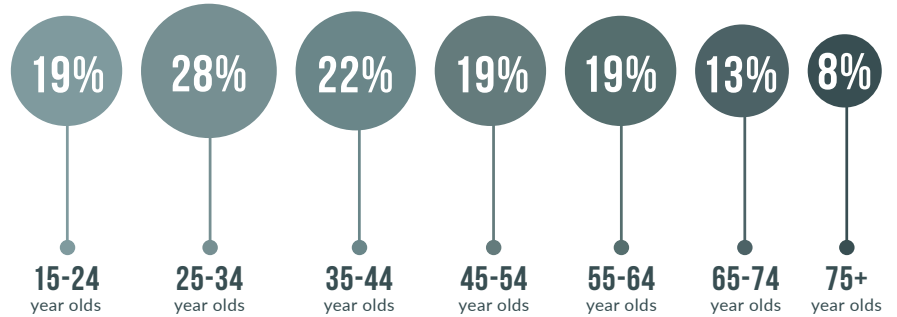
QUITTING

ATTITUDES TO QUITTING

TRYING TO QUIT — 8%

ACTIVELY PLANNING TO QUIT — 19%

THINKING ABOUT QUITTING BUT NOT PLANNING TO — 29%

NOT THINKING ABOUT QUITTING — 43%
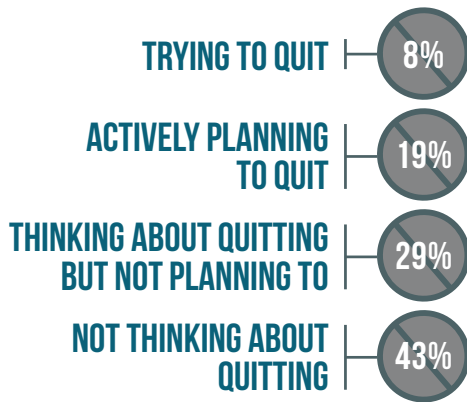
PREVALENCE OF SMOKING 2015 - 2018

23% 2015

23% 2016

22% 2017

20% 2018
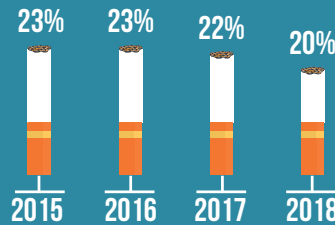
PROPORTION OF SMOKERS WHO HAVE DISCUSSED QUITTING WITH A HEALTH PROFESSIONAL*

40% GP

30% HOSPITAL DOCTOR

27% OTHER HEALTH PROFESSIONAL

26% NURSE

21% DENTIST

15% PHARMACIST
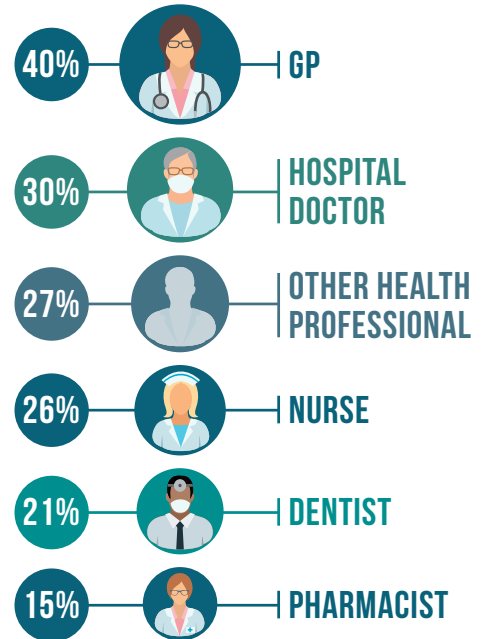
*Based on all those who saw that health professional in the last 12 months

OTHER FACTORS

E-CIGARETTE USAGE

Among Smokers

9% Use Currently

40% Used Previously

Among Ex-Smokers

10% Use Currently

10% Used Previously

Among Never Smokers

<1% Use Currently

2% Used Previously

Tobacco packaging and legislation

- 71% of the population approve of the upcoming plain packaging legislation. 14% disapprove of the legislation

- Those living in more affluent areas (75%) are more likely to approve of the legislation than those in more deprived areas (68%)

- 62% of smokers approve of this legislation

- 23% of smokers report that the health warnings on tobacco packaging have made them at least somewhat more motivated to quit smoking during the past month

- Smokers are consistent in their views that the health warnings on tobacco packaging have motivated them to quit. 23% of smokers aged under 35, and 22% of smokers older than this, report that the health warnings on tobacco packaging have made them at least somewhat more motivated to quit smoking during the past month

- 42% of smokers report that the warning picture is the first thing that they notice when they look at a tobacco pack, with a further 10% first noticing the warning label

STANDARDISED PACKAGING OF TOBACCO PRODUCTS

Standardised packaging of tobacco, also known as generic or plain packaging has been introduced in Ireland. All retail tobacco packaging must be in standardised form from 30 September 2018. This means that all forms of branding – trademarks, logos, colours and graphics – have been removed, except for the brand and variant name, which is presented in a uniform typeface for all brands on the market.

The aim of standardised packaging is to make all tobacco packs look less attractive to consumers, to make health warnings more prominent and to prevent packaging from misleading consumers about the harmful effects of tobacco. Ireland is the first country in Europe to introduce Standardised Packaging for all tobacco products and not just cigarettes and roll your own.

The introduction of standardised packaging represents part of a wider comprehensive tobacco control strategy as set out in Tobacco Free Ireland (2013), which aims to de-normalise smoking, to protect children from the dangers of tobacco consumption and sets a target for Ireland to be tobacco free (i.e. with a prevalence rate of less than 5%) by 2025.

The Healthy Ireland Survey has been asking the public (and smokers in particular) about their responses to plain packaging during this fourth wave of the survey. These questions are being asked again in the fifth wave in order to evaluate the public response to standardised packaging and the public health impact of the measure.

TOBACCO PACKAGING

PLAIN PACKAGING LEGISLATION

62% OF SMOKERS APPROVE OF THE LEGISLATION

71% OF THE TOTAL POPULATION APPROVE OF THE LEGISLATION

Alcohol consumption

- Overall, 75% of people in Ireland have consumed alcohol in the past 12 months

- Those aged between 25 and 44 are most likely to drink alcohol - 84% of 25 to 34 year olds and 82% of 35 to 44 year olds are drinkers. Those aged 75 and older are least likely (54%) to have drunk alcohol in the last 12 months

- Men (78%) are more likely than women (72%) to have drunk alcohol in the last 12 months.

- Almost two out of every three (62%) men who drink do so at least once a week, and 48% of women drink this frequently

- Over half (55%) of drinkers drink alcohol at least once a week with 30% of drinkers drinking on multiple days each week

- Older drinkers are more likely to drink more frequently. 59% of those aged 65 and older who drink do so at least once a week, and 38% do so on multiple days each week. This compares to 47% and 21% respectively among those aged under 35

Binge drinking

(Defined as drinking six or more standard drinks on a drinking occasion)

- 37% of drinkers binge drink on a typical drinking occasion. 22% of drinkers binge drink at least once a week, and 39% do so at least once a month

- Those who are younger are more likely to binge drink on a typical drinking occasion. 50% of drinkers aged under 35 binge drink in this way, compared with 20% of drinkers aged 65 or older

- Male drinkers (54%) are more likely than female drinkers (19%) to binge drink on a typical occasion

- Out of women who drink, 35% of those aged 15-24 and 32% of those aged 25-34 binge drink on a typical drinking occasion. This compares with 17% of 35-44 year olds and 9% of 55-64 year olds

- Out of men who drink, 67% of those aged 15-24 and 64% of those aged 25-34 binge drink on a typical occasion. This compares with 52% of 55-64 year olds

- Drinkers from more disadvantaged areas are more likely (43%) to binge drink on a typical drinking occasion than those from more affluent areas (33%)

- Those who smoke daily or occasionally (54%) are more likely to binge drink on a typical occasion than those who don't smoke (33%)

Harms from own drinking

- 15% of drinkers report that in the last 12 months they have had feelings of guilt or remorse after drinking

- Additionally, 14% report that they had a friend or family member tell them about things they said or did while drinking that they did not remember. Men (17%) are more likely than women (12%) to have experienced this

- Furthermore, 8% have failed to do what was normally expected of them because of drinking. Men (4%) are more likely than women (2%) to have needed a first drink in the morning to get themselves going after a heavy drinking session

ALCOHOL

ALCOHOL PREVALENCE

Alcohol consumption in the last 12 months

TOTAL Population

Within Population

Drink alcohol — **75%**

Among Those Drinking Alcohol in Last 12 Months

Drink at least once a week — **55%**

Proportion by age

Within Population

Drink alcohol

Among Those Drinking Alcohol in Last 12 Months

Drink at least once a week

	15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
Drink alcohol	66%	84%	82%	79%	75%	66%	54%
Drink at least once a week	40%	52%	54%	62%	66%	63%	53%

BINGE DRINKING* (Among those drinking alcohol in the last 12 months)

Prevalence Trend

BINGE DRINKING TREND 2015 - 2018

2015	2016	2017	2018
39%	37%	39%	37%

Total

37%

Prevalence by Gender

19% WOMEN

54% MEN

Prevalence: Gender by Age

	15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
Women	35%	32%	17%	17%	9%	6%	1%
Men	67%	64%	56%	50%	52%	41%	25%

* Defined as drinking 6 or more standard units on a typical drinking occasion

EXPERIENCES FOLLOWING DRINKING (LAST 12 MONTHS)

15% Feelings of guilt or remorse

14% Being told about something they said or did that they don't remember

8% Failed to do what was normally expected of them

3% Needed a drink in the morning to get them going after a heavy drinking session

Consumption of unhealthy foods

- Of the 5 unhealthy food types measured in the survey (sweets, cakes and biscuits, salted snacks, pastries and takeaways), 34% of people consume at least one of them daily and 91% of people consume at least one each week. This compares with 9% of people who never consume such foods, or consume them less than once a week

- Those aged 75 years and older are more likely (38%) than those aged under 25 (32%) to consume at least one type of unhealthy food daily

- The proportion of men consuming at least one type of unhealthy food daily is highest amongst those aged 35-44 (37%); in contrast, women aged 75 and over show the highest rates of daily consumption (42%)

- 37% eat a take away at least once a week

- 36% of people in more disadvantaged areas consume at least one or more unhealthy foods a day. This compares with 32% of people in more affluent areas

Consumption of sugary drinks and other drinks

- 9% drink sugar-sweetened drinks on a daily basis, and 33% drink them at least once a week

- Younger people are more likely than those who are older to drink sugar-sweetened drinks at least once a day. 15% of those aged under 25 consume these drinks daily, compared with 4% of those aged 65 and older

- Men (11%) are more likely than women (6%) to drink sugar-sweetened drinks at least once a day. This is the case across all age groups

- 6% of people drink diet and low sugar drinks on a daily basis

- Daily consumption of diet and low sugar drinks is highest amongst those aged 25-34 (10%) and the proportion drinking them declines from age 35 onwards

- Those who are unemployed are more likely than those who work to drink sugar-sweetened drinks (22% and 8% respectively) and diet and low sugar drinks (12% and 6% respectively) at least once a day

- Smokers are more likely than non-smokers to drink sugar sweetened drinks (17% and 7% respectively) at least once a day and are more likely to drink diet and low sugar drinks (8% and 6% respectively) at least once a day

- 29% of people drink milk at least once a day and 49% drink it at least once a week

- The majority of people (86%) drink water at least once a day with 51% of people drinking it 3 or more times a day

Consumption of fruit and vegetables

- 37% of people consume 5 or more portions of fruit and vegetables a day while women are more likely (43%) than men (30%) to consume 5 or more portions a day

- Consumption of fruit and vegetables is lower among those aged 75 and older (25%) and those aged between 15 and 24 (27%)

DIET AND NUTRITION

CONSUMPTION OF UNHEALTHY FOODS (sweets, cakes and biscuits, salted snacks, pastries and take-aways)

Unhealthy foods consumed at least once a day

Daily Consumption

34% TOTAL

Daily Consumption by Gender

34% MEN

35% WOMEN

Daily Consumption by Age

15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
32%	35%	37%	33%	32%	34%	38%
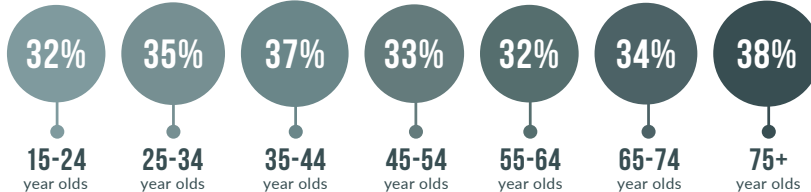
Daily Consumption by Food Type

CHOCOLATE/SWEETS	CAKES & BISCUITS	SALTED SNACKS	PASTRIES	TAKEAWAYS
21%	19%	6%	1%	1%

CONSUMPTION OF SUGAR-SWEETENED DRINKS (regular sugar-sweetened fizzy or soft drinks, energy or sports drinks)

Sugar-sweetened drinks consumed at least once a day

Daily Consumption

9% TOTAL

Daily Consumption by Gender

11% MEN

6% WOMEN

Daily Consumption by Age

15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
15%	13%	9%	7%	4%	3%	5%
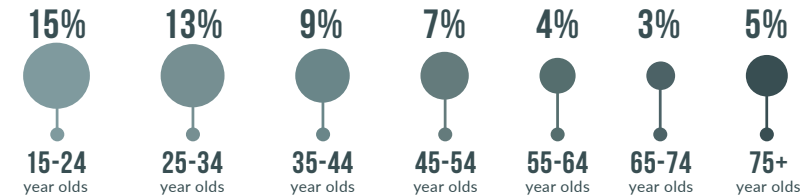
Daily Consumption of Other Drinks

WATER	MILK	UNSWEETENED FRUIT/ VEGETABLE JUICE	DIET OR LOW SUGAR DRINKS
86%	29%	11%	6%
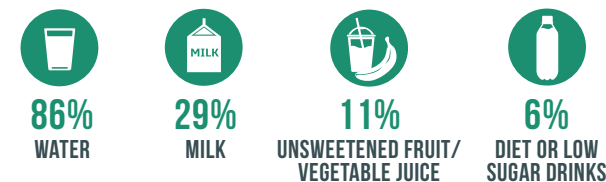
(excludes water and milk in tea/coffee)

Due to changes in survey measuremant, these figures are not directle comparable to previous waves

CONSUMPTION OF FRUIT & VEGETABLES (5 or more a day)

5 or more portions of fruit and vegetables consumed at least once a day

Daily Consumption

37% TOTAL

Daily Consumption by Gender

30% MEN

43% WOMEN

Total by Age

15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
27%	38%	42%	41%	40%	34%	25%
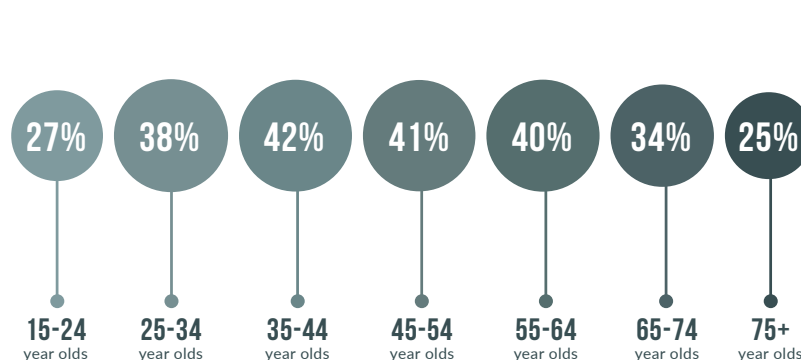
Self-reported health

- 85% perceive their health to be very good or good. 3% perceive it to be very bad or bad

- 86% of women and 84% of men perceive their health to be very good or good

- The gender gap in self-reported good health is largest among those aged 55 to 64. 81% of women in this age group perceive their health to be good or very good, compared with 73% of men

- Self-reported good health is higher among those who are working than among those who are unemployed (93% and 78% respectively). It is also higher among those living in more affluent areas than those living in more deprived areas (90% and 79% respectively)

Prevalence of certain health conditions

- 29% reported that they currently have a long-standing illness or health condition that will last for 6 months or more

- 56% of those reporting a long-standing illness or health condition perceive their health to be good or very good

- However, 59% of those reporting a long-standing illness or health condition report being limited in everyday activities because of health problems

- Respondents were asked about 25 specific health conditions. The conditions most commonly reported are high blood pressure (12%), arthritis (10%), high cholesterol (9%), asthma (8%) and depression/anxiety (6%)

- Older people are more likely to report having at least one of the specific health conditions (75 and older: 82%, 15 to 24: 20%)

- Women aged 75 and older are more likely than men of the same age to report having at least one of the 25 specific health conditions (87% and 77% respectively)

Flu vaccine

- 25% reported receiving the flu vaccine during the previous winter

- Incidence of receiving the flu vaccine increases with age from 9% of those aged 15 to 24, to 78% of those aged 75 and older

- Women were more likely than men to receive the flu vaccine (27% and 23% respectively)

- The difference between the genders is not consistent across all age groups. Women aged between 25 and 44 were more likely to have received the vaccine than men of the same age (18% and 10% respectively). However, among those aged 65 and older, men were more likely than women to receive the vaccine (68% and 64% respectively)

- The main reasons for receiving the vaccine were due to it being suggested by a GP or pharmacist (40%), being at risk due to age (26%) or being at risk due to chronic disease or disability (20%)
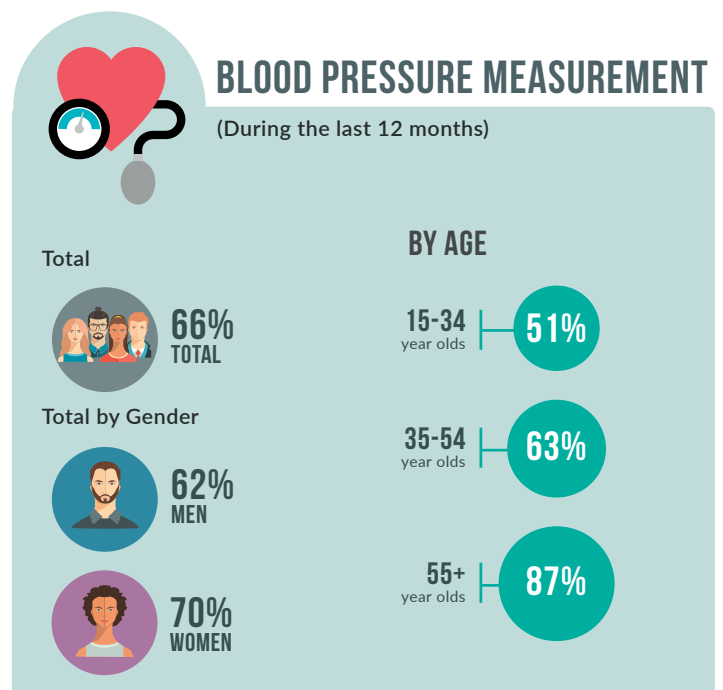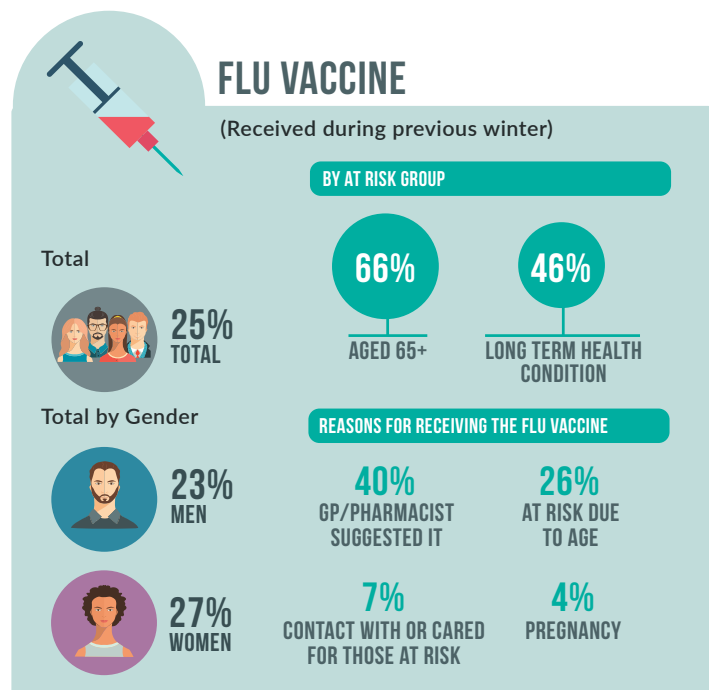
Blood pressure measurement

- 66% have had their blood pressure measured during the past 12 months

- Incidence of blood pressure measurement in the past 12 months increases with age from 51% of those aged between 15 and 34, to 95% of those aged 75 and older

GENERAL HEALTH

PROPORTION RATING HEALTH AS GOOD/VERY GOOD

TOTAL

85%

BY AGE

93%	94%	88%	88%	77%	74%	62%
15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds

PREVALENCE OF CERTAIN HEALTH CONDITIONS IN PAST 12 MONTHS

TOTAL

29% HAVE A LONG-STANDING ILLNESS OR HEALTH PROBLEM

HEALTH PROBLEM

HIGH BLOOD PRESSURE	ARTHRITIS	HIGH CHOLESTEROL	ASTHMA	DEPRESSION/ANXIETY
12%	10%	9%	8%	6%

RESPONDENTS WERE PRESENTED WITH A LIST OF 25 SPECIFIC HEALTH CONDITIONS INCLUDING:

Chronic Lung Disease - Asthma - Arthritis - Osteoporosis - Cancer/Malignant Tumour
Parkinson's Disease - Depression or Anxiety - Alcohol or Substance Abuse - Dementia
Alzheimer's Disease- Serious Memory Impairment - Stomach Ulcers - Varicose Ulcers - Cirrhosis
High Blood Pressure - Angina - Heart Attack -Congestive Heart Failure - Diabetes - Stroke
Ministroke or TIA - High Cholesterol - Heart Murmur - Abnormal Heart Rhythm - Other Heart Trouble

FLU VACCINE

(Received during previous winter)

BY AT RISK GROUP

66% AGED 65+

46% LONG TERM HEALTH CONDITION

Total

25% TOTAL

Total by Gender

23% MEN

27% WOMEN

REASONS FOR RECEIVING THE FLU VACCINE

40% GP/PHARMACIST SUGGESTED IT

26% AT RISK DUE TO AGE

7% CONTACT WITH OR CARED FOR THOSE AT RISK

4% PREGNANCY

BLOOD PRESSURE MEASUREMENT

(During the last 12 months)

Total

66% TOTAL

Total by Gender

62% MEN

70% WOMEN

BY AGE

15-34 year olds — **51%**

35-54 year olds — **63%**

55+ year olds — **87%**

Perceptions of oral health

- 79% describe their oral health as good or very good; in contrast, 4% describe it as bad or very bad. The remainder (17%) describe their oral health as "fair"

- Women are more likely than men to describe their oral health as good or very good (82% and 76% respectively)

- The proportion describing their oral health as good or very good declines with age. 89% of those aged 15 to 24 describe their oral health as good or very good, declining to 65% of those aged 75 or older

- The proportion describing their oral health as "fair" increases with age from 9% of those aged 15 to 24 to 30% of those aged 75 or older. The proportion describing their oral health as bad or very bad is broadly unchanged across different age groups

- 68% of smokers and 75% of ex-smokers describe their oral health as good or very good. In contrast, 85% of those who have never smoked describe their oral health in the same way

- The proportion describing their oral health as good or very good is lower among those who are unemployed (65%), and those living in more deprived areas (75%) than it is among those who are employed (83%) or those living in more affluent areas (83%)

False teeth and dentures

- 46% say that they have all their own teeth, and none are missing

- 36% say some of their teeth are missing but have no false teeth or dentures, while a further 12% have both their own teeth as well as false teeth or dentures

- 6% claim to have full dentures and less than 1% have no teeth and no dentures

- The proportion with all their own teeth (none missing) declines with age from 88% of those aged 15 to 24 to 4% of those aged 75 or older

- The proportion who indicated some of their teeth are missing (but have no false teeth or dentures) is highest among those aged 45 to 54 (53%) and those aged 55 to 64 (55%)

- 42% of those aged 75 or older have full dentures. Women in this age group are more likely than men to have full dentures (49% and 34% respectively).

Problems with teeth or dentures

- 5% report that they have had difficulty eating in the past 6 months due to problems with their mouth, teeth or dentures. This is highest among those aged 75 and older (11%). Furthermore, 2% have had problems with smiling laughing and showing teeth without embarrassment
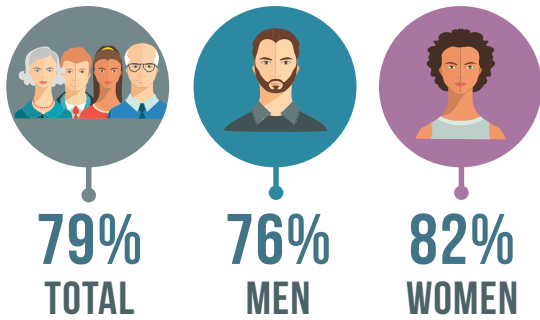
Visits to dentists

- 47% have visited a dentist in the past 12 months

- Between the ages of 35 and 74, women are more likely to visit a dentist than men (53% and 42% respectively). However, no gender difference exists among those younger or older than this

- Those who are unemployed (42%), and those living in more deprived areas (41%) are less likely to have visited a dentist in the past 12 months than those who are employed (51%) or those living in more affluent areas (55%)

- 65% of those visiting a dentist over the previous 12 months did so for a check-up (including routine scaling/cleaning). 19% did so to receive treatment for something that was not causing them pain, and 12% did so for treatment for something that was causing pain
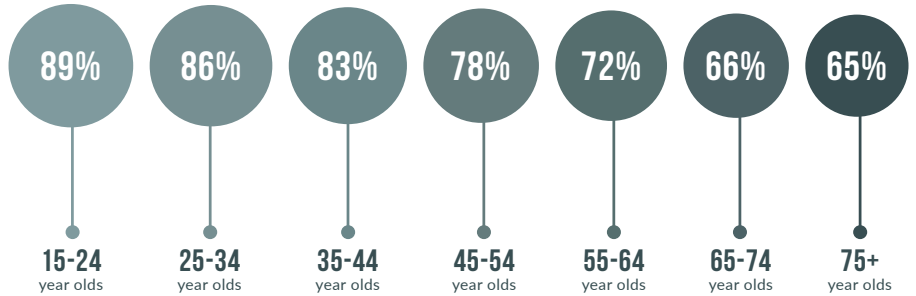
ORAL HEALTH

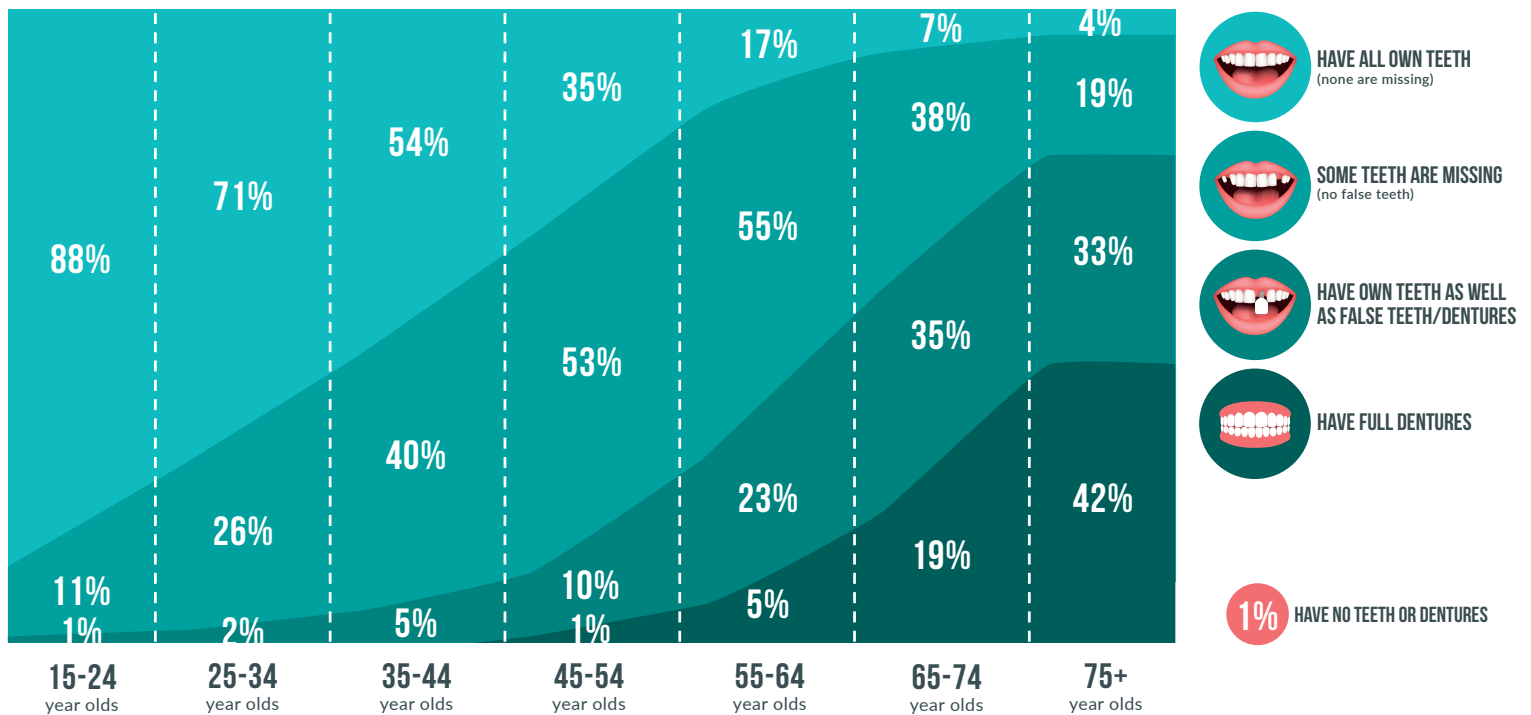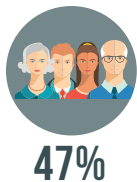## PROPORTION RATING ORAL HEALTH AS GOOD/VERY GOOD

Total by Gender

79% TOTAL

76% MEN

82% WOMEN

Total by Age

89%	86%	83%	78%	72%	66%	65%
15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds

PROPORTION OF PEOPLE WITH FALSE TEETH AND DENTURES

15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
88%	71%	54%	35%	17%	7%	4%
11%	26%	40%	53%	55%	38%	19%
1%	2%	5%	10%	23%	35%	33%
			1%	5%	19%	42%

- HAVE ALL OWN TEETH (none are missing)
- SOME TEETH ARE MISSING (no false teeth)
- HAVE OWN TEETH AS WELL AS FALSE TEETH/DENTURES
- HAVE FULL DENTURES

1% HAVE NO TEETH OR DENTURES

DENTIST VISITS (Visited in the last 12 months)

Total 47%

Visits by Gender

51% WOMEN
44% MEN

Visits: Gender by Age

	15-24 year olds	25-34 year olds	35-44 year olds	45-54 year olds	55-64 year olds	65-74 year olds	75+ year olds
Women	58%	50%	54%	56%	59%	39%	21%
Men	57%	48%	46%	43%	42%	31%	22%
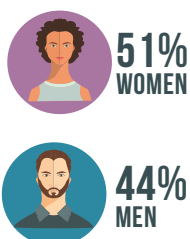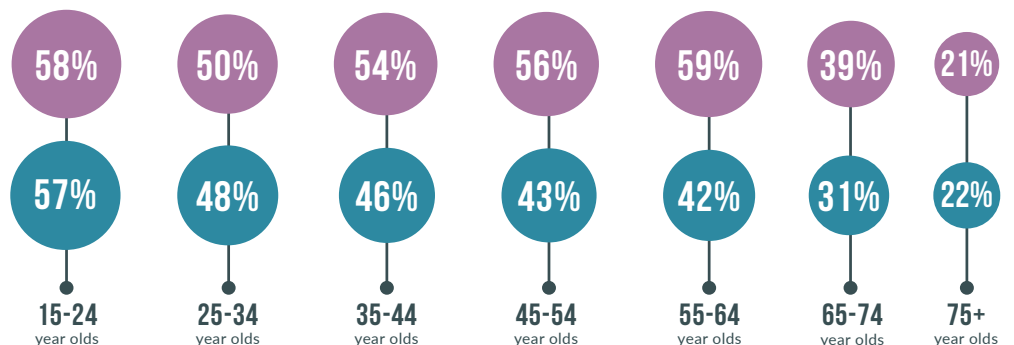
GP Visits

- 74% have visited a GP in the past 12 months with an average of 3.8 visits per person among all aged 15 and older. This average includes those who have not visited a GP.

- Women (79%) are more likely to have visited a GP than men (68%)

- Older age groups are more likely to have visited a GP than those who are younger (94% of those aged 75 and older; 64% of those aged 15 to 24)

- Those who are older also visit the GP more frequently than those who are younger. Those aged 75 and older have on average 6.4 visits per year, compared with an average of 2.5 visits for those aged 15 to 24

- 75% of those living in the most deprived areas have visited a GP in the past 12 months, while 71% of those living in the most affluent areas have done so

- Frequency of GP visits are also higher in the most deprived areas than they are in the most affluent ones (averages of 4.5 visits and 2.9 visits respectively)

- 35% have consulted a nurse in a GP surgery in the past 12 months with an average of 1.4 visits per person among all aged 15 and older

- Those living in more affluent areas are less likely to than those in more deprived areas to consult a nurse in a GP surgery (30% and 38% respectively)

GP out of hours services

- 8% have used a GP Out of Hours service during the past 12 months. 2% have used this service on multiple occasions during the past 12 months

- No notable difference exists by age, with 9% of those aged 15 to 24 and 10% of those aged 75 and older using a GP Out of Hours Service in the past 12 months

- 11% of those living in the most deprived areas have used a GP Out of Hours Service, compared with 5% of those living in the most affluent area

Hospital admissions

- 12% have been admitted to hospital as an in-patient in the past 12 months

- 9% have been admitted to a public hospital and 3% have been admitted to a private hospital

- 26% of those aged 75 and older have been admitted to hospital as an in-patient during the past 12 months. 7% of those aged 15 to 24 have been admitted during this time

- 23% of those with a long-standing illness or health problem have been admitted to hospital as an in-patient in the past 12 months

- 16% have been admitted to hospital as a day-patient in the past 12 months. 12% have been admitted to a public hospital as a day-patient and 4% have been admitted to a private hospital

Usage of emergency departments and other services

- Over the past 12 months, 10% have used an Emergency Department in a public hospital, and 2% have used an Emergency Department in a private hospital

- Usage of Emergency Departments in public hospitals is highest among those aged 15 to 24 and 75 and older (14% and 13% respectively)

- 6% have used a Medical Assessment Unit in a public hospital and 3% have used a Local Injury Unit in a public hospital

HEALTH SERVICE UTILISATION

AVERAGE NUMBER OF GP VISITS IN THE PAST 12 MONTHS

GP VISITS

3.8 TOTAL

3.3 MEN

4.3 WOMEN

2.5	**3.2**	**3.3**	**3.0**	**4.8**	**5.7**	**6.4**
15-24 YEAR OLDS	25-34 YEAR OLDS	35-44 YEAR OLDS	45-54 YEAR OLDS	55-64 YEAR OLDS	65-74 YEAR OLDS	75+ YEAR OLDS

6.2 THOSE WITH A FULL MEDICAL CARD

3.6 THOSE WITH A GP VISIT CARD

2.4 THOSE WITH NEITHER CARD
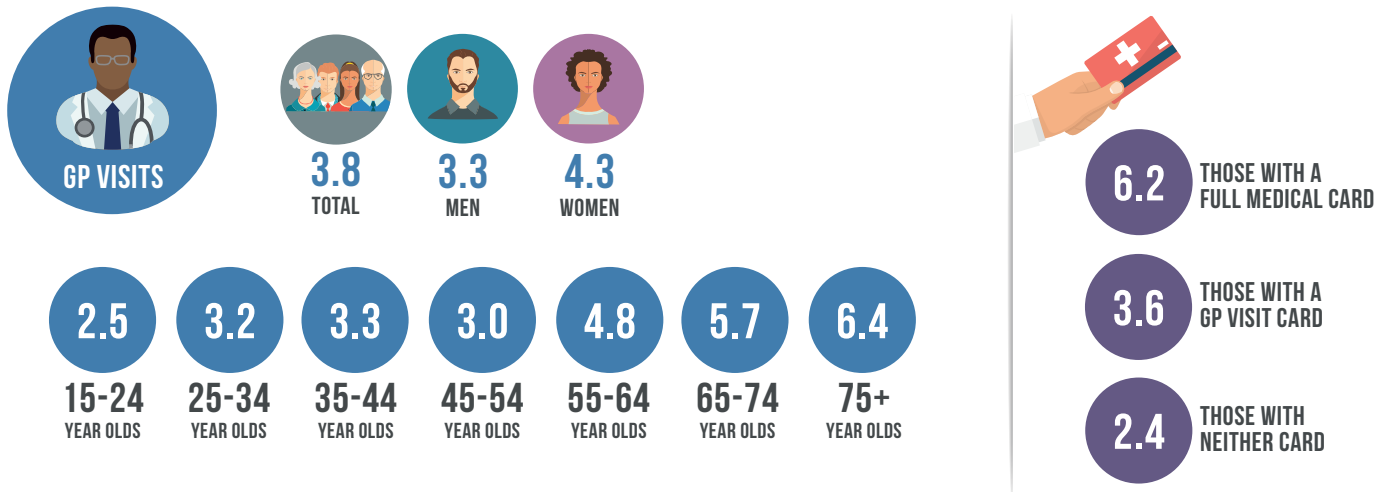
OTHER HEALTH SERVICES

(Proportion who have used certain health services at least once in the past 12 months)

10% EMERGENCY DEPARTMENT IN A PUBLIC HOSPITAL*

8% GP OUT OF HOURS SERVICE

6% MEDICAL ASSESMENT UNIT IN A PUBLIC HOSPITAL

3% LOCAL INJURY UNIT IN A PUBLIC HOSPITAL

2% EMERGENCY DEPARTMENT IN A PRIVATE HOSPITAL INCLUDING SWIFTCARE OR SIMILAR
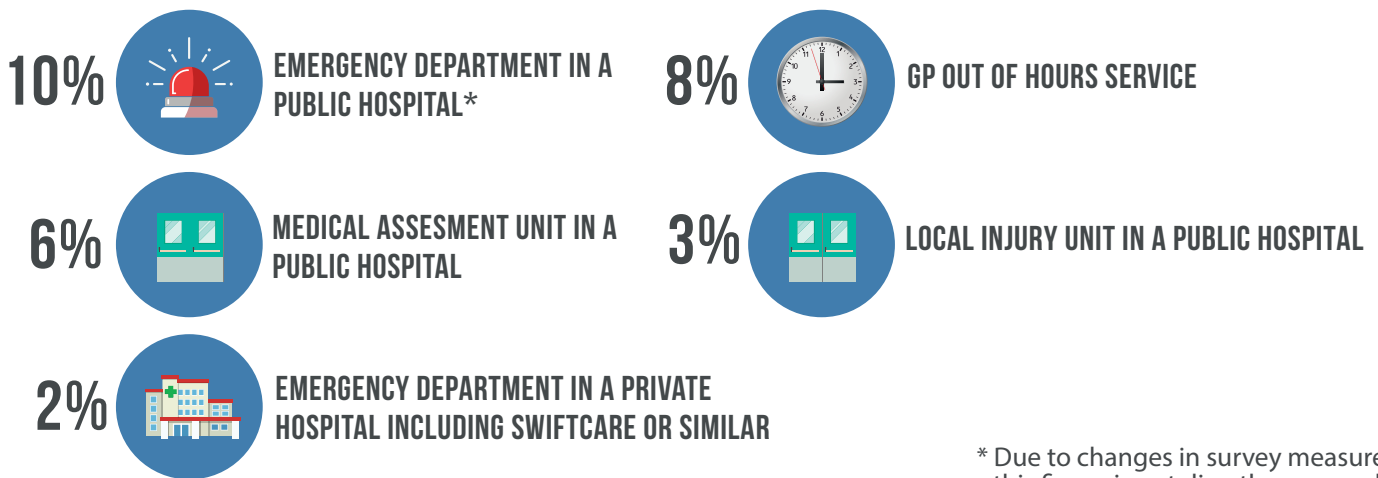
* Due to changes in survey measuremant, this figure is not directly comparable to previous waves

HOSPITAL ADMISSIONS

(Admitted as an in-patient in the last 12 months)

By Hospital Type

12% TOTAL

9% PUBLIC HOSPITAL

3% PRIVATE HOSPITAL

11 Health Behaviours and Inequalities
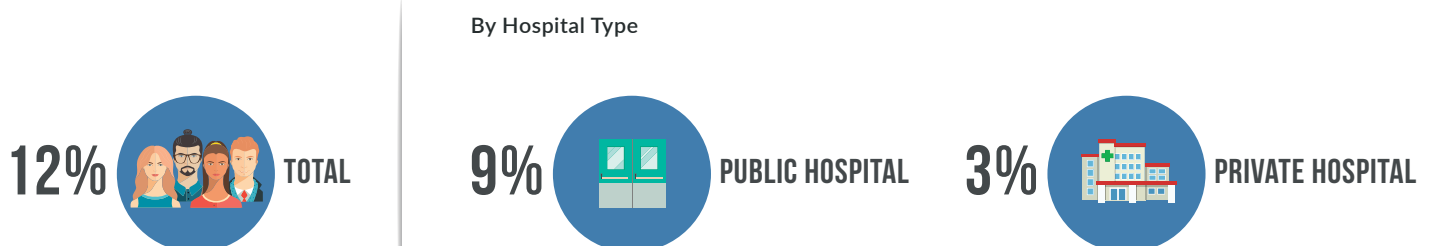
Summary

- Those in more deprived areas are less likely to rate their health as good or very good, and more likely to have a long-term health problem

- Those in more deprived areas are also more likely to smoke and binge drink

- Self-rated good health declines earlier for men in deprived areas (around the age of 55 to 64) than it does for both men in affluent areas and women in deprived areas

- Women living in more deprived areas are more likely than those in affluent areas to continue smoking and binge drinking into their 50s

Introduction

The Healthy Ireland Framework is built around four core goals.

- Increase the proportion of people who are healthy at all stages of life
- Reduce health inequalities
- Protect the public from threats to health and wellbeing
- Create an environment where every individual and sector of society can play their part in achieving a healthy Ireland

In the previous report of this research series, the first of these goals was explored through analysis of health behaviours among young people.

This year's report explores the second of these goals – reduce health inequalities.

Positive health is not evenly distributed throughout the population. While we can all make choices to improve our health and wellbeing, our ability to do so can be affected by the circumstances in which we are born, where we live, our level of education or whether or not we are in employment.

Healthy Ireland seeks to reduce the inequalities that exist and develop an environment in which everyone is equipped to make positive choices that benefit their longer-term health and wellbeing.

Findings presented earlier in this report relate to differences across population groups for specific behaviours, while this section seeks to explore these differences in a more holistic manner.

While there are a wide range of factors that may determine health inequalities, this report focuses primarily on one of these factors – where an individual lives – however it also takes into consideration differences in health behaviours throughout the life-course.

To explore differences in health behaviours in terms of where an individual lives, the Pobal Deprivation Index is used to understand differences depending on the degree of deprivation. This uses data from Census 2016 to categorise small geographic areas into degrees of affluence/disadvantage which are identified using demographic, social class and labour market information.

Figure 11.1 – Health behaviours by deprivation (%)

Health Behaviour	Deprived Area	Affluent Area
Smoke	26	16
Binge Drink	31	26
Consume 5 or more portions of fruit daily	32	42
Have a long standing illness or health condition	33	24
Rate health as good or very good	79	90
Visited GP in past 12 months	75	71

The typical pattern is one of higher risk health behaviours and more negative health situations in more deprived areas than in more affluent areas. Exploring this across the life-course shows that those in deprived areas are more likely than their peers in affluent areas (as well as their peers more generally) to exhibit negative health behaviours and are less likely to benefit from positive health.

General Health

Those in more deprived areas are less likely than those in more affluent areas to rate their health as good or very good (79% and 90% respectively). Similarly, those living in more deprived areas are more likely than those in more affluent areas to have a long-term health problem (33% and 24% respectively).

Figure 11.2 – Proportion rating own health as good or very good (by gender, age and deprivation - %)

	15-24	25-34	35-44	45-54	55-64	65-74	75+
Deprived Areas							
Men	87	92	85	81	59	57	55
Women	94	92	81	89	73	69	59
Affluent Areas							
Men	96	93	92	92	81	91	73
Women	93	94	94	90	87	83	59

Exploring this by age and gender illustrates a number of interesting dynamics in terms of perceptions of own health. While there is limited difference in self-rated good health between deprived and affluent areas among those in the younger age groups, from the 35 to 44 age group onwards a gap begins to emerge. This exists for both genders and is widest among those aged 55 to 74.

A slightly different dynamic exists for men than women. Self-rated good health declines earlier for men in deprived areas (around the age of 55 to 64) than it does for both men in affluent areas and women in deprived areas. This difference between deprived and affluent areas persists for men aged 75 and older, while self-rated good health is the same for women in this age group regardless of where they live.

Figure 11.3 – Proportion with a long-standing illness or health problem (by gender, age and deprivation - %)

	15-24	25-34	35-44	45-54	55-64	65-74	75+
Deprived Areas							
Men	19	18	28	26	55	60	55
Women	11	16	31	31	43	50	56
Affluent Areas							
Men	19	11	16	25	31	37	54
Women	21	20	19	26	34	41	60

Similar differences exist in terms of the proportions with a long-standing illness or health condition. The gap between deprived and affluent areas is widest among those aged between 55 and 74, with those in deprived areas more likely to report having a long-standing illness or health condition. However, this gap does not persist among those aged 75 and older.

One notable difference is that younger women (aged under 35) living in more affluent areas are more likely than their peers in deprived areas to report having a long-term illness or health condition.

The majority of men (57%) aged 55 to 74 living in more deprived areas report having a long-standing illness or health problem. This compares with 33% of men in this age group living in more affluent areas, and 46% of women in this age group living in more deprived areas.

21% of women aged 15 to 24, and 20% of women aged between 25 and 34 living in affluent areas report having a long-term illness or health condition. This compares with 11% and 16% respectively among those living in deprived areas.

However, no difference exists between deprived areas and affluent areas in terms of incidence of specific health conditions, with 20% of women aged under 35 in both areas identifying one of the listed health conditions on the survey (for example, asthma or depression).

Figure 11.4 – Proportion visiting a GP in the past 12 months (by gender, age and deprivation - %)

	15-24	25-34	35-44	45-54	55-64	65-74	75+
Deprived Areas							
Men	51	60	63	70	84	94	90
Women	72	77	71	75	82	91	96
Affluent Areas							
Men	68	49	61	67	73	87	90
Women	70	74	73	76	79	91	96

Given these differences in health conditions between deprived and affluent areas, it might be expected that the proportions in both areas visiting a GP will also be different. Figure 11.4 shows that slightly higher proportions in deprived areas have visited a GP in the past 12 months. Overall, three-quarters of those living in deprived areas have visited a GP in the past 12 months, compared with 71% of those living in affluent areas.

There is a noteworthy exception to this and that is among men aged under 25 where those in affluent areas are more likely to visit a GP than those in deprived areas.

Health Behaviours

Earlier in this report it is noted that those living in deprived areas are more likely to smoke and binge drink than those living in more affluent areas. Similar differences exist across the life-course with younger people more likely than those who are older to engage in each of these behaviours.

Given the differences in self-rated good health rating between deprived and affluent areas, it is necessary to consider the extent to which these two behaviours – smoking and binge drinking – differ between these two areas.

Figure 11.5 – Proportion that smoke (by gender, age and deprivation - %)

	15-24	25-34	35-44	45-54	55-64	65-74	75+
Deprived Areas							
Men	28	35	37	25	31	20	11
Women	21	30	27	29	31	13	12
Affluent Areas							
Men	18	31	23	17	12	10	8
Women	15	22	13	9	8	8	4

While those living in more deprived areas are more likely to smoke than those living in more affluent ones, the dynamic in respect of smoking is broadly the same in both areas. Men are more likely to smoke than women, and those who are younger are more likely to smoke than those who are older.

However, comparisons between each of the areas demonstrate some stark differences. While smoking levels are high in both areas among those aged under 35, the decline in smoking that occurs after this in affluent areas is not replicated in deprived areas and does not happen until much later.

This is particularly noticeable among women in deprived areas, for whom levels of smoking do not decline until the 65 to 74 age group. Women aged 55 to 64 in deprived areas are almost four

times more likely to smoke than their peers in affluent areas. Also, men in this age group living in deprived areas are 2.5 times more likely to smoke than their peers in affluent areas.

Given the strength of the differences in smoking behaviour between deprived and affluent areas, more detailed analysis was conducted to understand the factors that may lead to this.

A CHAID (Chi-squared Automatic Interaction Detection) analysis was performed on the complete Healthy Ireland dataset (2015 to 2018) to identify the most tobacco-dependent population sub-groups.

The analysis identified the population group most likely to smoke are single people engaged in home duties, aged 35 to 54 and who left school without a leaving cert.

Figure 11.6 – Proportion that binge drink (by gender, age and deprivation - %)

	15-24	25-34	35-44	45-54	55-64	65-74	75+
Deprived Areas							
Men	50	57	48	48	45	32	16
Women	25	37	18	18	5	8	2
Affluent Areas							
Men	43	55	46	33	34	30	17
Women	21	20	9	9	8	1	<0.5

As with smoking, the pattern in respect of binge drinking is one of a decline in this negative behaviour occurring later in life in deprived areas than in affluent areas.

This is very noticeable among women in particular. While binge-drinking levels in the two areas are closely aligned in the 15 to 24 age group, women in deprived areas between the ages of 25 and 54 are twice as likely as their peers in affluent areas to binge drink.

Among men the binge drinking levels are similar in both areas up to the 35 to 44 age group, however the decline in binge-drinking that happens at this stage for men in affluent areas is not replicated by their peers in deprived areas until after the age of 65.

Summary

Considerable progress is being made towards improving public health, most notably in respect of initiatives to reduce the prevalence of smoking and binge drinking in Ireland. Standardised packaging will make all tobacco packs look less attractive to consumers as well as making health warnings more prominent. The Public Health Alcohol Bill will bring about a number of changes which aim to impact on the consumption of alcohol and associated harms.

The success of these initiatives will be key in improving the nation's long-term health and enable people to live healthier for longer. Clear inequalities exist in this respect with those in more deprived areas feeling less positive about their health and more likely to suffer from long-term illnesses and health problems.

However, this chapter demonstrates that major health inequalities exist throughout all lifestages. The implementation of new policies will need to consider this if the reduction of health inequalities is to be achieved.

For example, given the high levels of smoking among those in deprived areas, reducing it to the level of a tobacco free Ireland presents a significant challenge. The analysis presented in this section suggests that certain groups - those who may be less connected socially and economically have not been impacted as favourably as their peers in wider society by tobacco control measures introduced to date, and further effort is required to support these groups in particular.

Similarly, the persistence of binge drinking into later life in deprived areas suggests that the motivations and reasons for those in affluent areas to drink less may not apply to the same extent in these areas. Measures to reduce the levels of binge drinking needs to consider these wide differences in behaviour.

Accessing these groups, with targeted supports and communications will come into sharper focus in years ahead as we move towards a healthier society and the emphasis shifts towards reducing the prevalence of smoking and binge drinking among the groups who are the most vulnerable to the significant harms associated with these behaviours.

Notes

Healthy
Ireland