

THE ISLE OF MAN:

AN EQUAL SOCIETY?

DO WE KNOW?

WHY DOES IT MATTER FOR HEALTH AND WELLBEING?



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INTRODUCTION

This is my third annual report as Director of Public Health. This year I've posed the question 'are we an equal society and does that matter for health and wellbeing?'. The short answer is we don't know and it does matter. I hope the report will show how variations in health and wellbeing are linked to differences in socio-economic status, discuss some of the indicators that have been developed elsewhere to measure inequalities, and look at how actions to address them can be organised across government, the third and private sectors and communities. We have an extraordinary opportunity as a small island nation to address inequalities through co-ordinated action through government policy and service delivery, and the contribution of those beyond government. However, at present we simply do not know what inequalities there are across our population, whether our current policies and interventions are addressing and changing these, or whether we have gaps that we are not currently addressing at all.

Over the past four years the Public Health team has been working to produce indicators for health and wellbeing in the Isle of Man. These form a standard dataset, the Public Health Outcomes Framework (PHOF), which not only helps us understand levels of health and wellbeing on the Island but also lets us compare ourselves with England and English local authorities. We published the first set of indicators as part of the 2017 Director of Public Health's Annual Report and we have now updated the set ⁽ⁱ⁾. (see Table 1)

For four out of these nine key indicators, our outcomes are statistically significantly worse than England. We need to understand what is behind these poorer outcomes for our population if we want to address and improve them. Wide variations in health and wellbeing are also seen between and within local authority areas across England and between United Kingdom countries. For example, if we look at life expectancy at birth for babies born in the UK between 2013 and 2015, a newborn baby boy could expect to live 79.2 years and a newborn baby girl 82.9 years. However, for boys, life expectancy varies from 83.4 years for babies born in Kensington and Chelsea, to 73.4 years for babies born in Glasgow City.

TABLE 1:

KEY INDICATORS FROM THE PUBLIC HEALTH OUTCOMES FRAMEWORK FOR THE ISLE OF MAN

INDICATOR DESCRIPTION	SEX	PERIOD	UNIT	IOM VALUE	ENGLAND VALUE
Healthy Life Expectancy at birth	Male	2015-2017	Years	63.8	63.4
Healthy Life Expectancy at birth	Female	2015-2017	Years	57.9	63.8
Life Expectancy at Birth	Male	2015-2017	Years	79.1	79.6
Life Expectancy at Birth	Female	2015-2017	Years	83.2	83.1
Breastfeeding - breastfeeding initiation	Female	2016/17	%	68.4	74.5
Child Excess weight - 4-5 year olds	All	2017/18	%	25.2	22.4
Mortality rate from causes considered preventable	All	2015-2017	per 100,000	206.4	181.5
Mortality rate from causes considered preventable	Male	2015-2017	per 100,000	269.7	228.6
Mortality rate from causes considered preventable	Female	2015-2017	per 100,000	144.8	137.7

Note: Isle of Man rates are compared to the England average rate to give a 'Red, Amber, Green' rating. Red = worse, Amber = similar, Green = better

(i) Available at gov.im/healthdata

“WE HAVE AN EXTRAORDINARY OPPORTUNITY AS A SMALL ISLAND NATION TO ADDRESS INEQUALITIES THROUGH CO-ORDINATED ACTION THROUGH GOVERNMENT POLICY AND SERVICE DELIVERY, AND THE CONTRIBUTION OF THOSE BEYOND GOVERNMENT.”



For baby girls, the variation is between 86.7 years for babies born in Hart (in South East England) and 78.7 years for babies born in West Dunbarton ⁽ⁱⁱⁱ⁾.

Variations are also seen within local areas. For example, a man born in the Bridgeton area of Glasgow can expect to live 14.3 years less than his counterpart in the Jordanhill area of Glasgow, whilst a woman can expect to live 11.7 years less. Behind the high overall figures for life expectancy in Kensington and Chelsea lies a variation in life expectancy between the most deprived neighbourhood and the least deprived neighbourhood of 16.0 years for men and 4.1 years for women ⁽ⁱⁱⁱ⁾.

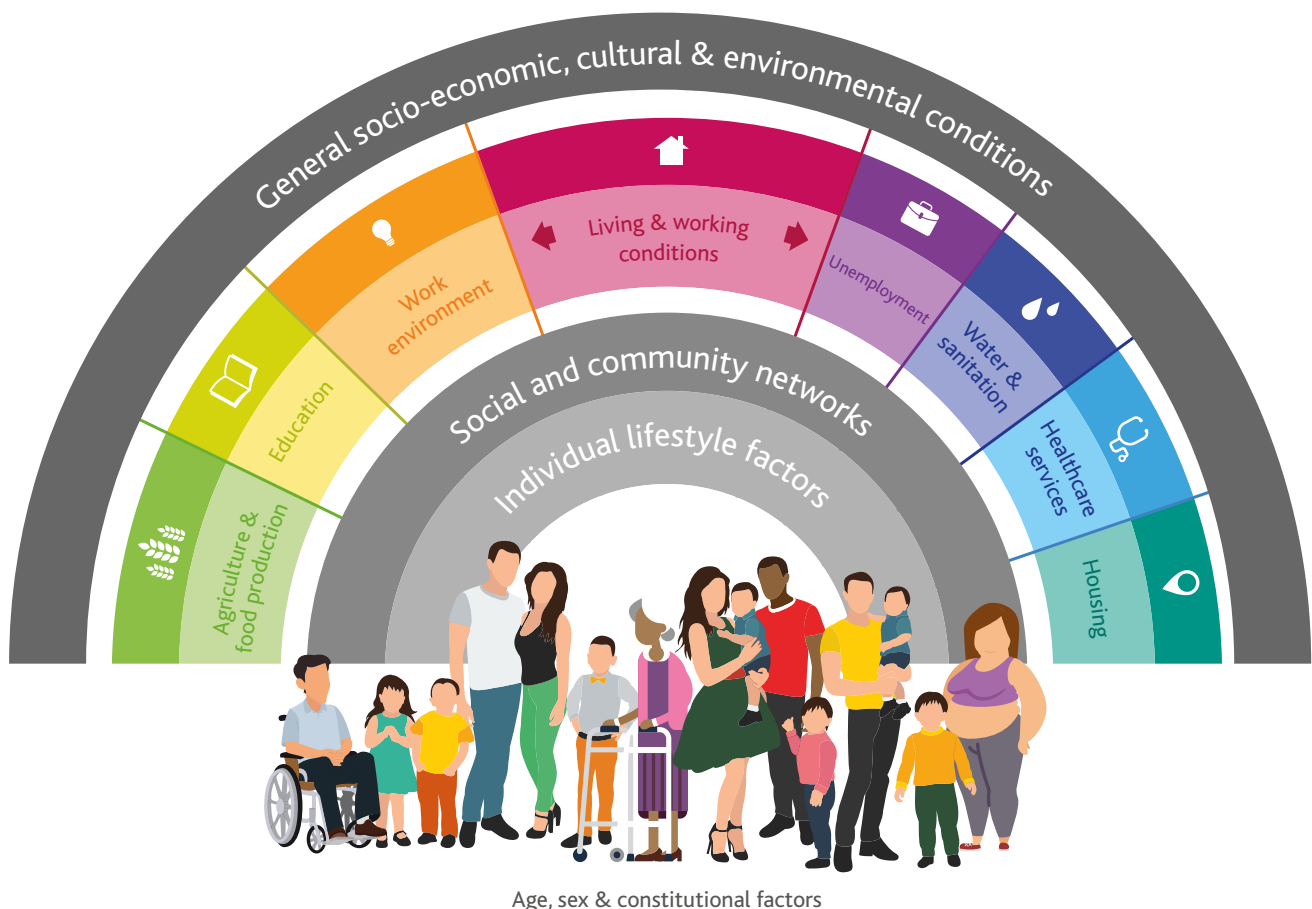
Differences in life expectancy reflect and result from differences in other health and wellbeing outcomes and the health behaviours that drive them. Underlying all this is the social gradient in health – social inequalities lead to health inequalities. The more socially and economically favoured people are, the better their health. The diagram in figure 1 shows the relationship between the individual, their environment and health.

The ability of individuals to choose healthy lifestyle behaviours and participate in social and community networks is strongly determined by their socio-economic status and the environment they live in. Reducing inequalities in health benefits society as well as individuals and families. It brings economic benefits through reducing economic losses due to illness – productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs to the NHS.

If we want to improve our population's health and wellbeing we have to address socio-economic and environmental factors (the so-called wider determinants of health) as well as health care and healthy behaviours. We can only do this if we understand the distribution of these factors across our population and how this correlates with health behaviours and outcomes. This is essential if we are to achieve the Programme for Government objectives of tackling the inequalities in our island society and living longer, healthier lives ^[1].

FIGURE 1:

DAHLGREN AND WHITEHEAD MODEL OF THE WIDER DETERMINANTS OF HEALTH



(ii) Source: Office for National Statistics, Health state life expectancies, UK: 2013-2015

(iii) Source: Public Health England, Kensington and Chelsea Health Profile 2016

(iv) Available online at: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>
<https://gweddill.gov.wales/statistics-and-research/welsh-index-multiple-deprivation/?lang=en>
<https://www2.gov.scot/Topics/Statistics/SIMD>

<https://www.nisra.gov.uk/statistics/deprivation/northern-ireland-multiple-deprivation-measure-2017-nimdm2017>



HOW CAN WE MEASURE VARIATIONS IN SOCIO-ECONOMIC STATUS ACROSS OUR POPULATION?

In the UK, there has been a long-standing interest in identifying geographic areas of deprivation to help target policies and spending to reduce inequalities. England, Wales, Scotland and Northern Ireland have all developed 'indices of deprivation' which combine data on a range of domains relating to social inequality. The four UK administrations have developed slightly different indices (the English Index of Multiple Deprivation, the Welsh Index of Multiple Deprivation, the Scottish Index of Multiple Deprivation and the Northern Ireland Index of Multiple Deprivation)^(iv).



Indices of deprivation enable the identification of small geographical areas within each country that are the most deprived (small areas are based on defined populations (1,500 people)). They combine information from different domains to give an overall measure of deprivation.

THE DOMAINS USED ARE:

- Income
- Education, skills and training
- Crime
- Environmental quality
- Employment
- Health and disability
- Housing and services

There is variation between the indicators within the domains and the weightings given to them between the different indices. This means that they cannot be used to compare areas between UK countries.

THE INDICES CAN BE USED TO:

- Compare and rank small areas across a UK country
- Identify the most deprived small areas in a country
- Explore which domains are most significant as underlying causes of deprivation in small areas
- Compare larger areas (e.g. local authorities)
- Look at changes in relative deprivation between different editions of the index

THEY CANNOT BE USED TO:

- Quantify how deprived a small area is
- Identify deprived people
- Say how affluent a place is
- Measure real change in deprivation over time ^[2]

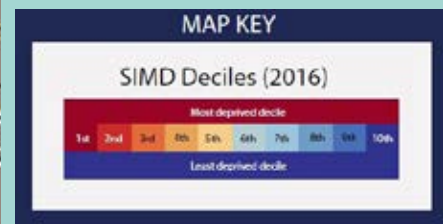


The indices cover the wider determinants of health as well as including data specifically on health and disability. The association between deprivation and levels of ill health and mortality and higher healthcare costs is well established from studies across the world [3]. An understanding of geographic patterns of deprivation can help target place-based interventions to reduce health inequalities. These could include improving the quality of and access to health care services (e.g. primary and community care) in deprived areas, or developing asset-based community development projects to improve community health and wellbeing. They are most useful to guide policy, planning and funding in densely populated urban areas. In rural areas, the population needed for the 'small area' will be spread out over a much wider geographical area. As a result, a rural 'small area' may appear overall to have a low level of deprivation but this can mask pockets of significant deprivation and poor health outcomes.

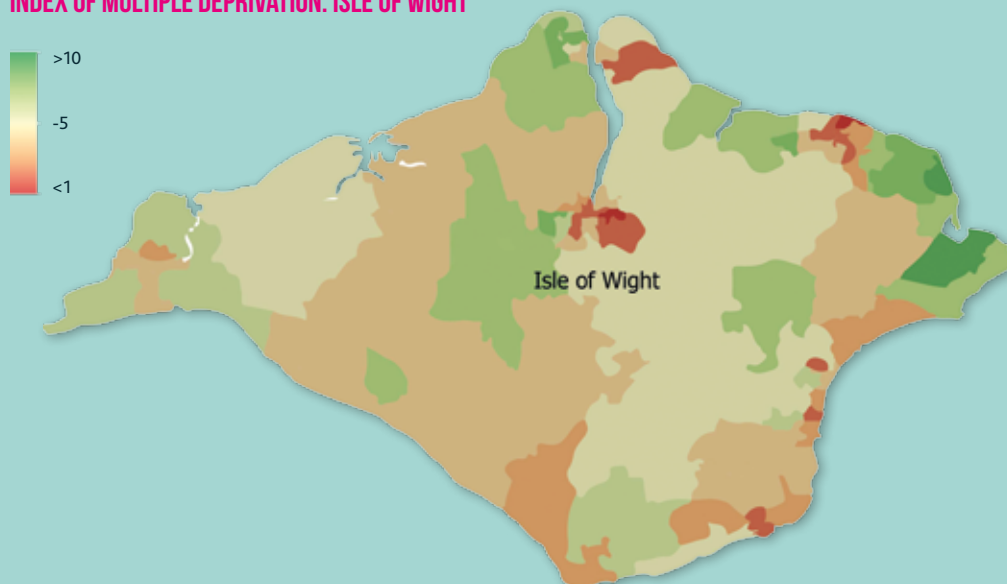
The Office of National Statistics (ONS) defines areas as rural if they fall outside settlements with more than 10,000 residents [4]. Based on the 2016 census, only one area in the Isle of Man, Douglas, has a population in excess of 10,000 [5]. The rest of the island would be classified as rural. This means that using a geographical approach to identifying deprivation and tackling inequalities may not be appropriate for the majority of our population.

We do not currently have the methodology to create the 'small area units' for the island and we do not routinely collect a set of indicators that would enable us to replicate the geographical approach to deprivation that is routinely done in the four UK nations (examples shown below).

INDEX OF MULTIPLE DEPRIVATION: STORNOWAY



INDEX OF MULTIPLE DEPRIVATION: ISLE OF WIGHT



FOCUSSING ON HEALTH INEQUALITIES

Reducing health inequalities is essential if we are to deliver Programme for Government objectives that we lead longer, healthier lives and that we are tackling the inequalities in our Island society^[6]. It is also a matter of fairness and social justice which requires action across all the socio-economic determinants of health. Indices of Multiple Deprivation based on small geographical areas are useful for targeting policies and funding to address inequalities in urban contexts but on-Island they may only be useful for larger urban areas, particularly Douglas.

There are other ways of analysing the distribution of health outcomes by socio-economic factors. In our 2018 annual report looking at childhood healthy weight, we discussed evidence from elsewhere to show that the prevalence of obesity in children is correlated with household income – children from the poorest households have higher levels of obesity^[7].

HAVING AN INADEQUATE INCOME CAN LEAD TO POOR HEALTH BECAUSE:



Struggling to make ends meet causes stress and takes away the sense of being in control of one's life. Growing up in poverty can have long term consequences for health. People living with chronic stress may use unhealthy behaviours (smoking, over-eating, drinking too much alcohol, using drugs, or gambling) as a coping mechanism^[8]



Low income makes adopting healthy behaviours difficult. For example, it is around three times more expensive to get the calories we need from healthy foods (fresh foods, vegetables, fruit) than it is from unhealthy foods (highly processed food, high sugar/salt/fat foods)

Low income makes it difficult to access the experiences and material resources that enable people to participate in their local community or wider society



People who feel overwhelmed with debt and/or the lack of a financial safety net find it difficult to make life plans that could improve long term prospects (e.g. deciding to study or retrain)^[9]



Measures that could indicate the proportion of people on-Island with low income would include entitlement to means tested benefits and those on below average incomes. However, low income is not quite the same thing as poverty, as individuals and households may have very different costs to cover such as childcare, housing, managing a chronic illness or disability and they may have different levels of additional resources (such as savings or other assets) that they can draw on. An income that could be adequate for a single older person could be very inadequate for a family with young children^[10]. This means that the experience of poverty can vary over an individual's life course, even if their income remains reasonably steady. For some people, poverty will be transient, whereas for others it may persist for many years regardless of their stage in the life course. Employment status is not a good indicator of income, although unemployment is related to poorer health outcomes (an association which remains after allowance for income and other measures of deprivation)^[11].

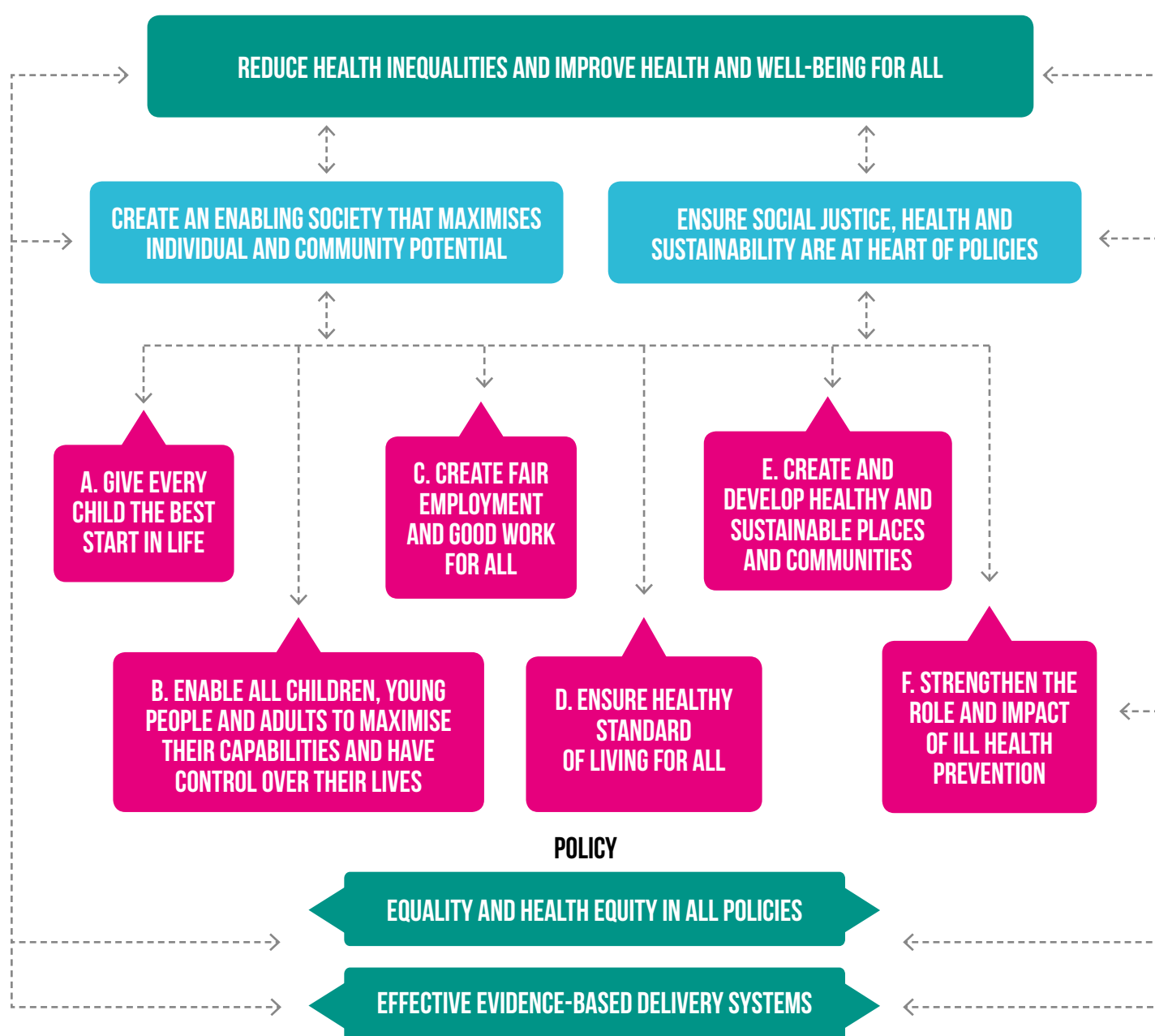
EVIDENCE-BASED STRATEGIES TO REDUCE HEALTH INEQUALITIES

The correlation between socio-economic status, environment and health and wellbeing has been well documented over many years ^(v). Effective interventions to reduce inequalities have been less well understood. In 2008, the Secretary of State for Health commissioned an independent review to propose the most effective evidence-based policies for reducing health inequalities in England from 2010. The review included not only identification of evidence to support policies but also consideration of how the evidence could be translated into practice. The resulting report *Fair Society, Healthy Lives* (known as the Marmot Review, after the chair of the working group, Sir Michael Marmot) was published in 2010 ^[12].

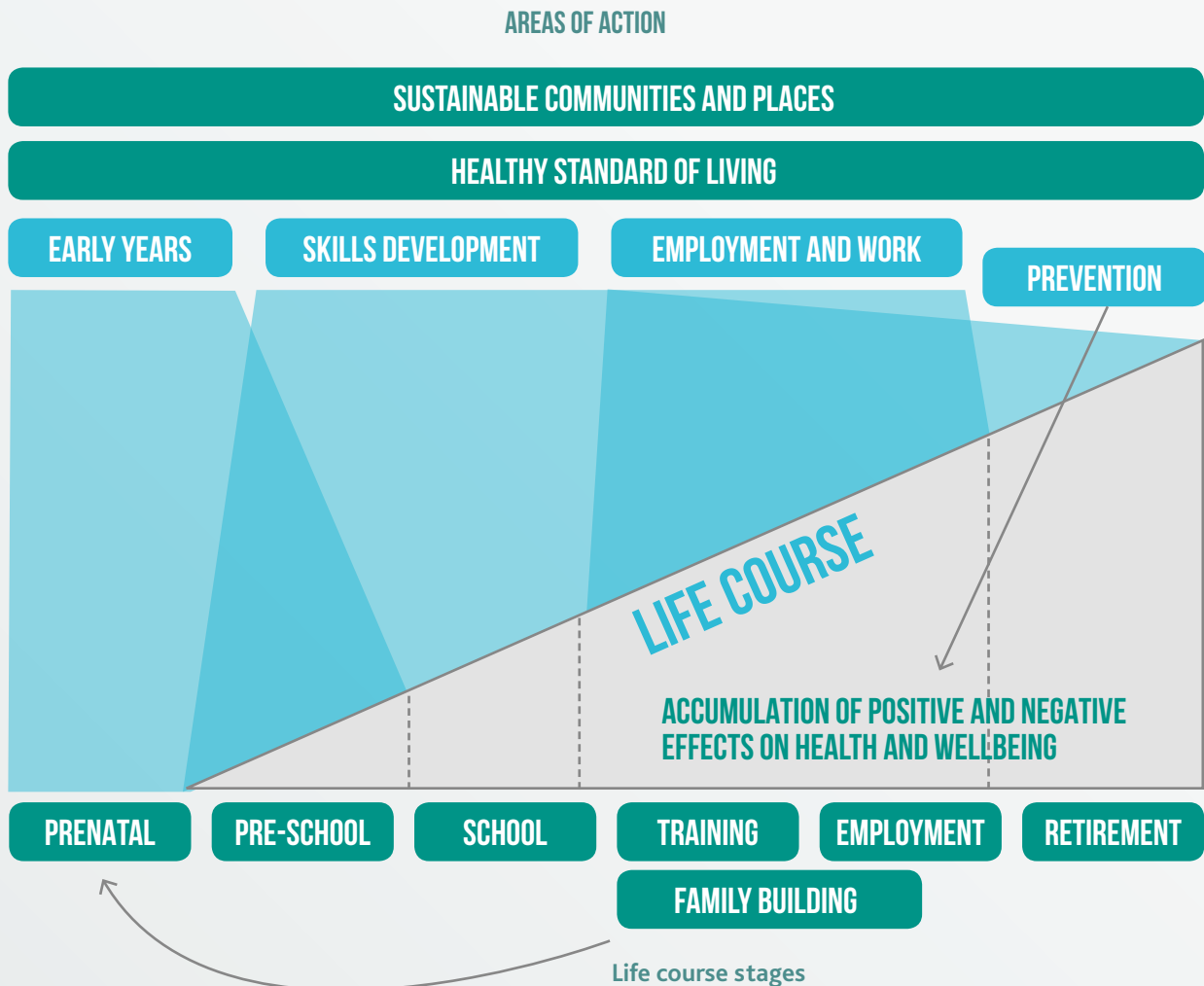
The evidence assessed by the Marmot Review led to the development of a framework for developing and delivering policies to reduce inequalities (shown in Figure 2) and demonstrated how this would require action across the life-course by all government departments (shown in Figure 3).

FIGURE 2:

MARMOT REVIEW – THE CONCEPTUAL FRAMEWORK



(v) Landmark reports over the past 40 years include The Report of the Working Group on Inequalities in Health, known as the Black Report after the working group chair (Sir David Black, president of the Royal College of Physicians), commissioned by the UK Department of Health and Social Security in 1980 and available at: Townsend P, Davidson N, Whitehead M (eds). *Inequalities in Health: The Black Report*; The Health Divide. London: Penguin Books, 1992; and the subsequent Independent Inquiry into Inequalities in Health (The Acheson Report) commissioned by the Secretary of State for Health and published in 1998 (available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/265503/ih.pdf)

FIGURE 3:**MARMOT REVIEW — ACTION ACROSS THE LIFE COURSE**

The evidence reviewed showed clearly that reducing health inequalities is not just about targeting healthcare services or health improvement initiatives in areas where there is deprivation or poverty – action to address social inequalities is essential.

THE MARMOT REVIEW IDENTIFIED SIX POLICY AREAS FOR ACTION:

- Giving every child the best start in life
- Enabling all children, young people and adults to maximise their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing healthy and sustainable places and communities
- Strengthening the role and impact of ill health prevention

“REDUCING HEALTH INEQUALITIES IS NOT JUST ABOUT TARGETING HEALTHCARE SERVICES OR HEALTH IMPROVEMENT INITIATIVES IN AREAS WHERE THERE IS DEPRIVATION OR POVERTY — ACTION TO ADDRESS SOCIAL INEQUALITIES IS ESSENTIAL.”

INDIVIDUALS, FAMILIES AND COMMUNITIES NEED TO BE INVOLVED IN BOTH THE PLANNING AND DELIVERY OF WORK TO DELIVER THESE POLICY OBJECTIVES – ALONGSIDE GOVERNMENT, LOCAL AUTHORITIES, THE THIRD AND PRIVATE SECTORS AND COMMUNITY ORGANISATIONS.

The Marmot review makes it clear that focusing on the most disadvantaged is not enough to reduce health inequalities across the social gradient^(vi) in health. It is unlikely that the gradient can be removed completely but it can be made shallower – as indicated by the variations in steepness of the gradient between regions in England. To achieve this, policies and interventions need to be universal but with a scale and intensity proportional to the level of disadvantage. This has been called 'proportionate universalism'.

There is a lot of work already going on here that addresses these objectives, although it could be clearer, in terms of policy and strategy objectives, and better co-ordinated across government. There are also gaps where we could be doing more.

However, if we are going to understand whether these policies and activities are being effective in reducing health inequalities, we need a set of indicators through which to check that we are addressing the priorities and are able to measure change. The Marmot review proposed the following set of indicators, which have been adopted by local authorities across England:

HEALTH OUTCOME INDICATORS:

- Life expectancy at birth (Male, Female)
- Healthy life expectancy at birth (Male, Female)
- Inequality of life expectancy at birth (Male, Female)
- Inequality of disability-free life expectancy (Male, Female)
- People reporting low life satisfaction

GIVING EVERY CHILD THE BEST START IN LIFE

- Children achieving a good level of development at age 5
- Good level of development at age 5 with free school meal status
- GCSE achieved (5 A*-C including English and Maths)
- GCSE achieved with free school meal status
- Young people (19 to 24 years old) who are not in education, employment or training (NEET)

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

- Unemployment (ONS model-based method)
- Long term claimants of Jobseeker's Allowance
- Work-related illness
- People in households in receipt of means-tested benefits
- Slope index of inequality for people in households in receipt of means-tested benefits

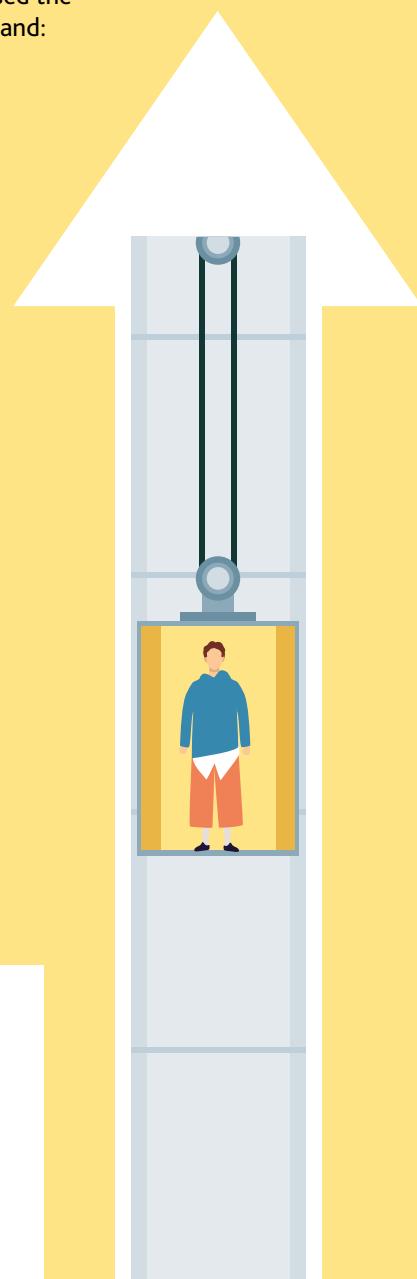
ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

- Households not reaching Minimum Income Standard
- Fuel poverty for high fuel cost households

CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

- Utilisation of outdoor space for exercise/health reasons

(vi) The slope representing the differences in outcomes from the most deprived to the least deprived



The indicators were chosen on the basis that they were already being produced for local areas and therefore additional work to collect, analyse and publish additional indicators was avoided.

There are some indicators, available at UK level, which have not been included. In particular, these include the poverty indicators:

- People in relative low income – living in households with income below 60% of median in that year; and
- People in absolute low income – living in households with income below 60% of median in a specified base year, usually 2010/11.

There are also indicators which report the number of children, pensioners or working age adults (with and without children) living in low income households ^[13].

The Social Metrics Commission (an independent body working on a new approach to poverty measurement) has developed a new measure which takes account of differences between households in costs such as childcare and disability or access to savings. The UK Department of Work and Pensions is developing experimental statistics based on the Social Metrics Commission measure and these will be published in 2020 ^(vii).

Three-quarters of English local authority Health and Wellbeing Boards use the Marmot Principles and indicators to shape and drive their work to improve health and reduce inequalities. It is now nearly ten years on from the publication of the Marmot Review and over six years since the establishment of Health and Wellbeing Boards. Work is underway to produce a 'ten years on' assessment of the impact of the review ^(viii).



**“CURRENTLY WE DO NOT HAVE
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DO WE CURRENTLY HAVE ANY MEASURES OF HEALTH INEQUALITY THAT ARE ROUTINELY PUBLISHED ON THE ISLE OF MAN?

Currently we do not have a comprehensive dataset to enable us to understand the distribution of either health outcomes or socio-economic factors across our population.

Of the indicators listed previously (many of which are statutory in the UK nations), we currently routinely publish:

- Male life expectancy at birth (first published as part of the IOM PHOF 2017, updated August 2019)
- Female life expectancy at birth (as above)
- Male healthy life expectancy at birth (published as part of PHOF 2019)
- Female healthy life expectancy at birth (as above)
- People reporting low life satisfaction (included in PHOF, from lifestyle survey data)
- Utilisation of outdoor space for exercise/health reasons (PHOF, from lifestyle survey data)
- GCSE achieved (including maths and English) (published in Isle of Man in Numbers 2019)
- Unemployment rate (using the International Labour Organisation methodology, Isle of Man in Numbers 2019)

The indicators we currently have are inadequate for us to understand inequality, poverty and deprivation on-Island, how this relates to health outcomes and how policies and interventions are impacting on these.

“THE INDICATORS WE CURRENTLY HAVE ARE INADEQUATE FOR US TO UNDERSTAND INEQUALITY, POVERTY AND DEPRIVATION ON-ISLAND, HOW THIS RELATES TO HEALTH OUTCOMES AND HOW POLICIES AND INTERVENTIONS ARE IMPACTING ON THESE.”



(vii) See: <https://www.gov.uk/government/news/new-poverty-statistics-developed-to-help-government-target-support>

(viii) Further information about the Marmot Review, indicators and networks for delivering work to reduce inequalities at global, national and city level can be found here: <http://www.instituteofhealthequity.org/home>

CONCLUSION AND RECOMMENDATIONS

HEALTH INEQUALITIES ARE THE RESULT OF SOCIO-ECONOMIC INEQUALITIES AND ACTION TO REDUCE THEM NEEDS TO BE ACROSS ALL THE WIDER DETERMINANTS OF HEALTH. THIS REQUIRES CO-ORDINATED AND SUSTAINED POLICIES AND INTERVENTIONS ACROSS GOVERNMENT, THIRD AND PRIVATE SECTORS AND COMMUNITIES.

We cannot understand how health and social inequalities are distributed across our population, or measure the impact of actions to address them until we have a dataset of indicators that will show where we are now and what are the priority issues for action.

As noted previously, the indicators used in England largely draw on those that are already available. We have an opportunity to agree a set of indicators that will be appropriate to the island context (and allow benchmarking/comparison with areas of England). We then need to set up systems to collect the data for these indicators, so this is a project which will require long term commitment and will have a time lag until the full dataset can be available. This work is essential if we are to deliver on the Programme for Government objectives related to inequalities and it will support and strengthen the work around poverty, homelessness, cold and hunger that is already underway. It will also ensure that health outcomes are an integral element in the resulting policies.

As a small island nation, we have an extraordinary opportunity to co-ordinate social and health policy at all levels to address inequalities, in a way which cannot be done in larger nations.

Based on the evidence presented in this report, we should consider:

- Establishing a high level Board to take strategic and policy ownership of health and social inequalities. This would include political representatives and chief officer level representation across government, the third and private sectors and community organisations. The Board would be responsible for receiving intelligence on health and social inequalities on-Island, evidence of policy and other interventions likely to have an impact, setting strategy and holding to account for delivery and improvement in outcomes. In designing the structure and functions of the Board, good practice and examples of success from English Health and Wellbeing Boards should be taken into account.
- Design and deliver an Isle of Man core dataset to measure inequalities in health and socio-economic status.
- Test the feasibility and usefulness of designing a geographically based Isle of Man Index of Multiple Deprivation, bearing in mind the limitations of this approach for rural populations.
- Explore the potential of working with others to maximise learning relevant to our population. This could include:
 - Working with Public Health England and the Local Government Association to keep up to date with the progress of work to develop a better understanding of deprivation in rural areas;
 - Working with organisations such as the Health Equity Institute (to participate in networks of nations and cities which are applying the Marmot principles as a framework for policy and action), or the Commission for Social Metrics to develop measures of poverty that are most meaningful for our context;
 - Working with the Crown Dependencies of Jersey and Guernsey to share capacity and improve understanding of the specific context of small nation islands.

“THIS WORK IS ESSENTIAL.”

**“THIS IS A PROJECT WHICH WILL REQUIRE
LONG TERM COMMITMENT”**

UPDATE FROM THE 2018 REPORT: CHILDHOOD HEALTHY WEIGHT

PROGRESS ON THE AREAS FOR ACTION FROM THE 2018 REPORT INCLUDE SPECIFIC PROJECTS TO IMPROVE POLICY, SERVICES AND SCHEMES, AS WELL AS A CHILDHOOD HEALTHY WEIGHT STRATEGY THAT WILL GO TO PUBLIC CONSULTATION IN SEPTEMBER 2019, AND WILL BE IMPLEMENTED ACROSS GOVERNMENT ONCE THE RESPONSES FROM THE CONSULTATION HAVE BEEN CONSIDERED.

Three Island-wide goals, around transforming the food and physical environment and encouraging and enabling people to live healthier lives, are at the heart of the new strategy.

GOAL A:

We aim to create a healthy food environment, where people can access healthy meals, snacks and drinks across government settings and across the wider community. The ultimate aim is for the healthy food choices to be the easiest options to access on the Isle of Man.

GOAL B:

We aim to create a healthy physical environment, which supports people to be more physically active. We want to be able to encourage children and young people to travel actively between settings, play in a safer environment, and support any activity to reduce sedentary behaviour during and outside of the school day. The ultimate aim is that being physically active is the norm across the entire Island.

GOAL C:

We aim to enable the population to develop a positive relationship with food and physical activity from birth to adulthood.

Projects have been initiated around the following areas:

- Breastfeeding
- Active Travel
- Extension of the Child Measurement Programme to include year 7
- Commissioning of a multi-component family based weight management programme for overweight children
- Introduction of the Healthy Eating Welcome Scheme by Taste Isle of Man

We look forward to working across government and with the wider community to transform these goals into a reality for a healthier Isle of Man.



UPDATE FROM THE 2017 REPORT: A HEALTHY ISLAND?

The 2017 report presented an overview of health and well-being on the Isle of Man based on local data – the first time this had been done. We have now built on that data to create a standard dataset of indicators that we can regularly update and publish. This forms the Isle of Man Public Health Outcomes Framework (PHOF)(iv), the latest edition of which was published in August 2019. Although we now have better data than we have had before, there are still some key data items that we cannot calculate for the Isle of Man. Many of the missing items relate to the wider determinants of health and well-being (e.g. economic, environmental and educational outcomes).

We know that socio-economic and environmental factors are major drivers of health and wellbeing across the lifecourse so it is important that we develop the PHOF to include these. We will be working with other government departments to expand the PHOF, and our understanding of Island health and well-being, over the coming years.



(iv) available from gov.im/healthdata

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GLOSSARY

NEET – Not in education, employment or training

ONS – Office for National Statistics

PHE – Public Health England

PHOF – Public Health Outcomes Framework

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