THE 2011 **PFIZER HEALTH INDEX**

Working together for a healthier world™

INTRODUCTION

Welcome to the 2011 Pfizer Health Index, now in its sixth year. This study details the findings of a nationally representative quantitative research survey of the health and wellbeing of the Irish population.

In keeping with previous years where we have isolated data to look more closely at specific demographics, this year we have analysed the health and wellbeing of women in Ireland. By introducing specific questions relating to women's health we have built a more detailed picture of the health status of women in Irish society, as rated by themselves.

Working women tend to be a healthier group than any other. 34% believe themselves to be in good health in comparison to just 25% of non-working women, 29% of working men and 31% of non-working men. However 81% of people agree that women tend to put their children's health above their own. Almost 37% of women work in paid employment outside of the home, while the balance 63% do not. Of those women who work about half are full time workers while the rest are part time. Interestingly, 36% of working women are the sole earners for the household.

There appears to be a growing apathy towards improving personal health or lifestyle habits. In previous studies there had been a general enthusiasm for this. For example, in 2005 35% said they intended to get more exercise. This has decreased to 25% in 2011. 22% said they wanted to adopt a more balanced diet in 2005, dropping to 12% in 2011. Those saying they intended to do nothing to improve their health have risen from 14% in 2005 to 34% this year. Coupled with this there has been an increase in the number of people who have drunk alcohol, whether at home or in pubs or bars. 7% more people are drinking in the home while there is a 5% increase in on-trade drinking. Likewise, smoking levels have increased this year with the increase being predominantly seen in the less well off.

When asked about the possibility of introducing universal healthcare access in Ireland as many as 2 in 3 people seemed to be broadly in favour of the concept. This sentiment remains even when including the caveat that income taxes would have to be increased by 1% to fund such a programme, or, as was suggested in the question, about three times the level of current private health insurance premiums.

The recession continues to impact on peoples' concerns and unfortunately health is now lower on that list of priorities. Indeed financial concerns now outrank happiness as a personal priority. Almost half of all households have been affected by the recession either through loss of a job or reduction of salary or work hours. A direct result of this has been the amount of people cancelling their private medical insurance. There has been a reduction of 120,000 (or by four percentage points) in the number of people with health insurance since 2010. Correspondingly there has been a substantial increase in the numbers availing of, or entitled to, the medical card thus placing a greater burden upon state provision. Those without private medical insurance or medical cards account for 23%, or 842,000, of the population.

The Irish population is becoming considerably more financially and money fixated. More than a quarter of people (26%) rate finance and money as their main concerns, representing a notable increase from 21% in 2010. The personal impact of the recession continues to grow with 69% of people confessing they find it much harder to make ends meet which may well have an impact on their health and that of their families. This is an increase by 21 percentage points from 2009. Difficulties in making loan or mortgage payments have increased from 18% in 2009 to 31% in 2011.

As we face into 2012 we must ensure that personal health and access to adequate healthcare services are guaranteed for all members of society and not just the privileged few. While there is much attention paid to current economic difficulties we must remember that the health of the nation is one of our most important resources and must be protected as such.

Yours sincerely,

David Gallagher
Managing Director
Pfizer Healthcare Ireland

HOW THE SURVEY WAS UNDERTAKEN

This report details the findings of the 2011 Pfizer Health Index. This research series has been underway since 2005 and is an important barometer of the health status of the Irish population.

A comprehensive questionnaire is addressed to a nationally representative sample of adults aged 16 and over. Fieldwork was undertaken face-to-face and in-home at 63 sampling points nationwide from 22nd July to 5th August 2011. The survey is designed, administered and reported by Behaviour & Attitudes and the company conforms with ESOMAR, Market Research Society and all other relevant standards and guidelines vis-à-vis data quality and content sensitivity.

In the 2011 study, the data on disease incidences has been presented cumulated with the four preceding years of research. This enables data for diseases to be shown based on a sample of more than 5,000 respondents and reduces the error margin of the data to a very low level.

A specific focus of the 2011 survey was to explore female health and indeed attitudes of women to work, income and raising children.

The broad content of the 2011 Pfizer Health Index matches previous studies and the method of administration and analysis is maintained from year to year, although new topics and focus have been incorporated annually. The 2011 survey updates an important barometer of recession impact, initially included in 2009 and updated in 2010. The data in this survey can be quoted with a degree of statistical accuracy of +/- 3.5 percentage points, although as commented before, the data on disease incidence and impact has an error margin that, at its greatest, stands at 1½ percentage points. All data should be quoted with reference to the Pfizer Health Index 2011 and copyright in the data is retained by Pfizer and Behaviour & Attitudes.

SOCIAL CLASS DEFINITIONS

The market research industry classifies respondents relative to the occupation of the Head of Household. In other words, a working adult, still living in the parental home, will be classified relative to their parents' classification.

A:	These are professional people, very senior managers in business or commerce or top-level civil servants.
B:	Middle management executives in large organisations, with appropriate qualifications. Principal officers in local government and civil service, top management or owners of small business concerns, education and service establishments.
C1:	Junior management, owners of small establishments, and all other non-manual positions.
ABC1's:	All of the above: approximately 39% of the population. Collectively ABC1's are referred to as **middle class**.
C2:	All skilled manual workers and those manual workers with responsibility for other people. C2s are approximately 23% of the population.
D:	All semi-skilled and unskilled workers, apprentices and trainees to skilled workers.
E:	All those entirely dependent on the state, long term, through sickness, unemployment, old age or other reasons. Those unemployed for a period exceeding six months, casual workers and those without regular income.
DE's:	Are approximately 28% of the total population.
C2DE's:	51% of the adult population, and referred to in a group as **working class**.
F:	A separate social grade in Ireland, referring to **farmers and their dependents**. This group has contracted very severely over the past 15 years to about 10% of the population, having been over 20% at one stage.

KEY THEMES IN THE 2011 STUDY

WOMEN'S HEALTH

The 2011 Pfizer Health Index has adopted a particular focus on female health and among other aspects reports a substantial uplift in cervical smear test participation, in line with the greater national prominence of this programme.

Equally, women remain more involved in the medical system, and represent the majority of patients for check-ups and indeed other medical procedures. Likewise they are the gatekeepers of domestic and family health and are universally acknowledged to place their children's health before their own.

Although working may lead some women to postpone first childbirth, it remains starkly apparent that many may be working mainly out of financial need, despite broad agreement that there is a substantial social benefit to working for mothers.

Women are the only group that are in effect availing of STI screening or testing and the study would support the notion that men almost entirely abdicate responsibility for sexual health.

RECESSION IMPACT

There seems to be evidence of a slight but gradual pattern of deterioration in perceived or subjective health, although we know that the levels volunteered in Ireland still surpass those of most other countries. It is hard not to relate this marginal drift to the waning performance of our national economy, the onset of various quite severe recession effects, and a general decline in the national mood.

There is a substantial rise in apathy about attempting to institute changes in personal health routines, and it is difficult not to conclude that many may be in a state of despondency, which may further undermine their actual health.

Smoking and drinking incidences have risen and this has been sharply driven upwards by those on medical cards. Poorer health practices and worse lifestyle habits will exacerbate health system difficulties. This is compounded by an upward spiral of the numbers on medical cards and a profound collapse in the number privately insured.

There is apparent enthusiasm for free universal healthcare access but it is difficult not to conclude that such enthusiasm might be limited by a more fulsome debate of the costs and principles underlying it.

Overall the 2011 Pfizer Health Index underlines the need for greater vigilance and positivity at a time of national weakness, and illustrates starkly that a continuation of current national despondency could prove catastrophic both personally and systemically.

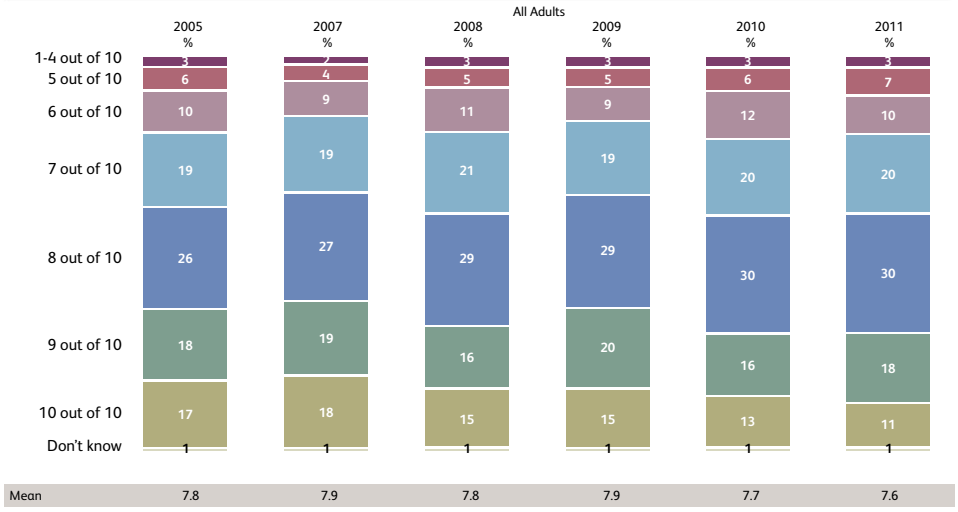
HEALTH IN CONTEXT

PERSONAL HEALTH ASSESSMENT

When asked to categorise or describe the state of their own health, by volunteering a mark out of ten, where ten is excellent and one is very poor, the Irish continue to give themselves very high marks overall. The average result of 7.6 is very marginally lower than the 7.7 recorded last year or the 7.9 the year before. Indeed the results are quite stable from year to year, but there is some slight evidence of a gradual diminution in the proportion with higher scores over time.

Personal Health Assessment
Base: All Adults Aged 16+, 971 / 3,591,000

Q. If you were to assess your own personal health out of 10, where 10 is excellent health and 1 is very poor health, how would you rate yourself?



Patterns broadly similar in 2011 but with a continuing reduction in 9s and 10s and a growth in 1-5s, suggesting a possible trend stretching back to 2005.

What is apparent when focusing closely on the specific results volunteered is that the numbers scoring themselves 10 out of 10, or indeed 9 or 10 out of 10, have consistently reduced since 2007. This marginal pattern of reduction in higher scores is evident across the social grades and the same pattern remains of higher scores being volunteered by those in the younger age groups and lower scores by those over the age of 50 and beyond.

There is equally a long term trend of notably higher subjective perceptions of own health being volunteered by those who indicate that they are not suffering from any of the listed diseases than by those who are. In other words, the 40% who currently suffer with a condition such as arthritis, cholesterol or blood pressure gives themselves a mark out of 10 which is notably lower than adults of similar age or social class who do not suffer with these conditions.

Health Perceptions of Healthy & Unhealthy Compared
Own Health Marked Out Of 10

	2005			2007			2008			2009			2010			2011		
	Unhealthy Group	Healthy Group	GAP	Unhealthy Group	Healthy Group	GAP	Unhealthy Group	Healthy Group	GAP	Unhealthy Group	Healthy Group	GAP	Unhealthy Group	Healthy Group	GAP	Unhealthy Group	Healthy Group	GAP
Total	6.80	8.35	1.55	7.02	8.42	1.40	7.02	8.25	1.23	6.96	8.30	1.34	7.02	8.15	1.13	6.81	8.20	1.39
Men	6.90	8.32	1.42	7.12	8.42	1.30	6.92	8.35	1.43	6.89	8.29	1.40	6.84	8.16	1.32	6.90	8.17	1.27
Women	6.71	8.37	1.66	6.97	8.44	1.47	7.11	8.14	1.03	7.02	8.30	1.28	7.17	8.15	0.98	6.73	8.23	1.50
U25*	7.20	8.57	1.37	7.32	8.75	1.43	7.39	8.49	1.10	7.32	8.48	1.16	7.41	8.35	0.94	7.24	8.33	1.09
25 - 34	6.87	8.38	1.51	7.02	8.24	1.22	7.63	8.19	0.56	7.26	8.30	1.04	7.32	8.01	0.69	6.94	8.19	1.25
35 - 49	6.76	8.21	1.45	7.19	8.40	1.21	6.56	8.06	1.50	6.89	8.22	1.33	6.76	8.00	1.24	6.60	8.18	1.58
50 - 64	6.92	8.20	1.28	7.06	8.33	1.27	7.13	8.24	1.11	6.99	8.41	1.42	7.08	8.29	1.21	6.90	8.07	1.17
65+	6.56	8.18	1.62	6.80	8.14	1.34	6.86	8.89	2.03	6.77	7.63	0.86	6.91	8.62	1.71	6.73	8.18	1.45
ABC1	6.99	8.36	1.37	7.33	8.39	1.06	6.97	8.19	1.22	7.23	8.38	1.15	7.25	8.14	0.89	7.00	8.11	1.11
C2	6.77	8.37	1.60	7.04	8.45	1.41	7.23	8.25	1.02	6.98	8.19	1.21	6.87	8.30	1.43	6.91	8.26	1.32
DE	6.62	8.21	1.59	6.61	8.46	1.85	6.83	8.22	1.39	6.79	8.27	1.48	6.86	7.94	1.08	6.47	8.26	1.79
F	6.80	8.64	1.84	7.07	8.44	1.37	7.36	8.77	1.41	6.64	8.21	1.57	7.06	8.46	1.40	7.17	8.40	1.23
Urban	6.64	8.29	1.65	7.04	8.21	1.17	7.06	8.15	1.09	7.02	8.25	1.23	6.94	7.92	0.98	6.91	8.05	1.14
Rural	7.01	8.43	1.42	6.94	8.70	1.76	6.96	8.43	1.47	6.88	8.38	1.50	7.15	8.51	1.36	6.64	8.44	1.80

The widest gaps between healthy and unhealthy groups are among DE's.

Thus, perceived health is notably lower amongst those with poorer health indications. This is to be expected, but does reinforce the accepted view that there is a strong relationship between actual and perceived health, and indeed a high probability that results volunteered on one (subjective) assessment are highly influential of those given for the other.

HEALTH INTENTIONS

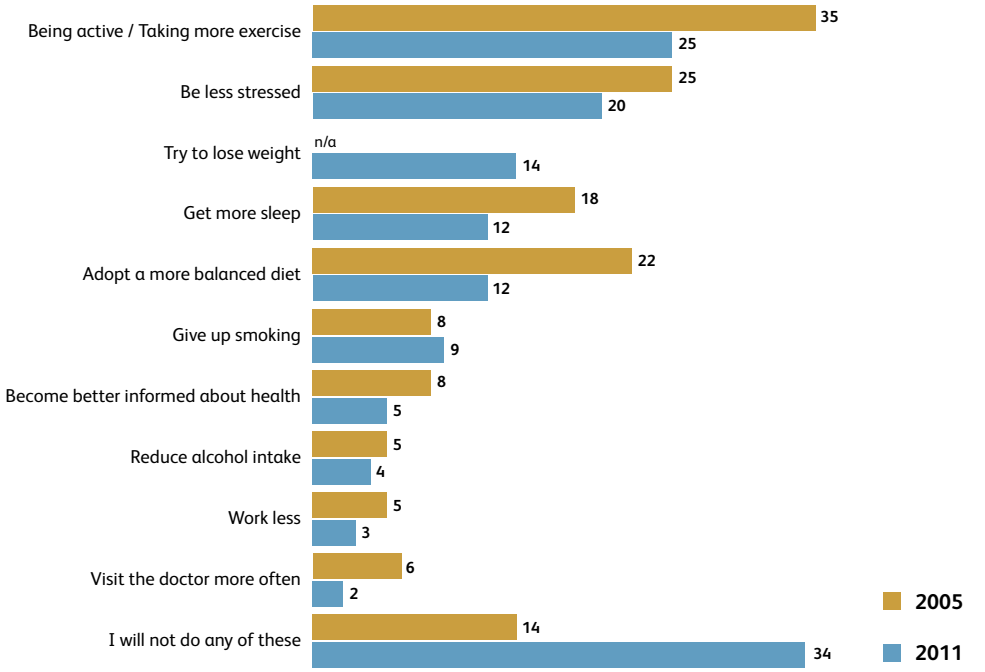
Respondents were asked to indicate the beneficial steps they are likely to take in the next three months in the context of their health or lifestyles. Direct year to year continuity is impinged slightly by the incorporation of a single new category or potential response, "trying to lose weight". This new element is third highest mentioned of ten possible options, but it should be noted that there has been a disproportionate reduction for two of the statements, namely adopting a more balanced diet, being active or taking more exercise. The responses in relation to each of these drop by ten percentage points year on year, while the numbers suggesting that they would like to try and lose weight has emerged as 14% in this first study to include that statement.

The most notable finding in relation to good intentions this year however is the very sharp increase in numbers saying that they don't intend to make any changes. Previously the proportion indifferent in this regard stood at 14%, but this has almost trebled to 34% in the current study. This reduction is presumably related to apathy or indifference, which one suspects may be shaped by the current economic climate and many negative forecasts which appear to be undermining national confidence.

Short Term* Health Intentions

Base: Adults Aged 16+, 971 / 3,591,000

***Likely to do in the next 3 months**



There is a sharp shift in 2011 with many more unlikely to make changes: Comparability diminished with introduction of "Weight Reduction" but significant falls now for sleep, activity and dietary balance.

Health intentions differ markedly by lifestage, with those in middle age and older being much more anxious about remaining active, reducing their stress levels and the adoption of a more balanced diet. Those in the mid 20's to mid 30's are anxious to get more sleep and disproportionately more likely to want to reduce their alcohol intake, in common with those from their mid 20's onwards.

The desire to give up smoking is more apparent from the mid 20's to mid 30's, so it is apparent that the most common desire for younger adults is to eradicate bad habits, whereas many tend to become more weight and diet fixated as they age.

Short Term Health Intentions*
Base: Adults Aged 16+, 971 / 3,591,000

***Likely to do in the next 3 months**

	TOTAL			SEX		AGE					SOCIAL CLASS				AREA	
	2005	2010	2011	Male	Female	15-24	25-34	35-49	50-64	65+	ABC1	C2	DE	F	Urban	Rural
Being active/ Taking more exercise	35	40	25	24	27	25	27	32	23	14	28	27	24	13	30	18
Be less stressed	25	25	20	22	19	11	24	25	24	10	19	23	17	29	21	18
Adopt a more balanced diet	22	21	12	10	13	9	12	17	12	5	14	11	10	8	10	13
Get more sleep	18	23	12	8	16	12	14	13	11	11	13	10	14	9	14	10
Try to lose weight	-	-	14	10	18	6	12	19	18	12	17	13	14	7	16	12
Reduce alcohol intake	5	5	4	6	2	8	7	1	3	1	3	4	5	4	5	2
Give up smoking	8	9	9	10	9	12	9	11	10	4	8	9	13	5	10	8
Work less	5	5	3	3	3	1	2	4	7	2	4	2	2	4	3	3
Become better informed about health	8	9	5	6	4	3	7	5	4	8	6	5	6	-	4	7
Visit the doctor more often	6	4	2	2	2	2	1	3	4	1	3	1	3	4	2	3
I will not do any of these	14	13	34	39	29	41	27	27	30	51	32	30	35	45	28	42

Many younger respondents have no significant health ambitions beyond giving up smoking and alcohol reduction and getting more sleep. Stress, diet and weight come to the fore in middle age.

Clearly, the fundamental concern for the year ahead is to endeavour to boost the positivity and enthusiasm of adults generally, so that they are keen to take the steps necessary to improve their own health. A sustained bout of apathy in relation to health intentions would undoubtedly be damaging to national health status, and would be likely to result in an increase in bad health and lifestyle habits.

HEALTH AS A PRIORITY

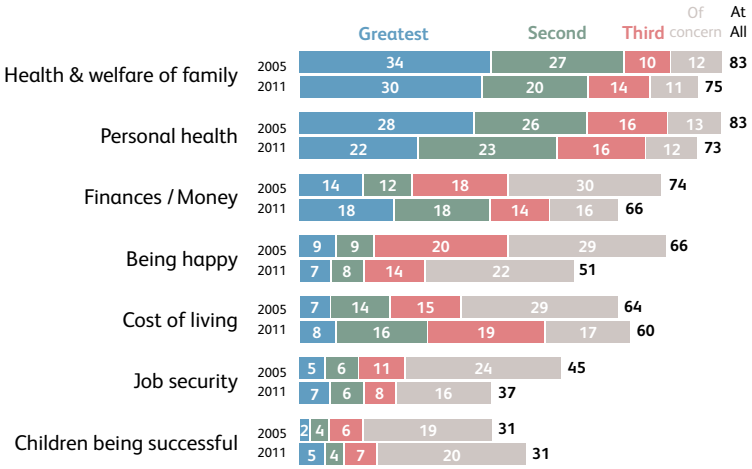
The health and welfare of one's family and indeed one's own personal health remain the greatest personal concerns for Irish adults. These are followed in third place by the prioritisation of finances and money and next by the cost of living.

Happiness used to be considered more important than the cost of living, but has been outstripped by it in recent years. In short, the Irish population is becoming considerably more financially and money fixated, and this is leading to a gradual reduction in the numbers nominating personal health or family health as the core issues for them at present.

Currently almost 1 in 5 indicate that finances and money are the most important thing to them while a further 8% suggests that the cost of living is their key concern. Together more than a quarter (26%) are similarly fixated on things financial, whereas this level stood at just 21% a year ago.

Ranking of Personal Concerns, 2005 vs 2011
Base: Adults Aged 16+

"Thinking about the future, which of the following concerns you most etc...?"



Broad priorities are consistent, but prioritisation of happiness has sharply reduced.

As has always been the case, women and those in the middle aged range tend to be more concerned about family health, whereas personal health becomes a greater concern as we age.

The central focus which is placed on finances and money, or indeed upon the cost of living, is most in evidence under the age of 50 and has increased in the core family lifestages.

Greatest Personal Concern X Demographics, 2011
Base: Adults Aged 16+ - 971 / 3,591,000

		SEX		AGE					SOCIAL CLASS				AREA	
	Total	Male	Female	-24	25-34	35-49	50-64	65+	ABC1	C2	DE	F	Urban	Rural
Base:	971	485	486	165	193	270	202	141	433	232	235	71	600	371
	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Health & welfare of family	30	25	35	19	25	36	39	25	34	27	25	37	30	30
Personal health	22	23	22	14	12	17	28	49	17	24	25	36	18	29
Finances / Money	18	18	18	23	22	21	12	9	16	15	23	16	18	18
Job Security	7	11	3	10	13	6	4	-	9	6	6	1	8	4
Cost of Living	8	8	9	12	9	9	7	5	9	9	8	3	9	8
Being Happy	7	7	8	16	12	3	3	6	10	7	6	1	9	5
Children being successful	5	5	4	3	6	6	5	4	3	8	5	3	6	4
Nothing / DK	2	3	1	4	1	*	3	2	1	3	2	3	2	2

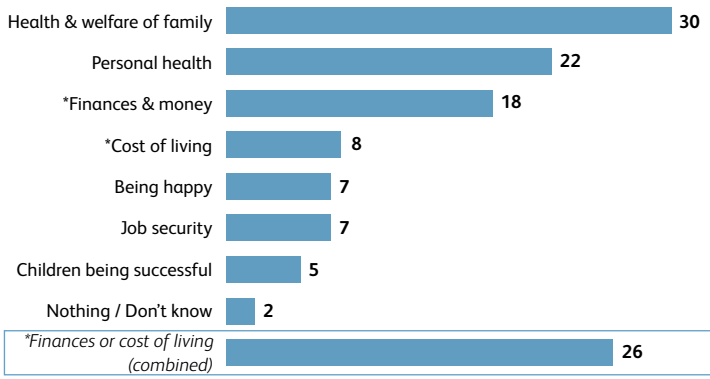
Attitudes are reasonably consistent but with health an older concern and money largely younger.

When relating one's key concerns to the prevalent economic climate, it becomes apparent that for those where there has been domestic job loss that money, finance and the cost of living have become much greater issues. Their prioritisation of personal or family health has been somewhat relegated by these new financial realities and worries.

Thus, the Pfizer Health Index demonstrates a clear link between the reduction of focus on one's personal or family health and its replacement with a heightened focus on monetary aspects. It evidently becomes harder to maintain or prioritise a health focus in a straightened economic environment.

Key Concern by Recession Impact

Base: 971 Adults Aged 16+, 3,591,000



	Job loss in home (27%)	Work hours reduction in home (27%)	Salary reduced in home (37%)
Health & welfare of family	25	33	36
Personal health	17	12	15
*Finances & money	27	21	20
*Cost of living	9	8	7
Being happy	7	6	7
Job security	9	10	8
Children being successful	6	8	6
Nothing / Don't know	1	*	*
Finances or cost of living (combined)	36	29	27

In homes with job loss (and other recession impacts) financial concerns start to outweigh the perceived importance of personal or family health.

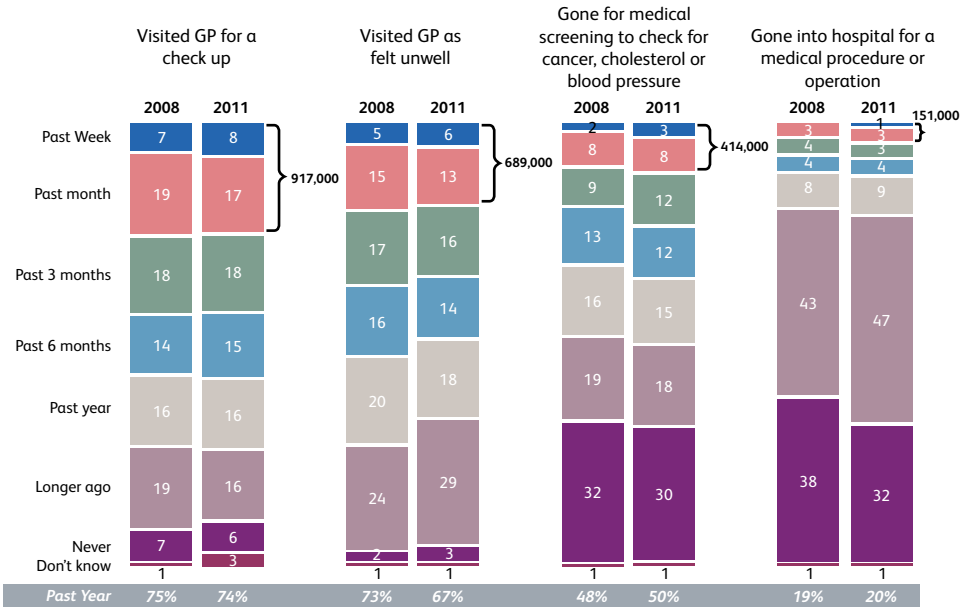
HEALTHCARE SYSTEM INTERACTION AND ITS IMPLICATIONS

VISIT PATTERNS

The broad pattern of interaction with the healthcare system is largely similar to that observed previously, with about a quarter having been to the GP for a check-up in the past month, a fifth to the GP because they were unwell and about 11% having participated in some form of medical screening in the past month.

What is notable is that there is a marginal increase in the numbers having participated in GP visits as a result of not being well in the past week, growing from 5% to 6% overall. Although this increase is not statistically significant, it should be noted nonetheless as there is evidence emerging within the study of both the deterioration in personal health vigilance and of a concurrent increase in bad habits.

Recency of Interaction with Mainstream Medical Services



Similar pattern, but with an apparent uplift in screening and a lift generally at the past week level.

Those who are more likely to go to the GP for a check-up tend to be female and there is a marked concentration in the DE social grades, among those with medical cards and indeed those over the age of 65.

FEMALE AND REPRODUCTIVE HEALTH

Broadly speaking women are more likely to interact with the medical services than men and indeed an element of this must presumably be linked to child birth and reproductive cycles, but more probably is also reflective of greater health vigilance among women than men.

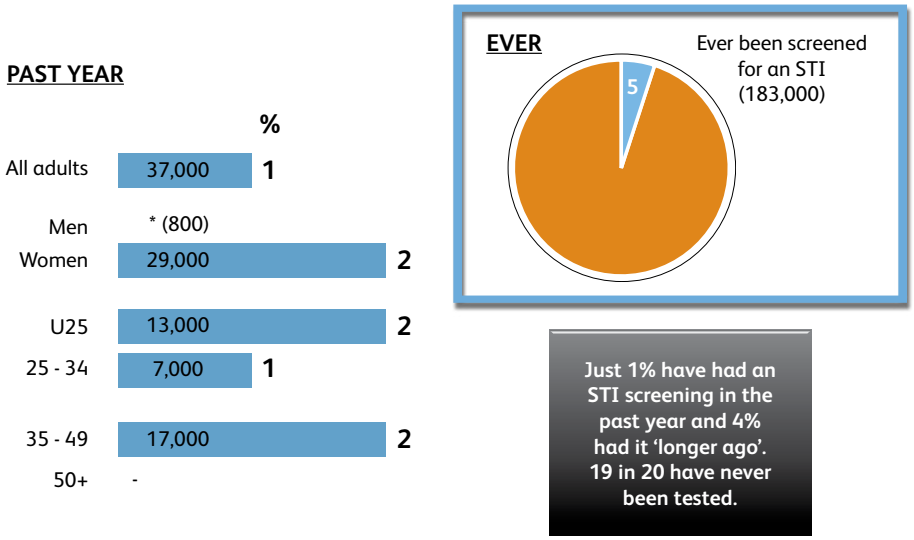
The study also notes that about 19% of women have had a mammogram as part of BreastCheck in the past year, essentially an identical result to that recorded in 2010. In other words, almost 360,000 women, or 30,000 a month are participating in BreastCheck.

Over the same time period, there has been a marked uplift in the number of women who have undergone a cervical smear. The figures recorded in 2010 suggested that 29% of women or 520,000 had taken part, but this has risen by 5 percentage points over the past year to a level of 34% or 623,000.

Thus, almost 8,000 more women per month claim to have undergone cervical smear tests. This may be driven by greater awareness and indeed by the spread of the programme nationwide, but we suspect also relates to broader awareness of issues to do with cervical cancer, in light of the national vaccination programme of teenage girls.

SEXUALLY TRANSMITTED DISEASES

Screening for Sexually Transmitted Infections



No class or regional pattern of note. While we suspect under-reporting, this data suggests that many are ignoring the possibility of STIs.

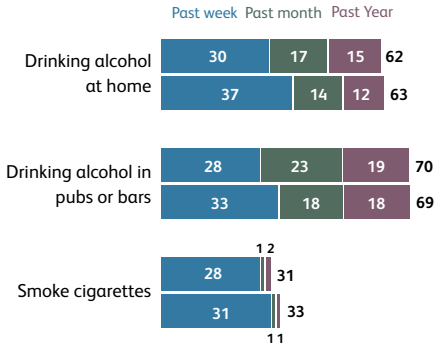
About 5% of all adults indicate that they have ever been screened for a sexually transmitted infection. This corresponds with a figure of about 183,000. Within this group, just 1% indicate that they have been screened in the past year, or a population group of about 37,000. Notably, almost all of the screenings for STIs are indicated by women rather than by men. Corresponding with the conventional wisdom about STIs, there appears to be two peaks, with one under the age of 25 and a second between 35 and 50. These are postulated to stem from 'conventional' sexual activity (i.e. pre-marriage), with the second peak indicative of 'second time-around', thirty and forty something patterns of sexual activity.

VICES

A worrying aspect in the current study is the increase in the numbers indicating that they have drunk alcohol either at home or in pubs and bars over the past week. There is a 7% increase in the incidence of past week domestic drinking, and a 5% increase in incidence of past week on-trade drinking. Either shift is of statistical significance.

Over the same time period, there has been an increase by 3 percentage points in the numbers who claim to smoke cigarettes. 31% now smoke in comparison with just 28% before. While this increase is not statistically significant, there would be substantial basis for worry as it moves in tandem with an increase in the incidence of alcohol drinking, and a growth in general despondency about health as the recession starts to intensify.

Vices



Vices Past Week x Demographics								
Total	Gender		Health Status			Medical Funding		
	Male	Female	Good	Average	Poor	Med Card	Private Insurance	Neither
%	%	%	%	%	%	%	%	%
30	31	29	24	33	30	23	34	41
37	42	33	38	37	39	32	40	42
+7	+11	+4	+14	+4	+9	+9	+6	+1
28	35	21	26	29	31	26	28	32
33	43	24	32	37	27	28	36	36
+5	+8	+3	+6	+8	-4	+2	+8	+4
28	32	24	21	28	39	33	21	32
31	35	27	25	33	33	38	17	36
+3	+2	+3	+4	+5	-6	+5	-4	+4

Recent drinking, particularly domestically, has risen sharply.
Important to note that this relates to numbers doing the activity (and not to volume).
The privately insured are quitting smoking but the less well off may be taking comfort in it.

It is apparent that the increase in weekly domestic alcohol drinking noted over the past year is primarily attributable to those who qualify for the medical card. Furthermore, it is also driven more by men than it is by women.

In parallel with this shift we note that the increase in smoking is almost entirely attributable to those on the medical card, whereas there has been a reduction in the incidence of smoking amongst those who have private insurance.

Thus a worry remains that the deepening of the recession is causing certain groups in society to embark upon escapist ill-advised behaviour, which will ultimately be damaging to their health and a further drain upon the healthcare system.

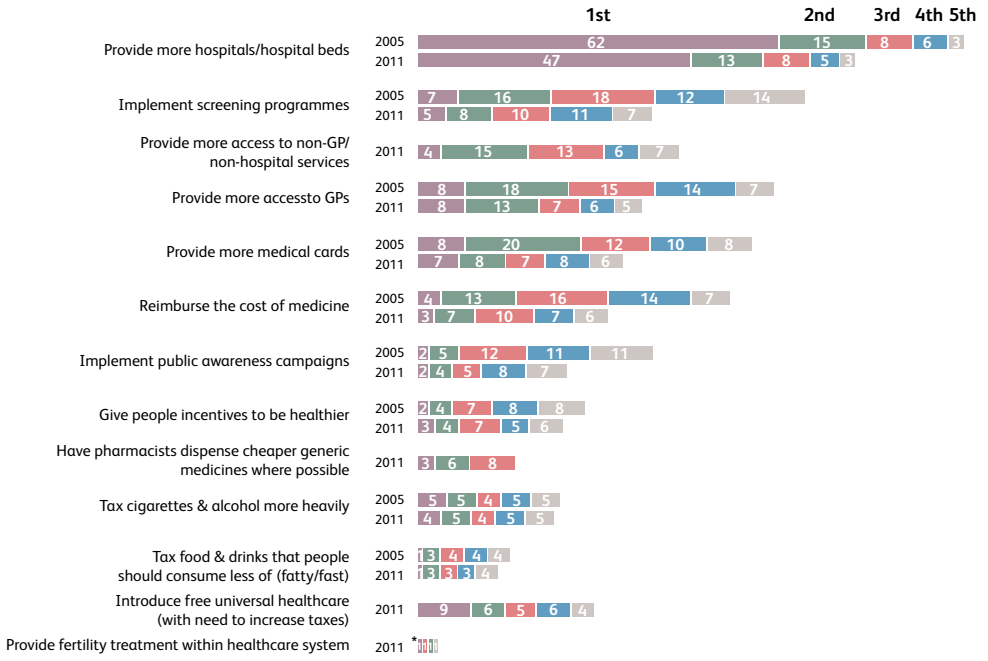
HEALTH REFORM, FUNDING & ACCESS

HEALTH REFORM

Survey participants were asked to prioritise a series of fourteen health related proposals and to indicate the order in which they would approach these were they appointed Minister for Health.

A number of new initiatives have been included in recent surveys and indeed the provision of access to non-GP, non-hospital services, added two years ago, is now ranking in third place on the overall list of priorities.

Prioritisation of Health Issues 2005 - 2011



The introduction of free universal healthcare as an option has significantly shifted priorities.

As has been the long term case the provision of more hospitals or hospital beds remains the overriding number one concern, although the emphasis placed on this has reduced substantially over time. The perceived importance of screening programmes tends to place these in second place while the improvement of access to GPs comes in fourth place after the provision of non-GP, non-hospital services.

Among lower tier priorities, although significant nonetheless, is the view that pharmacies should dispense cheaper generic medicines where possible, suggested by about 1 in 5.

A quite substantial 3 in 10 would place the introduction of free universal healthcare, albeit with the possible need to increase taxes, among their top five priorities.

The taxation of food and drinks which are bad for people is seen as a lower order priority overall. Interestingly, few placed any particular emphasis on the provision of free fertility treatments within the healthcare system. It would seem that such options may be too narrowly pitched or relevant to be of broad interest. A sample which is narrower in age focus and gender may yield a higher interest in such options.

Top 3 Priorities x Age

		GENDER		AGE					CLASS		
	TOTAL	Male	Female	15-24	25-34	35-49	50-64	65+	ABC1	C2	DE
	%	%	%	%	%	%	%	%	%	%	%
Provide more hospitals/more hospital beds	66	65	68	70	59	68	66	70	60	77	69
Provide more access to non-GP/non-hospital services	32	28	36	34	28	33	30	37	34	32	30
Provide more access to GPs	27	27	27	22	28	25	30	32	24	25	31
Implement screening programmes	23	21	26	17	21	27	28	20	26	22	21
Provide more medical cards	22	19	24	31	23	18	19	18	17	26	26
Reimburse the cost of medicines	20	18	23	19	21	20	22	17	20	20	22
Introduce free universal healthcare access for all	20	20	19	19	20	25	18	12	23	19	16
Have pharmacist dispense cheaper generic medicines whenever possible	17	15	19	13	19	18	20	12	20	16	14
Give people tax incentives to be healthier	14	18	10	11	16	13	15	14	17	15	10
Tax cigarettes and alcohol more heavily	13	16	11	16	13	15	8	14	14	14	14
Implement public awareness campaigns	11	13	10	12	8	8	14	15	12	8	11
Tax foods and drinks that people should consume less of (fatty foods/fast foods)	7	8	6	8	6	7	6	6	10	3	4
Provide fertility treatment within healthcare system	3	1	4	3	3	5	1	-	2	4	3

Interest in free Universal Access higher within middle aged and middle class.

When we focus upon the top three issues that the public would like to prioritise, we see that the introduction of free universal healthcare access for all, bearing in mind the probable need to increase taxes, is pitched at about 20% support. This places it in joint sixth place but what is most striking is that it is better supported by those from middle class backgrounds than those from working class backgrounds. It is also in greater demand from those in the family lifestage than in other age categories.

Working class adults place much greater emphasis on the provision of more hospitals or hospital beds whereas middle class adults are relatively more interested in the provision of non-GP, non-hospital services. However, the latter still ranks in second place for them behind the improvement of access to hospital.

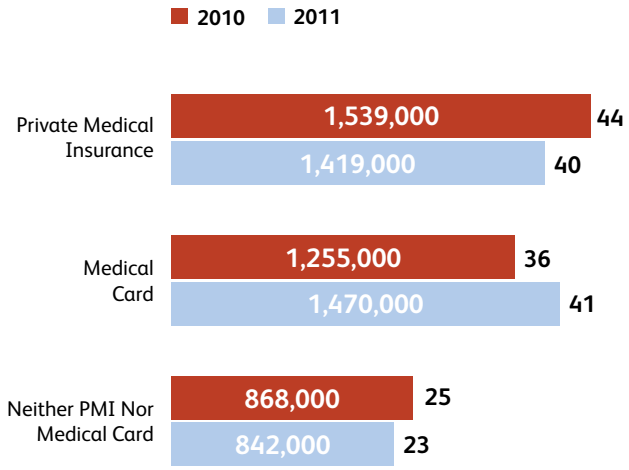
HEALTHCARE FUNDING & ACCESS

STRUCTURAL SHIFTS

Over the past twelve months there has been a profound shift in the underlying structure of healthcare funding in Ireland. This shift has been accelerated by the continuing recession but constitutes a step-change in how healthcare is being paid for or will be paid for in the future.

Firstly, there has been a reduction by about 120,000 in the numbers with private medical insurance. In essence this reduction by about 10,000 per month corresponds with the published figures released by the regulator of health insurance. Nonetheless the figure remains stark, with a reduction from 44% of adults under cover to just 40% in 2011, or a 10% fall-off year on year. The group most likely to have cancelled private medical insurance in the past twelve months are from unskilled working class backgrounds and indeed there has been a halving in their incidence of cover over the course of the year.

Funding Medical Care



	CLASS			
	ABC1	C2	DE	F
	%	%	%	%
2010	64	30	24	43
2011	63	31	13	46
2010	19	39	56	38
2011	21	36	73	37
2010	20	34	25	20
2011	21	37	18	19

There are 120,000 fewer with medical insurance, with most of the fall-off among unskilled/working class adults. A 5% increase in medical card holding (+220,000) is largely DE-driven as well.

By contrast, there has been a substantial increase in the numbers availing of, or entitled to, a medical card this year. 36% had a medical card a year ago and this has risen to 41% now, an increase by almost 220,000 people. Again, these figures have been substantially driven by shifts amongst the unskilled working class and unemployed grades (DE).

The third group of significance is the rough quarter of the adult population that has neither private medical insurance nor a medical card. This group is notable as, by 'falling between two stools', it probably struggles to a greater extent with healthcare funding than others. Prominent here is social grade C2, the skilled working class, mainly the trades people who had been cash rich in the boom time but for whom the property crash has had arguably the bleakest implications.

It is interesting to note that among those with a medical card there is a higher disease instance for each of the substantial conditions recorded, with the exception of osteoporosis, high cholesterol and obesity.

The groups with these conditions are as prevalent amongst the privately insured as they are amongst those with medical cards. However it is important to stress that the group of the population with the highest levels of disease incidence tend to have medical cards and thus place a greater burden upon state provision.

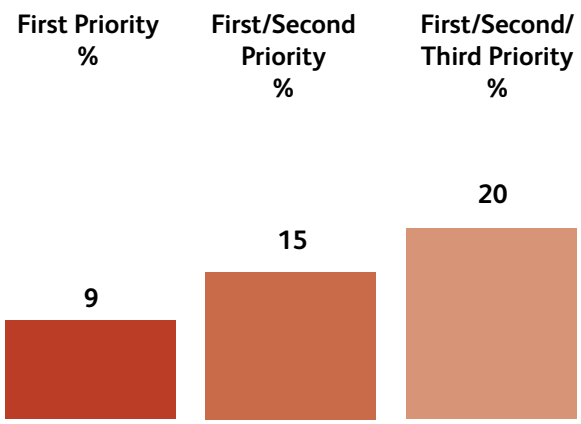
FREE UNIVERSAL HEALTHCARE ACCESS

The possibility of the introduction of free universal healthcare access was examined in two different ways. Firstly, it was evaluated as a possible priority in the context of 13 other healthcare alternatives, with respondents being asked to nominate a first, second and third choice etc.

This having been done, a more direct question about free universal access was also posed.

Prioritisation of the introduction of Free Universal Healthcare Access
(when assessed as one of 13 healthcare priorities)

Q. 6 If you were to be made Minister for Health, could you give me the order in which you would address the following priorities? Only rate those you feel you would want to address. Option: introduce free universal healthcare access for all bearing in mind the probable need to increase taxes.



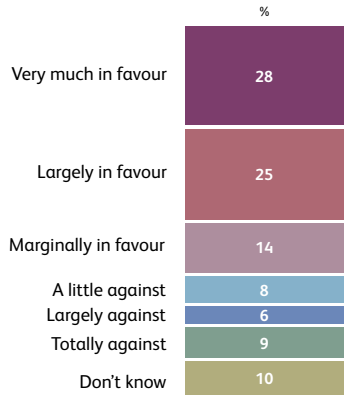
Higher prioritisation among middle aged and middle class but particularly by those who have neither private insurance nor a medical card.

Turning to the initial introduction to the issue, we note that as many as 1 in 5 would regard its introduction as a top three priority for them. Just 9% made it a first priority while for 15% it is their first or second choice out of twelve alternatives.

While this might not seem demonstrably that high, it is striking that as many as 2 in 3 adults claim to be broadly in favour of the principle of introducing free universal access to healthcare, even though it would increase income tax rates by an average of about one percentage point.

Attitude to Free Universal Access to Healthcare

Q. 13 At present there is discussion of introducing free universal access to healthcare, including free hospital and GP visits, for all. This is likely to cost about three times the average level of private medical insurance premium and might necessitate a general increase in income tax of about 1%. Would you be broadly in favour of or opposed to this change?



Attitudes don't differ significantly by demographics although those in poorer health, or who have neither private medical insurance nor a medical card, are the most supportive of the idea. Thus while there is broad support we need to balance this against just 1 in 5 picking it as one of their Top 3 Health priorities.

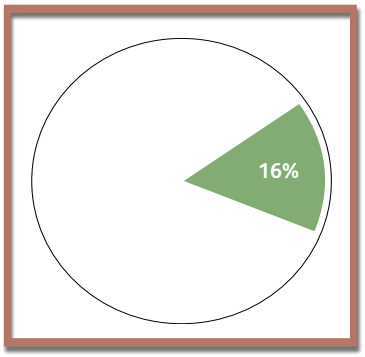
In the same context, about 1 in 4 would be opposed to this introduction in principle, so there would seem to be ostensibly broad support for the concept. However, it is likely that the full intricacies of the change have not been thought about in great detail by people, and that attitudes might shift when a more focused debate on universal healthcare access takes place.

RECESSION IMPACT

RECESSION IMPACT

As many as 16% of the adult population indicate that they now suffer from stress related difficulties as a result of workplace or financial concerns. Such stress is more apparent with those who have experienced job loss in their own home, for those who are parents, and for adults aged between 25 and 49. The lower social grades are somewhat more stressed in this regard than others. Women equally, whether working or not, tend to be a little more likely to admit to such stress than men.

Experience of Stress Related Difficulties as a Result of Workplace or Financial Concerns



Almost one in six claims to feel stress related to money or work issues at present

Higher for:

Job loss in home	29%
Parents	21%
35 - 49 year olds	22%
25 - 34 year olds	19%
DEs	19%
Working Women	18%
Non-Working Women	17%

(these figures are for stress in the relevant group, as opposed to the 16% average)

One in six have money or work related stress but the incidences of these are considerably more pronounced for those in the core family stage, or for those living in a home that has experienced recession-related job loss.

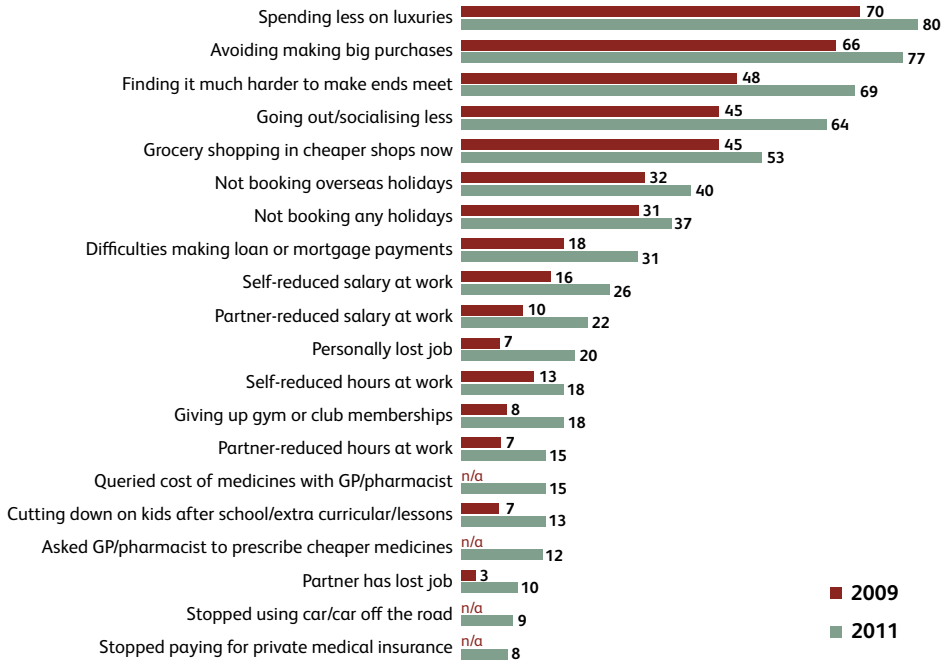
There has been a substantial shift in recession related cut-backs and changes in consumption behaviour over the past two years. 7 in 10 now indicate that they are finding it much harder to make ends meet, an increase by almost 20 percentage points over two years. 31% now admit that they are having difficulties with mortgage or loan repayments, in comparison with just 18% two years ago.

Up to 1 in 5 claim that they have now lost a job as a result of the recession, in comparison with a figure of just 7% two years ago.

Some interesting findings not measured in the previous studies show that 15% now indicate that they are querying the cost of medicines with their GP or pharmacist as a result of the recession. 1 in 8 have asked the GP or pharmacist to prescribe cheaper medicines for them and as noted earlier, almost 8% indicate that they have stopped paying for private medical insurance. Taken as a proportion of those currently under cover, this suggests that up to 20% of the market for private cover has evaporated since the onset of the recession.

Personal Impact of Current Recession – 2009 & 2011

Base: 971 Adults Ages 16+, 3,591,000



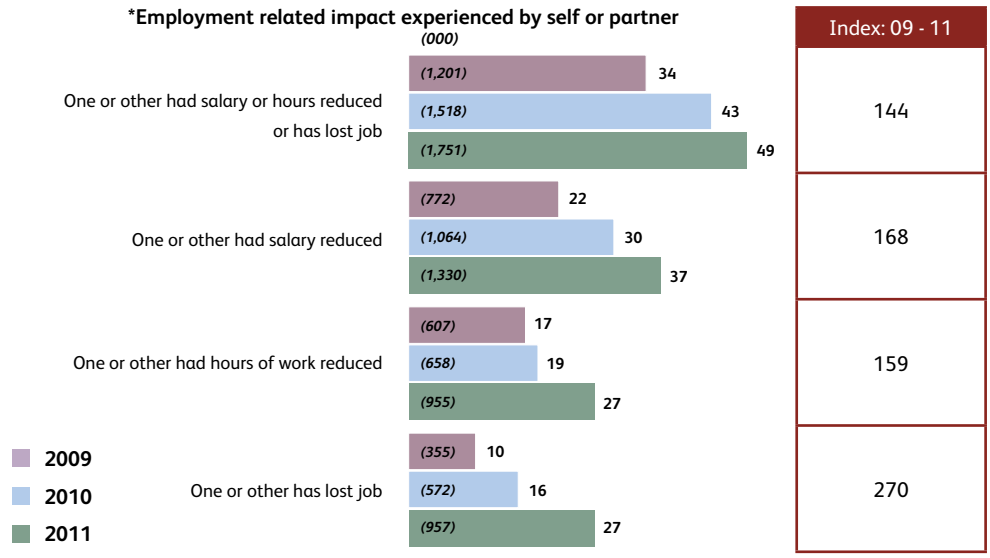
The really sizeable shifts over two years relate to making ends meet and socialising, but the numbers who have lost jobs has trebled (to a fifth) and almost one in three are having problems making repayments

The results show that almost half of the sample has been affected by the recession i.e. have lost a job or have had their salary or work hours reduced. This measure, unique to the Pfizer Health Index, which we call 'profound recession impact', has by now affected half of all homes, in comparison with just 2 in 5 last year and a third in 2009.

The rate of increase of job loss over the past twelve months is quite palpable, although this may run slightly contrary to the published job loss data as issued by the CSO. It is worth pointing out at this juncture however that other surveys illustrate that about 40% of those who lose their jobs remain out of work for a year or more, and the discrepancy between the Pfizer Health Index data and that published by the State may be explicable by the proportion regaining employment in the interim, although perhaps often in jobs not commensurate with their qualifications or experience.

Fundamental Recession Impact*

Base: 971 / 3,591,000 Adults Aged 16+



49% now live in a home with 'a fundamental recession impact', a rise by 233,000 year-on-year.
A quarter of homes have experienced job loss and a quarter work hours reduction.
The overall acceleration and breadth of impact may be slowing but job loss impact is huge.

Looking at the change in recession impact over a two year period, a worrying analysis emerges which illustrates a faster increase in recession impact upon those who are in poorer health. In other words, the rate of increase of individual recession factors has been more significant for those who are in average or poorer health, whereas it has escalated more modestly for those in better health. Some of this may relate to age and so forth but it is hard not to conclude that working and economic prosperity is better for one's health.

2 Year Actual Change in Recession Impact x Health Status

Base: 971 / 3,591,000 Adults Aged 16+

N.B. percentage point change not rate of change

	ALL ADULTS	HEALTH STATUS		
		Good Health	Average Health	Poor Health
Much harder to make ends meet	+21	+14	+23	+24
Going out/socialising less	+19	+9	+24	+20
Partner-reduced salary at work	+15	+13	+15	+18
Personally lost job	+13	+10	+14	+13
Self-reduced salary at work	+13	+13	+14	+5
Difficulties making loan or mortgage payments	+13	+9	+14	+13
Avoiding making big purchases	+11	+10	+12	+8
Spending less on luxuries	+10	+10	+10	+12
Giving up gym or club memberships	+10	+8	+11	+16
Not booking any holidays	+9	+5	+10	+12
Grocery shopping in cheaper shops now	+8	+8	+7	+6
Partner has lost job	+7	+4	+9	+7
Cutting down on kids after-school or extra curricular activities or lessons	+6	+2	+8	+8
Partner-reduced hours at work	+5	+1	+4	+11
Not booking overseas holidays	+5	-1	+7	+9
Self-reduced hours at work	+2	-4	+4	+7

There may be no clear impression that recession impact and health status are related but there is an apparently steeper escalation of impact for those with poorer health status, while those in better health see more marginal growth in impact.

WOMEN'S HEALTH & LIFESTYLE

INCOME & GENDER

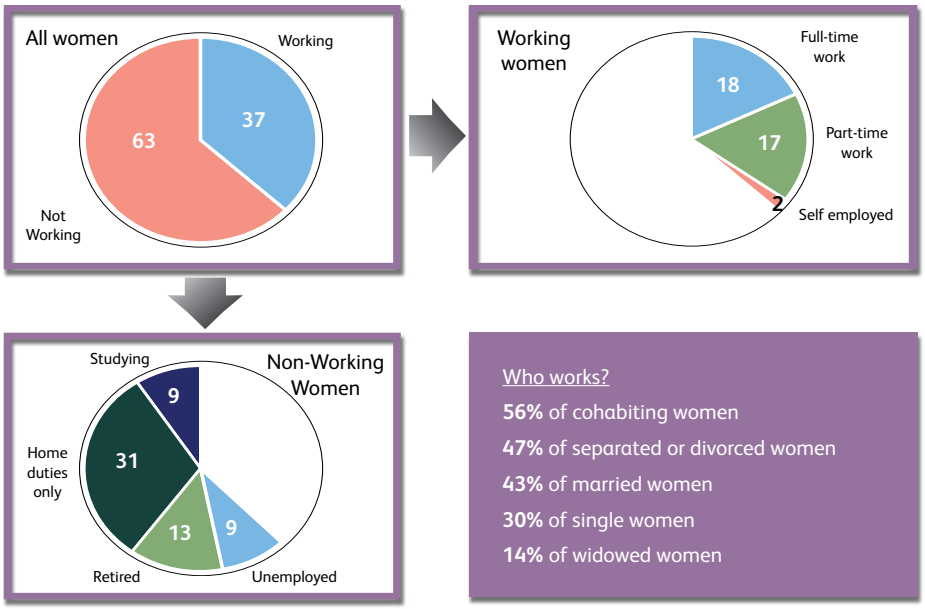
CHARACTERISTICS

Focusing on the female half of the sample, we note that 37% of women work in paid employment outside the home, and the balance of 63% do not.

The greatest proportion describe themselves as full time housewives or carers, with 9% of all women studying and 9% currently unemployed. In other words, 9% of the female population, or about 4.5% of the full adult population, are currently unemployed women. Taking the current rate of unemployment at 14% roughly we can see that unemployed women make up a smaller proportion of those seeking work than do men.

Looking at working women by hours worked in a typical week, we note that half of them (or 18% of all women) are classifiable as full time workers and the balance, 17% as part time workers.

An Overview of Womens' Paid Work Status



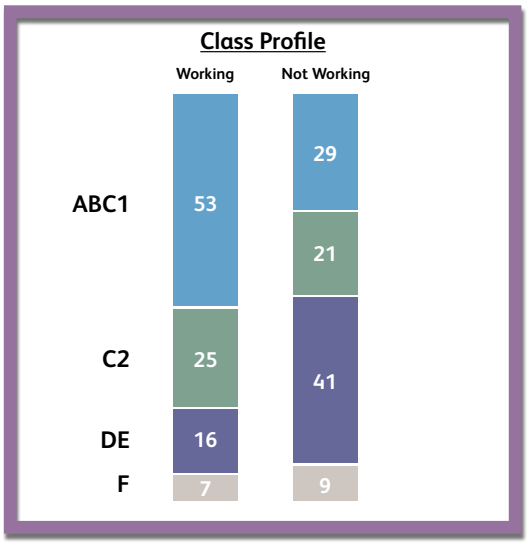
There are slightly more full time than part time working women.

Women who work are significantly more likely to be co-habiting, separated or divorced, whereas single or widowed women are substantially less likely to work. About 43% of married women work for payment outside the home.

Focusing upon the distinctions between working and non-working women, we note that more than half of women who work outside the home are from what are classifiable as middle class, ABC1 backgrounds. In contrast, 41% of non-working women are from DE backgrounds and as many as 62% are from C2 or DE backgrounds, whom we classify as working class. Thus there is a very strong class correlation in respect of working outside the home. For whatever reason, the majority of working women tend to be from the better educated middle class group, whereas the majority of non-working women tend to be from the more poorly educated working class group.

If working outside the home is symbolic of female emancipation it remains a primarily middle class phenomenon.

Class Profile of Working and Non-Working Women



Working women are considerably more likely to be middle class, while non-working tend to be working class.

36% of working women are the sole earners for their household.

Working women are marginally more likely to have children at home than non-working women (**46%** versus **43%**)

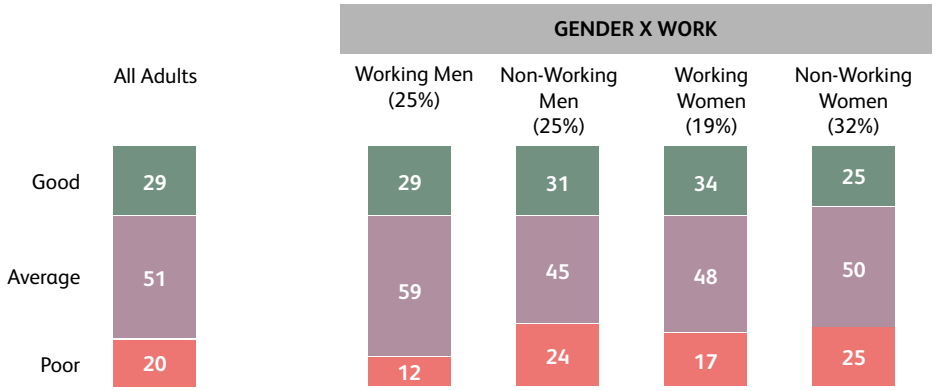
It is also worth pointing out that working women are marginally more likely to have children than non-working women, although the difference is comparatively slight at 46% vs 43%.

Furthermore, slightly more than a third of working women (36%) indicate that they are the sole income earners for their own households.

Analysing the male and female population by work status illustrates some interesting insights. Working women tend to be a much younger group on average than working men, presumably because many working women may give up working as they age and with the arrival of children.

Perhaps it should not be surprising that working women tend to be a substantially more healthy group on average than others. Their perceived health status is notably higher than that of non-working women and indeed it also surpasses that of either male group, whether working or not.

Personal Health and Work Status

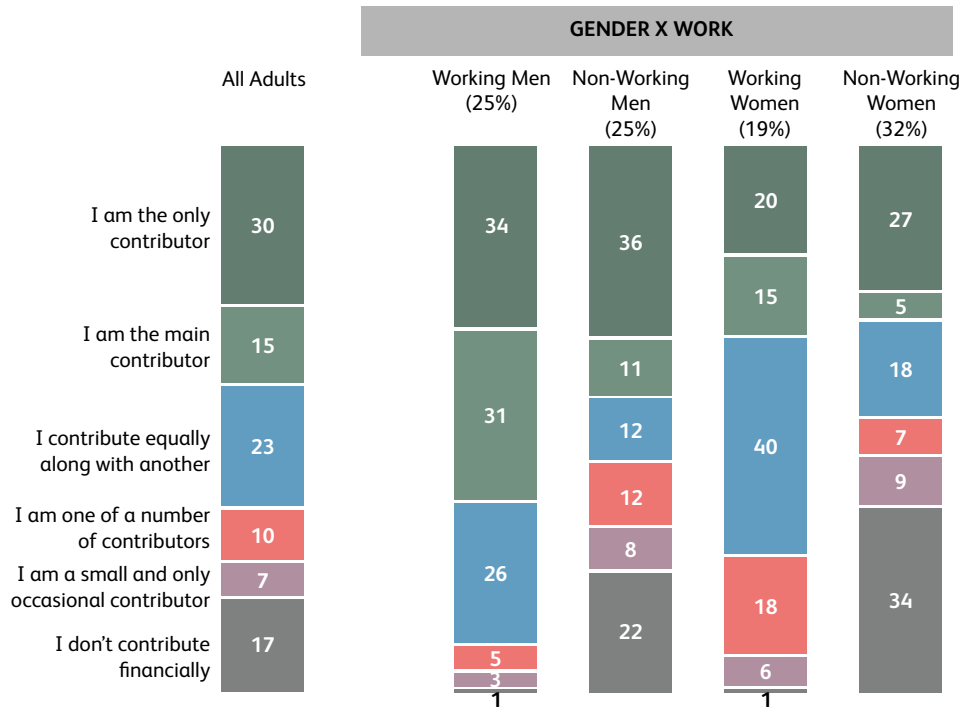


Working women, probably for age and social class based reasons, are effectively the group in best health, while non-working women are the less likely to be well

INCOME AND DOMESTIC CONTRIBUTION

Turning to look at income earned by male and female groups, it is notable that there is only a slight difference in whether one contributes to the household finances or not between male and female working adults. In other words, 89% of men who work outside the home indicate that they make some contribution to the household finances in comparison with 78% of working women. Thus, it would seem that the vast majority of women who work may do so out of some financial necessity or imperative.

Personal Contribution to Household Finances X Gender & Work Status



Working women are less likely to be the primary income contributor: 2/3s are not main. This may lessen the stress perhaps of work. Just 1 in 3 working men are not the main contributor.

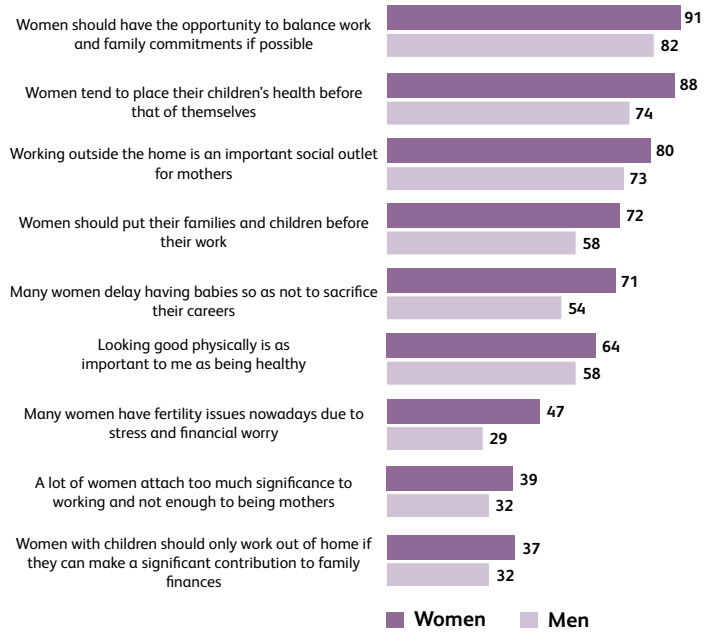
Ultimately working women are less likely to be the primary income contributor in their homes, and indeed two out of three of them are not the main contributor. This might perhaps lessen the stress of working for women, or conversely may be indicative that women are under pressure to work to provide an income top up for the family.

GENDER & WORK ISSUES

There is almost universal agreement that women should have the opportunity to balance work and family commitments if possible. 9 in 10 men and 8 in 10 women agree with this and the only group which differs from the average is the group of women who don't work.

Attitudes to Womens' Issues x Gender and Work Status within Gender

Base: Adults Aged 16+ - 971 / 3,591,000

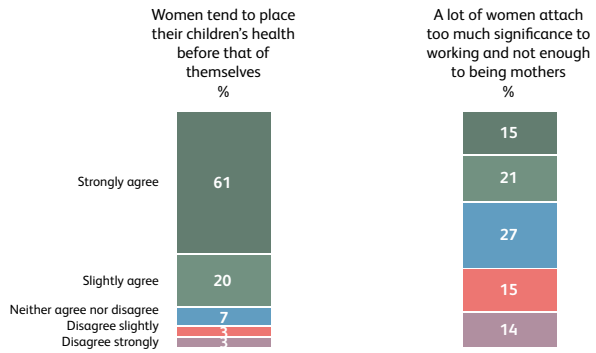


	WOMEN		MEN	
	Working	Not Working	Working	Not Working
Women should have the opportunity to balance work and family commitments if possible	95	89	87	77
Women tend to place their children's health before that of themselves	89	87	78	70
Working outside the home is an important social outlet for mothers	85	76	80	65
Women should put their families and children before their work	69	74	57	59
Many women delay having babies so as not to sacrifice their careers	75	68	59	49
Looking good physically is as important to me as being healthy	69	62	61	55
Many women have fertility issues nowadays due to stress and financial worry	46	48	35	23
A lot of women attach too much significance to working and not enough to being mothers	34	43	32	31
Women with children should only work out of home if they can make a significant contribution to family finances	31	41	33	32

Gender differences are not that great with men slower to admit to controversial views perhaps.

Again there was broad and almost universal agreement that women tend to place their children's health before that of themselves, while only a minority believe that women attach too much significance to working and not enough to being mothers.

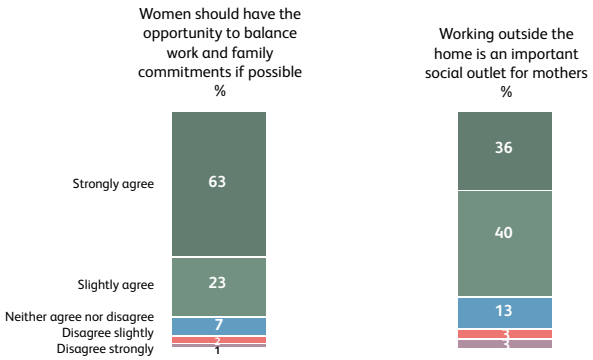
Family First?



Irrespective of other attitudes, few feel that women tend to put their jobs before their children.

Nonetheless there is a substantial majority of women in agreement that many delay having babies so as not to sacrifice their careers. 71% of women agree in this regard and as many as 75% of women who work.

Balancing Work and Family Commitments



Most are in agreement on the social and life benefits of working for mothers.

The study also focused on female enthusiasm to work out of home and whether they are keen to do so, or alternatively do so out of necessity.

Slightly more than half of all women indicate that they would be enthusiastic to work out of home, but an almost identical number suggest that it is something that they would only do out of financial necessity.

About half of women would prefer to work on a strictly part time basis and indeed this is very reflective of the actual distribution of hours worked, as noted before.

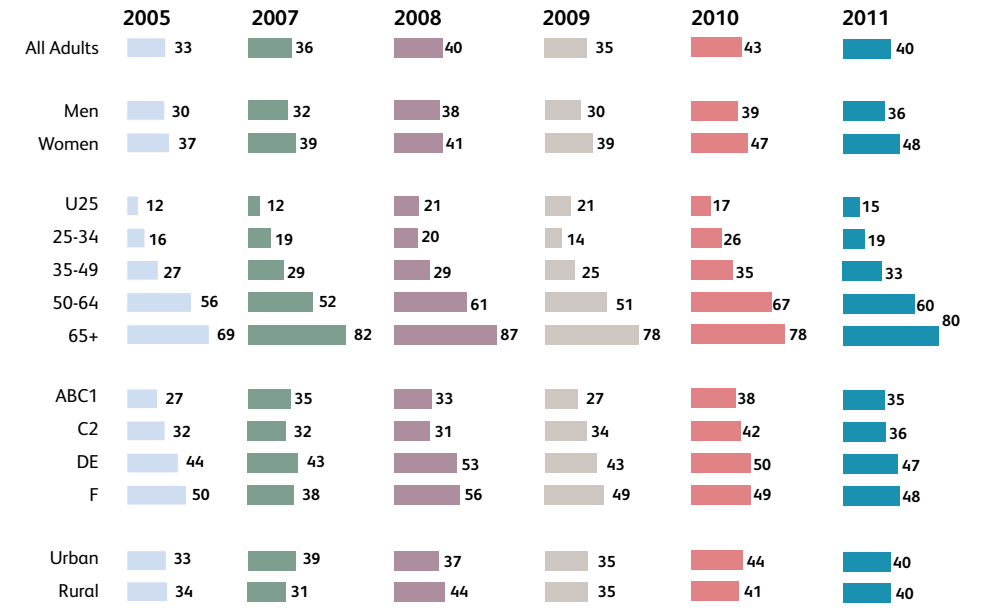
Irrespective of the reluctance of some to work, about 40% indicate that working out of home as a mother is something that they would not like to give up. Not surprisingly, working women are more enthusiastic in this regard than non-working women, but it is perhaps instructive that just 56% of working women indicated that they would not give up working as a mother. By contrast 32% of non-working women believe that working out of home is something that they would not give up. Thus there is very clear enthusiasm to work amongst women generally, although it is apparent that many may only be doing so because of the perceived need to boost family finances.

EXPERIENCE & IMPLICATIONS OF ILLNESS

INCIDENCE

The Pfizer Health Index has been fielded six times since 2005 and in each of these studies the population incidence of each of a variety of conditions has been recorded. These conditions include blood pressure, arthritis, high cholesterol and asthma alongside lower incidence illnesses such as cancer and osteoporosis.

Incidence of Any Listed Condition: 2005 - 2011



The 'shape' of the ill group is similar by age but much more even among ABC1 and C2 with DEs and F's very separate.

The level of experience of any of these conditions currently stands at 40% of the adult population. This broad incidence of illness has ranged as high as 43% in 2010, but also had been as low as 33% in 2005. The levels have not shifted significantly, but the longer term trend illustrated below is of a gradual increase in disease incidence. As has been the case consistently, the incidence of any of these conditions tends to be higher among women than men and indeed rises significantly with age. Furthermore, those from working class and farming backgrounds and specifically, from unskilled working class and unemployed backgrounds (DE), are notably more likely to suffer from one of the listed conditions.

The marginally higher incidence of 'any condition' amongst women which has been consistently observed throughout the research series may be explicable by the greater longevity of women, leading to a higher average age for the female population than the average male sample. As disease incidence rises in line with age, the marginally more elevated age of women on average may go some way towards explaining their higher incidence of disease overall.

The profile of those suffering from any of these conditions tends to be heavily concentrated over the age of 50, with 55% of sufferers female and 45% male. The DE group is the group which is most notably 'over indexed', whereas those from more affluent ABC1 backgrounds tend to be less prevalent amongst the groups suffering from any form of illness.

Disease Incidence

5 Year Cumulative Data

	Penetration	Population Estimates
Blood pressure	12%	414,000
Arthritis	11%	387,000
High Cholesterol	8%	304,000
Asthma	6%	219,000
Heart Disease	4%	154,000
Diabetes	4%	140,000
Depression	4%	128,000
Chronic Pain	4%	154,000
Infections	5%	167,000
Cancer	2%	69,000
Osteoporosis	2%	88,000
Other mental illness	1%	21,000

For the first time in the current study the decision was taken to cumulate data on disease incidence from the last five years of fieldwork, essentially rolling together the disease incidences between 2007 and 2011. The basis for doing this is to give us larger and more robust sample sizes to work with, enabling more detailed analysis of those groups suffering with individual conditions. The error margin on a sample of 5,000 is as low as +/- 1.5%.

The consolidated data indicates that suffering with blood pressure is experienced by about 1 in 8, while arthritis experience registers among 1 in 9. 1 in 12 suffer with high cholesterol and 6% are similarly afflicted with asthma. For almost all of the conditions under review, the incidences increase with age, although asthma stands out as different from this rule being evenly spread by age group. Furthermore those who suffer with infections such as chest, urinary, ear or throat are comparatively evenly distributed throughout the population on an age basis.

It is also notable in the consolidated five year data set that although the cumulated incidence of any of the conditions stands at 40%, this varies quite substantially by age. Under 1 in 5 suffers from any of these conditions up to the age of 35, rising to 3 in 10 between 35 and 49, doubling to 3 in 5 between 50 and 64 and increasing again to 4 in 5 over the age of 65.

Conditions Experienced X Demographics
Base: All Respondents Combined 5 yrs: 5,049 / 3, 591,000

5 years consolidated data

	TOTAL	SEX		AGE					SOCIAL CLASS			
	2011	Male	Female	15-24	25-34	35-49	50-64	65+	ABC1	C2	DE	F
Base:	**5049**	**2495**	**2554**	**846**	**1029**	**1284**	**1060**	**830**	**2079**	**1150**	**1323**	**497**
	%	%	%	%	%	%	%	%	%	%	%	%
- Suffer from ANY	40	36	43	18	20	31	59	81	35	34	48	49
High/Low Blood Pressure	12	10	13	1	2	6	20	34	9	10	14	19
Arthritis	11	9	13	1	2	5	18	36	7	8	15	21
High Cholesterol	8	8	9	0	1	6	16	22	8	8	10	11
Asthma	6	5	7	10	6	6	5	4	6	6	7	4
Infections (chest, urinary, ear, throat)	5	3	6	4	4	5	5	4	4	4	6	5
Heart Disease	4	6	3	1	1	2	6	15	3	4	6	6
Chronic Pain (i.e. head/back)	4	4	5	1	2	4	7	7	4	3	5	4
Diabetes	4	4	4	0	1	2	5	13	3	3	6	5
Depression	4	3	4	1	3	5	4	3	2	4	6	2
Other	3	2	3	1	1	3	4	5	2	2	3	3
Cancer	2	2	2	0	0	2	3	5	1	2	2	3
Osteoporosis	2	1	4	0	0	1	4	9	2	1	4	4
Other mental illness	1	1	0	0	1	1	1	-	0	1	1	-
Obesity	1	1	1	0	1	1	1	1	1	1	1	1
Alzheimer's	0	-	0	-	-	-	-	0	-	-	0	-
Multiple Sclerosis	0	0	0	-	0	0	0	0	0	0	1	-
COPD	0	-	0	-	-	0	-	0	0	-	0	-
Substance/Drug Abuse	0	0	0	0	0	0	0	-	0	-	0	-
Other addiction issues	0	0	0	0	0	0	0	0	0	0	0	0
None	60	64	57	82	80	69	41	19	65	66	52	51

Most incidences are heavily age and class driven, with female reporting consistently higher too.

The survey also separately probed the incidence of obesity, whether personally or in one's immediate family, and the current study indicates that as many as 15% suggest that there is a personal or family incidence of obesity, with the personal incidence standing at about 1 in 8.

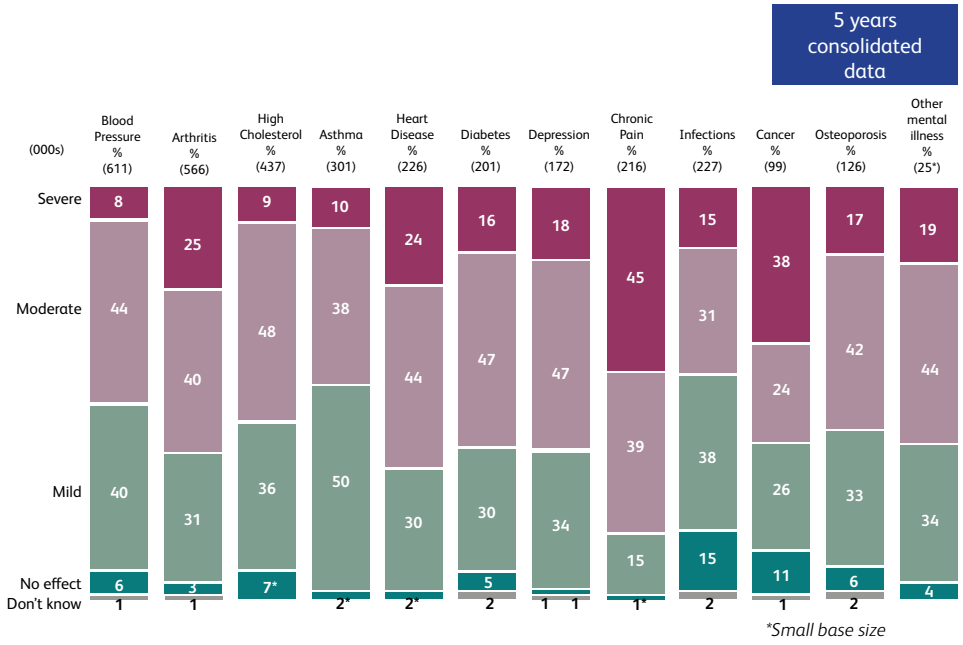
6% indicate broad personal or family incidence of alcohol related issues, although this is much more likely to be claimed amongst one's family than personally. Family experience of unplanned pregnancy is indicated by 6%, with half of these having experienced it themselves and half within their family group.

IMPLICATIONS

Again staying with the cumulated five year data set, sufferers were asked about the perceived severity of the illness from which they are suffering. The group who suffer with chronic pain are the most severely afflicted, with almost half categorising their illness as severe. Next most severe is the group with cancer, with just under 4 in 10 regarding their condition as severe. Arthritis at 25% and heart disease at 24% follow next in line.

It should be noted that three of the largest conditions, blood pressure, high cholesterol and asthma are categorised as severe by just 1 in 10 or less. Thus, arthritis is the most severe high incidence condition, whereas chronic pain and cancer are comparatively more severe, but are fortunately of lower incidence.

Severity of Medical Conditions (Rolling 5 Year Data)
Base: All Respondents 5,049 / 3,591,000



Arthritis, heart disease, chronic pain and cancer are the most severe conditions.

DUPLICATION

Duplication of Conditions
Base: All Respondents 5,049 / 3,591,000

5 years consolidated data

		SUFFER FROM											
	Total	Heart Disease	Cancer	Arthritis	Chronic Pain	Osteo-porosis	Blood Pressure	Asthma	Dia-betes	High Chol.	Depression	Infections	Obesity
Base:	5049	226	99	566	216	126	611	301	201	437	172	227	44
	%	%	%	%	%	%	%	%	%	%	%	%	%
High/Low Blood Pressure	12	43	17	31	23	36	100	14	31	45	24	20	41
Arthritis	11	31	15	100	31	43	29	16	27	28	23	16	23
High Cholesterol	8	32	17	22	19	31	33	11	21	100	19	13	36
Asthma	6	11	13	9	12	10	7	100	8	8	13	14	18
Infections (chest, urinary, ear, throat)	5	6	6	7	15	7	8	11	5	7	13	100	17
Heart Disease	4	100	16	12	12	15	16	8	18	16	12	6	7
Chronic pain (i.e. head/back)	4	12	5	12	100	12	9	9	7	10	17	13	12
Diabetes	4	16	7	10	7	10	11	5	100	9	6	4	7
Depression	4	10	8	8	14	9	7	8	5	8	100	10	21
Other	3	3	2	4	3	4	2	3	2	2	4	2	3
Cancer	2	7	100	3	2	6	3	4	4	4	4	3	4
Osteoporosis	2	8	7	10	7	100	8	4	6	9	6	4	2
Other mental illness	1	0	1	0	1	-	0	0	-	1	6	1	8
Obesity	1	1	2	2	3	1	3	3	2	4	5	3	100

There is significant duplication of conditions: for example 45% of the cholesterol group have blood pressure issues etc.

As has been consistently noted in the reporting of the previous studies, there is a tendency for sufferers of individual conditions to be more likely to have a duplication of conditions. For example, of those with high cholesterol, almost 45% have a blood pressure issue too. Furthermore a quarter of them suffer with arthritis, in comparison with just 11% of the adult population. Thus, for age or other reasons, there is a tendency for heart disease to correlate with illnesses such as blood pressure, arthritis and cholesterol, although the relationship is not necessarily causative, but in many instances a function of age or other issues.

TECHNICAL NOTE

The Pfizer Health Index is undertaken on Behaviour & Attitudes' National Barometer Survey, a quota controlled survey of 971 adults aged 16 and over, with fieldwork face-to-face and in home. Fieldwork is undertaken on portable Computer Assisted Web Interviewing (CAWI) Units rather than using traditional pen and paper questionnaires. Interviewing conforms with the standards dictated by Behaviour & Attitudes' membership of ESOMAR (the European Society of Opinion and Marketing Research) and the Market Research Society (UK). A rigorous back check of completed work is undertaken and interviewers are fully trained and closely supervised. Fieldwork was completed across 63 randomly selected sampling points with each interviewer completing an allotted number of interviews at the chosen point and was undertaken between 22nd July and 5th August 2011.


Pfizer