

# healthy living

Helping people in our region to eat well, be active and make healthy choices

**Nelson Marlborough DHB Health Survey 2011  
Summary Report: December 2011**



Summary of the Nelson Marlborough DHB Regional Health Survey 2011 Technical Report, School of Population Health, University of Auckland, December 2011 Prepared by Dr Rob McNeill

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## Introduction

In 2008 the Nelson Marlborough District Health Board (NMDHB) commissioned a regional health survey to provide information about the current health status of the population, focussing on personal, environmental, social and behavioural factors relating to nutrition and physical activity, as well as general health issues, health services utilisation and health outcomes within the Nelson Marlborough population aged 16 years and over. A full technical report and a summary report were produced from those findings in 2008 giving NMDHB more information about their population than any other DHB in New Zealand (McNeill et al., 2008). In order for NMDHB to continue to access current data to reliably inform service planning, another health survey was commissioned in 2011 to update health-related information about this district's population.

The 2011 full technical report (McNeill et al., 2011) provides an up to date resource to support comprehensive understanding of the knowledge, attitudes and behaviours relating to nutrition and physical activity, obesity and chronic conditions in the general population for the NMDHB region at this time.

This report summarises the key findings from the 2011 Regional Health Survey full technical report which is available on the NMDHB website.

## Method

A total of 1810 telephone interviews were conducted between March and May 2011 with participants aged 16 years or older who were residents within the NMDHB region. Interviewing was conducted by Phoenix

Research on behalf of the School of Population Health, University of Auckland.

A large enough sample was selected to enable statistical analysis of potentially small differences between Territorial Authorities (TA) and between Maori and Non-Maori. The sampling method ensured a quota of 600 participants from each TA with at least 150 from each TA being Maori.

The survey was designed to focus primarily on measuring nutrition and physical activity, but also asked about general health and health service utilisation. The questionnaire was developed from a review of the literature, adapting existing validated questionnaires, and in consultation with experts in the area of nutrition and physical activity. Where possible questions were taken or adapted from population-based questionnaires previously used in the New Zealand setting. The survey was a repeat of the questionnaire used in 2008 except for some minor changes (see McNeill et al., 2011 for a full copy).

Data were weighted for analysis to ensure accurate reflection of the population in terms of household size, age, gender, ethnicity and socioeconomic status.

Data were analysed for overall results and also to examine sub-group differences within TA, age, gender, ethnicity and socio-economic status<sup>1</sup> (SES). A 95% confidence level was used to report a significant difference between sub-groups. All reported differences are statistically significant.

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<sup>1</sup> A proxy SES was derived from quintiles of area-level deprivation measured by the New Zealand Deprivation Index from the 2006 Census (i.e. NZDep2006).

## Nutrition

### Fruit and Vegetables

The WHO and the NZ Ministry of Health (MoH) recommend consumption of at least 2 servings of fruit and 3 servings of vegetables a day to be 'adequate'.



#### Adequate intake of fruit and vegetables

Fewer than half of all participants (42%) reported consuming the recommended intake of at least 2 servings of fruit and 3 servings of vegetables per day.

Females (52%) were more likely than males (31%) to report an 'adequate' daily intake of fruit and vegetables and participants aged 16-64 (42-46%) were all more likely than those aged 65+ (33%) to do so.

Figure 1: Daily intake of fruit and vegetables by gender

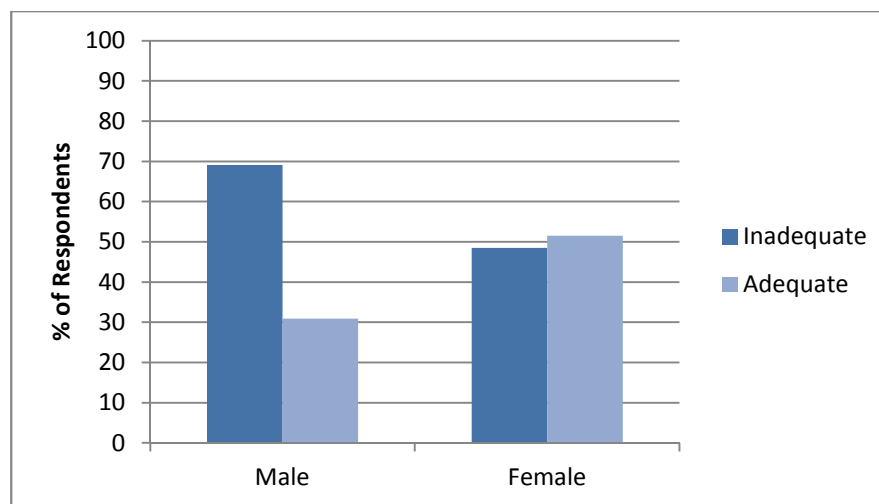
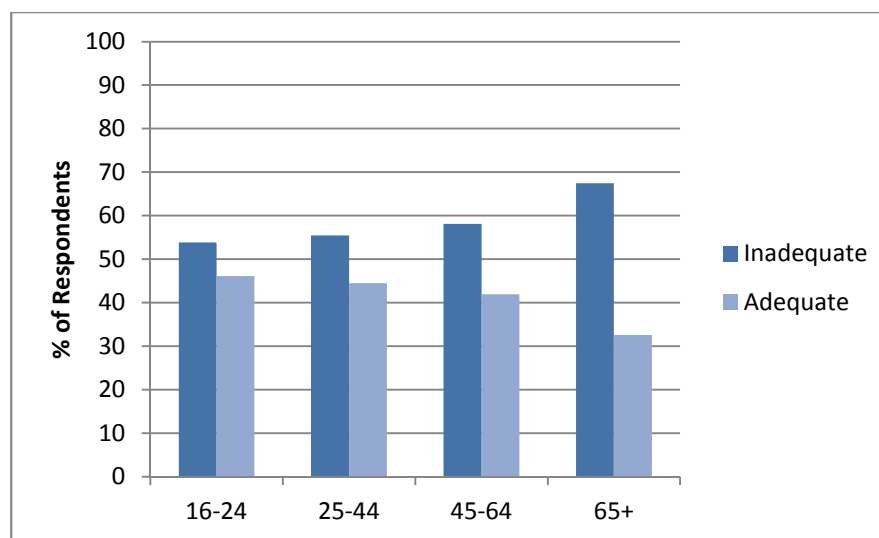


Figure 2: Daily intake of fruit and vegetables by age group



### Barriers to eating fruit and vegetables

The most commonly reported barriers to consuming more fruit and vegetables were cost (52%) and spoiling too easily (35%). Other barriers included availability at work or school (21%), availability at local shops (14%), time to prepare (6%) and dislike of fruit and vegetables (2%).

Cost was the greatest barrier among all sub-groups of participants, but it was significantly more so to Maori (62%) than Non-Maori (51%) and to participants aged 25-44 (59%) than any other age group (47-49%).



Figure 3: Barriers to fruit and vegetable consumption by ethnicity

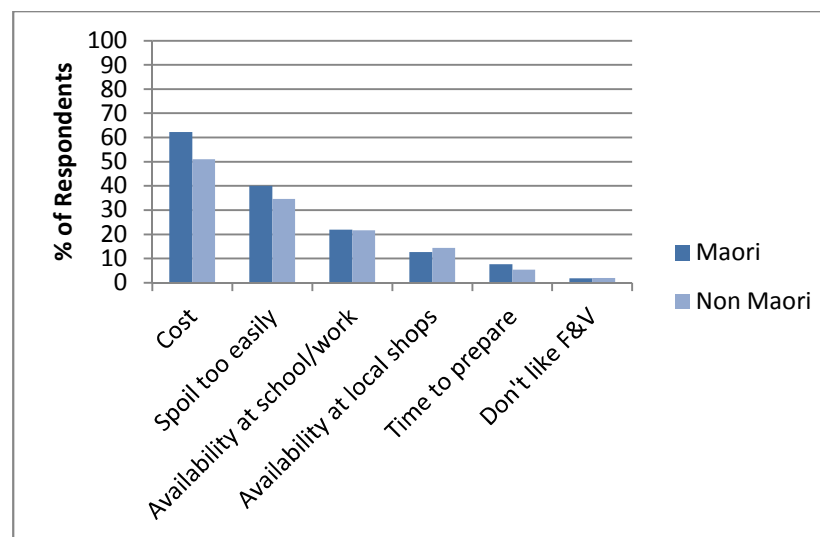
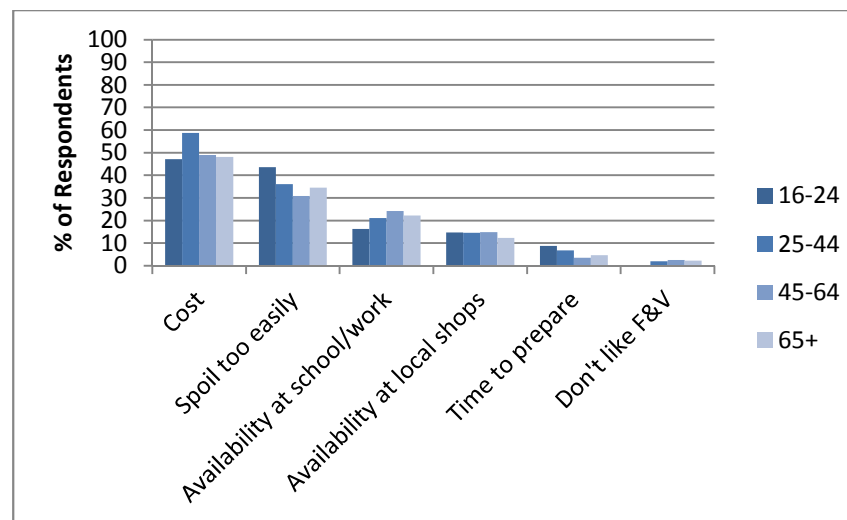


Figure 4: Barriers to fruit and vegetable consumption by age group



## Other food and drinks

Participants reported diverse eating habits in a range of areas including regular breakfast consumption, sharing main meals with households, frequency of fish, meat and poultry consumption, fat-content of milk used and consumption of takeaways and high sugar drinks.

### Regular breakfasts

The majority (81%) of participants reported having breakfast every day for the last 7 days. However Non-Maori (83 %) were more likely than Maori (62%) to do so, females (84%) were more likely than males (77%) and participants living in areas of SES quintiles 1-4 (78-85%) were all more likely than those in quintile 5 (65%) to report this positive dietary pattern.

Among those participants with school aged children, 94% reported that their children had breakfast on all of the last 7 days and there were no clear trends by sub groups for the frequency of children having breakfast.



## Meals at home

More than half (54%) of all participants reported having eaten their main meal at home with all or most members of their household every day for the last 7 days, there were no sub-group differences among this group.

The majority of participants (82%) also reported that at work they usually ate lunch brought from home. This was more likely among Non-Maori (84%) than Maori (76%), participants aged 24-44 (86%) or 45-64 (85%) than those aged 16-24 (73%), and among participants living in areas of SES quintiles 1 (89%) and 2 (85%) than quintile 5 (71%).

### Fish, red meat and chicken

Just over half (55%) of all participants reported eating fresh or canned fish at least once a week but 13% reporting having fish never or less than once a month.

A greater majority (85%) reported eating chicken or pork at least once a week with only 5% eating this never or less than once a month.

90% of all participants reported eating red meat at least once a week, but 13% were doing so 5 or more times a week. Few participants (5%) reported having red meat less than once a month or never.

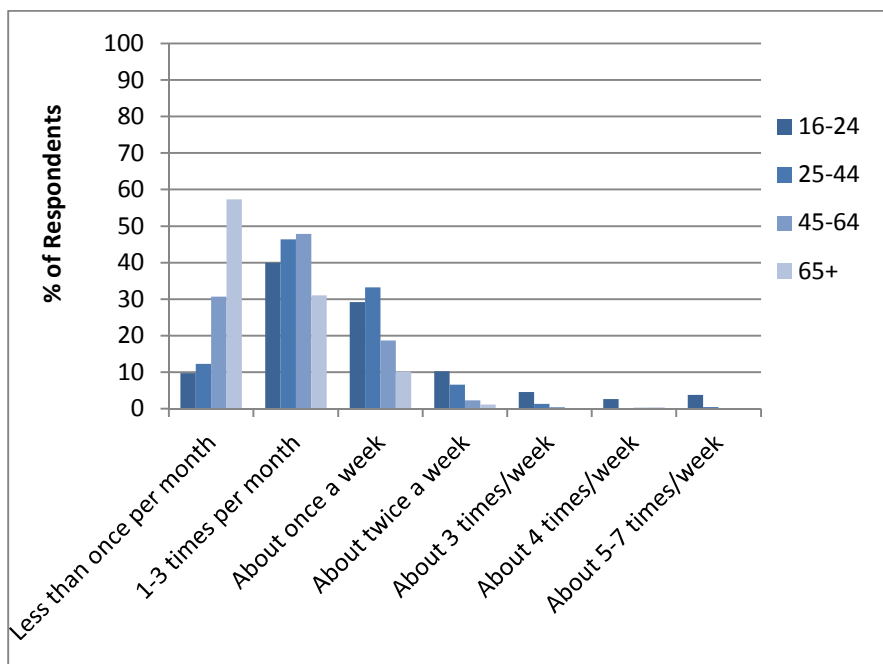
Nearly half (43%) of all participants reported eating processed meat or fish less than once a week. Almost a third (32%) eat processed meat or fish once a week and about a quarter (26%) report eating these two or more times a week.

### Takeaways

About a quarter (26%) of all participants reported eating takeaways less than once a month, almost half (44%) reported having takeaways 1-3 times a month and almost another quarter (24%) were having takeaways once a week. Only about 7% were having takeaways more than once a week.

There were no differences between the territorial authorities in frequency of eating takeaways but younger participants across all regions were more likely than those older to eat takeaways more frequently. Differences within the other subgroups were not strictly linear.

Figure 5: Frequency of eating takeaways by age group



### Fat content of milk

Most participants reported using low fat or skim milk (49%) while 40% reported using full fat milk. Soy, other or no milk accounted for the remaining 11%. Full fat milk was more likely to be used by Maori (51%) than Non-Maori (39%), males (45%) than females (34%) and participants aged 16-44 (48-56%) versus those aged 45+ (29-30%).



### High sugar drinks

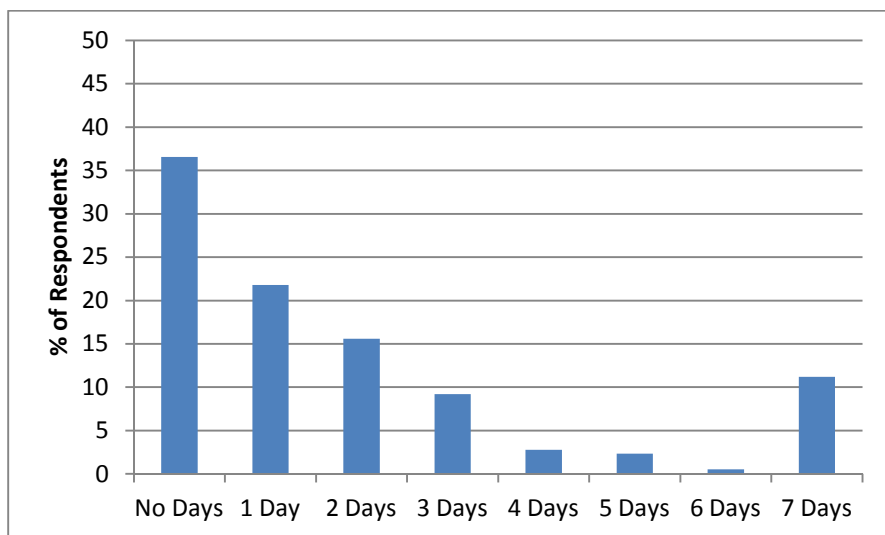
More than half of all participants (59%) reported having no ‘fizzy’ or ‘energy’ drinks for the last 7 days, while 27% reported having fizzy/energy drinks on 1-2 days in the last week, 8% on 3-4 days, and 6% of 5-7 days. Those having no fizzy/energy drinks in the last week were more likely to be female (70%) than male (50%), Non-Maori (61%) than Maori (47%), and aged 25-65 (50-79%) than 16-24 (21%).

Most participants (87%) reported having no powdered fruit drinks in the last 7 days. These participants were more likely to be Non-Maori (88%) than Maori (80%), aged 25-65 (87-90%) than 16-24 (74%) and living in areas of SES quintiles 1-4 (88-90%) than quintile 5 (73%).

### Over-eating

More than a third (37%) of participants reported that they had not over-eaten on any of the last 7 days. The same proportion (37%) reported over-eating on only 1-2 of the last 7 days with the remainder (26%) over-eating between 3-7 of the last 7 days. Those reporting over-eating on all 7 days were more likely to be Maori (17%) than Non-Maori (11%), residents of Marlborough (15%) than Tasman (9%) or Nelson (9%) and aged 16-24 (16%) than 65+ (6%).

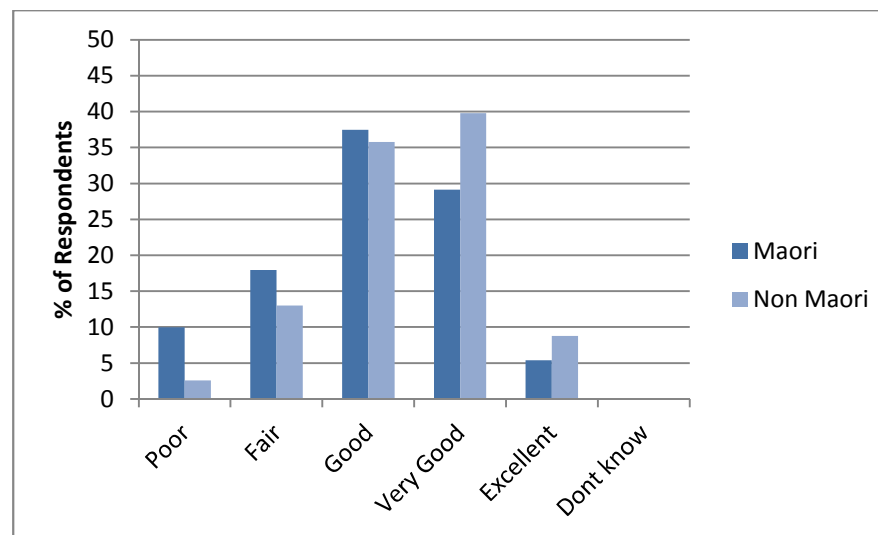
Figure 6: Frequency of overeating in the last 7 days



### Self reported rating of eating habits

Most participants (84%) felt positive about their eating habits, rating their own diet as 'good', 'very good' or 'excellent'. Only 3% rated their own eating habits as 'poor'; this group were more likely to be Maori (10%) than Non-Maori (3%) and more likely to be aged 16-24 (10%) than any of the older age groups (<1-3%).

Figure 7: Self rating of eating habits by ethnicity



### Barriers to healthy eating

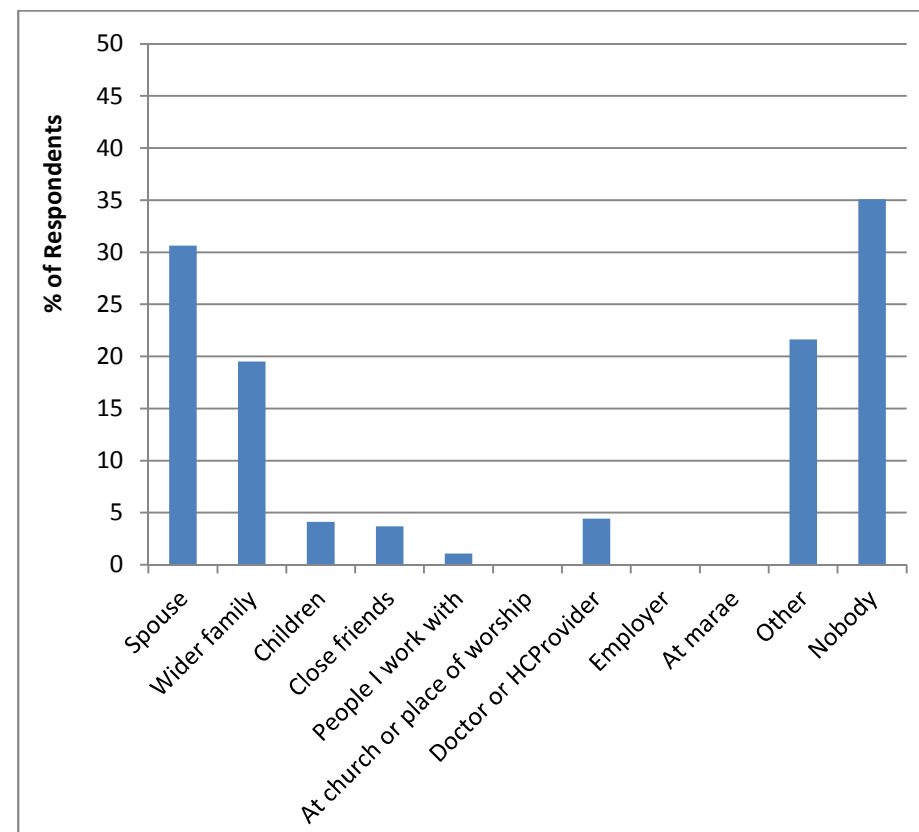
Almost all (97%) participants agreed that it was important to have healthy eating habits; however 14% reported that they couldn't afford healthy foods and 36% felt that eating healthy foods meant giving up preferred foods. The cost of healthy foods was more likely to concern participants in Marlborough (17%) than Tasman or Nelson (12-13%), Maori (25%) rather than Non-Maori (13%), participants aged 25-44 (20%) than older age groups (8-11%) and participants living in areas of SES quintiles 4 and 5 (19-20%) than those in quintiles 1 and 2 (8-11%).



### Sources of encouragement to eat healthily

More than a third (35%) of all participants reported that nobody encouraged them to eat healthily, however many participants reported being encouraged by family members (54%), friends or colleagues (5%) or 'others' (21%). Only 4% were given encouragement by their doctor or health care provider. Males (44%) were much more likely to be encouraged by their wives than females (17%) by their husbands.

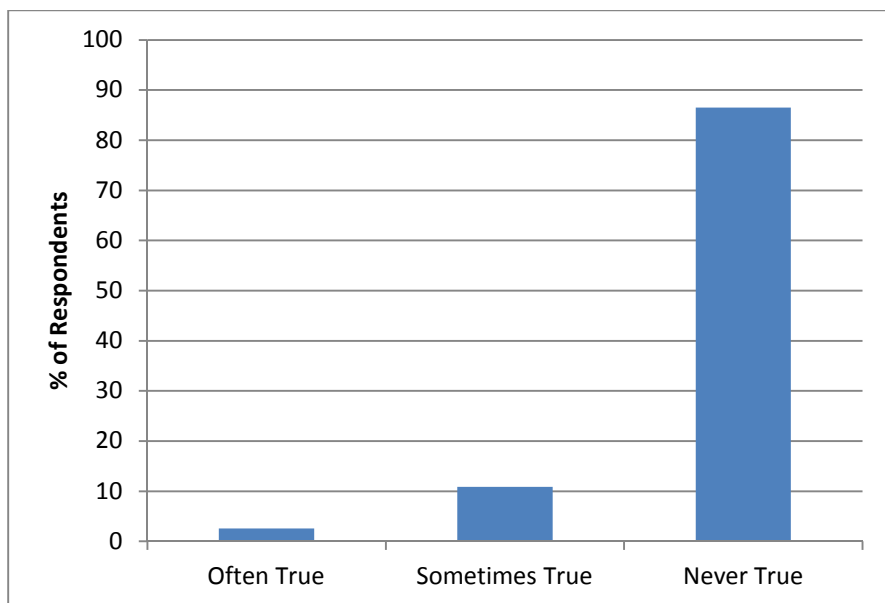
Figure 8: Sources of encouragement to eat healthily



## Food security

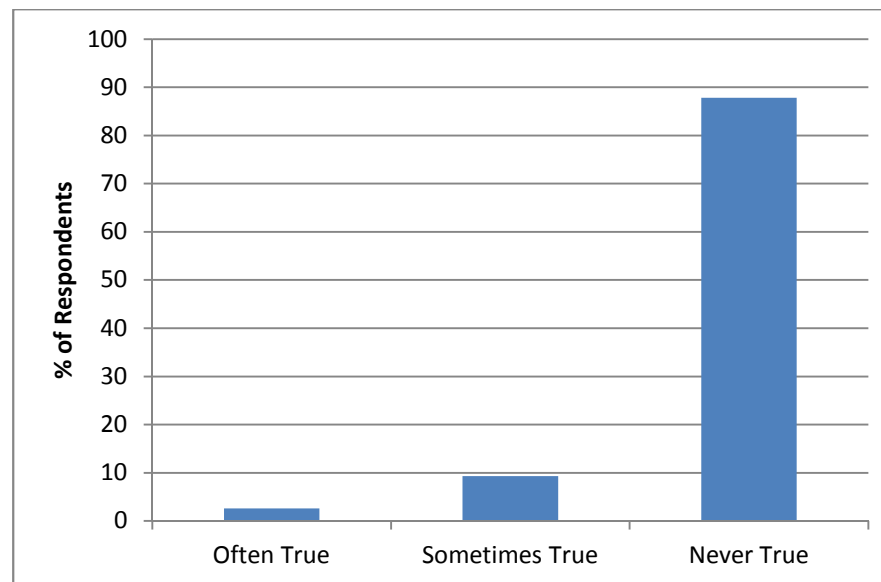
While most participants ‘never’ ran out of food and could not afford to buy more (87%) for 14% this was ‘sometimes’ or ‘often’ true. Those with the greatest food security by this measure were more likely to be Non-Maori (88%) than Maori (78%), living in Marlborough (89%) rather than Tasman (84%), aged 25-65+ (83-96%) than 16-24 (73%) and living in areas of SES quintiles 1 and 2 (90%) than quintiles 4 and 5 (76-84%).

Figure 9: Running out of food and can't afford to buy more



Again while most participants (88%) ‘never’ had to reduce portion sizes or skip meals due to lack of money for food, this was ‘sometimes’ or ‘often’ true for 12% of all participants. Those with the greatest food security by this measure were more likely to be Non-Maori (89%) than Maori (82%), living in Nelson (91%) rather than Tasman or Marlborough (87%), aged 25-65+ (86-96%) than 16-24 (75%) and living in areas of SES quintiles 1 and 2 (90-92%) than quintiles 4 and 5 (80-84%).

Figure 10: Adults in the household reduce portion size or skip meals due to lack of money for food



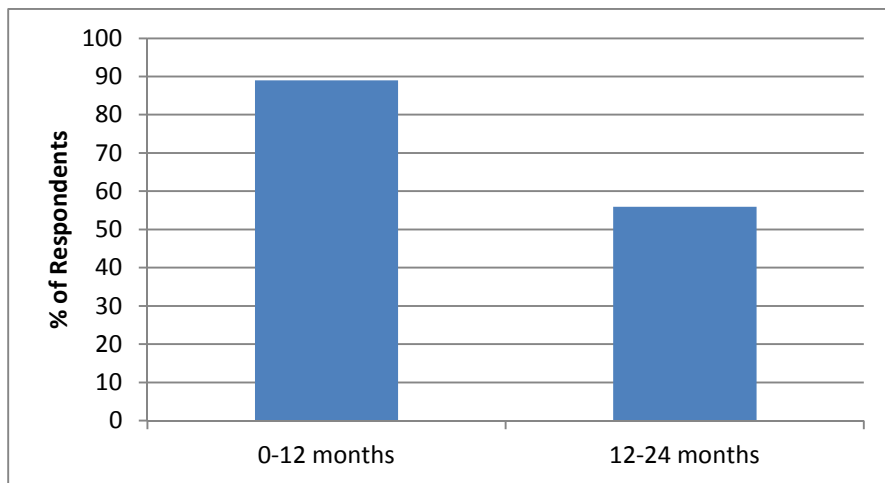
## Attitudes towards breast feeding

The WHO and the MoH recommend that infants are exclusively breast-fed for 6 months and that breast-feeding continues with complementary solids until at least 12 months.

While 92% of all participants agreed or strongly agreed that breast milk is the ideal food for babies, only 63% agreed or strongly agreed that babies should only be fed breast milk for the first 6 months.

Most participants (89%) reported feeling comfortable when a mother breastfeeds a 0-12 month old infant in public but only 56% felt comfortable when mothers fed 12-24 month old infants in public. Participants aged 25-64 were more comfortable with mothers feeding in public than younger or older age groups.

Figure 11: Comfortable to see mothers breastfeeding 0-12 month and 12-24 old infants in public



## Physical Activity

The MoH recommend at least 30 minutes of moderate physical activity a day on at least 5 days a week.



## Regular and intended physical activity levels

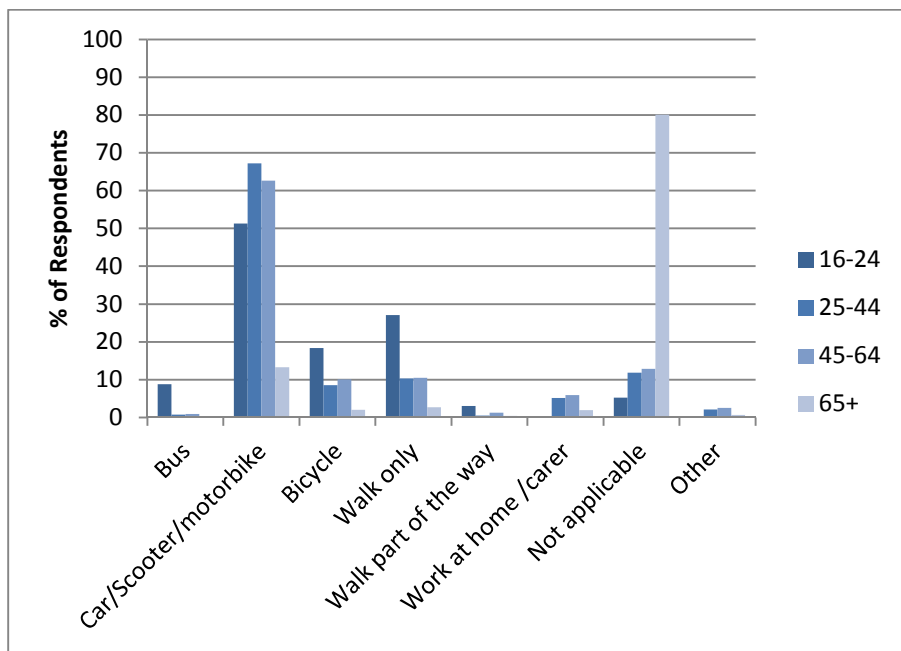
While 59% of all participants reported that they considered themselves to be 'active', slightly fewer (51%) reported having actually achieved the recommended amount of physical activity each week. Males (60%) were more likely to achieve this than females (44%), participants aged 16-64 (53-54%) were more likely than those aged 65+ (41%) to achieve this, and participants living in areas of SES quintiles 1-3 (53-55%) were more likely than those in quintile 5 (38%) to do so.

Among the 41% who did not already consider themselves to be active, 17% intended to start regular activity within the next 30 days and 11% within the next 6 months; 6% did not intend to take up regular activity and 7% were unable to do so for health reasons.

## Transport to work or school

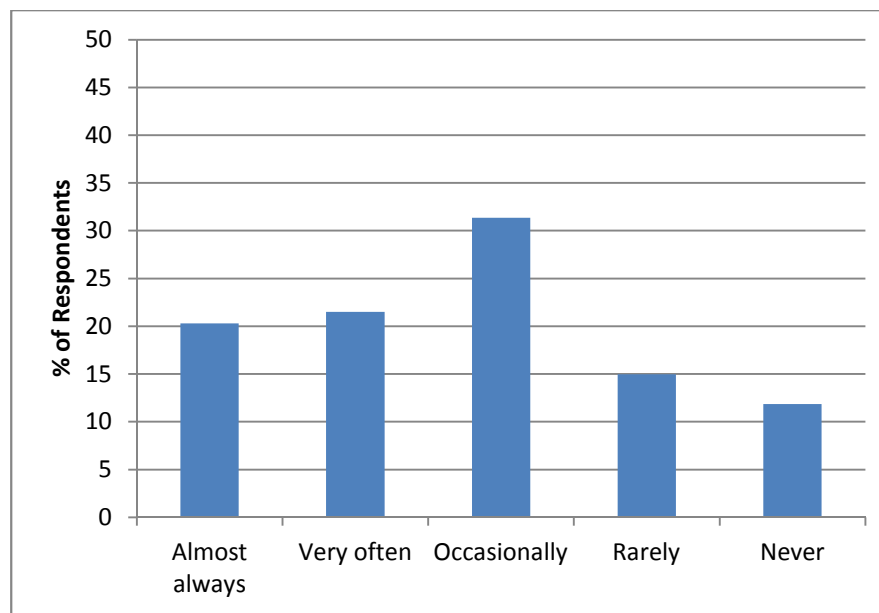
Most participants reported getting to work or school via car, scooter or motor bike (53%) with only 22% walking or cycling. Younger participants are the most likely to walk or cycle.

Figure 12: Usual transport to work or school



41% of all participants also reported that they would walk or cycle for short journeys of up to 2.5km either ‘almost always’ or ‘very often’.

Figure 13: Frequency of walking or cycling for short journeys up to 2.5km



## Barriers to regular physical activity

The most frequently cited barriers to regular physical activity were time (47%), health problems (31%), overall difficulty (29%) and road safety (26%).

Other barriers reported were availability of cycle paths and lanes (22%), cost (16%), not seeing others being active in the neighbourhood (13%), footpath availability or maintenance (12%), availability of gyms or parks (10%) and neighbourhood safety (4%).

## Health Status

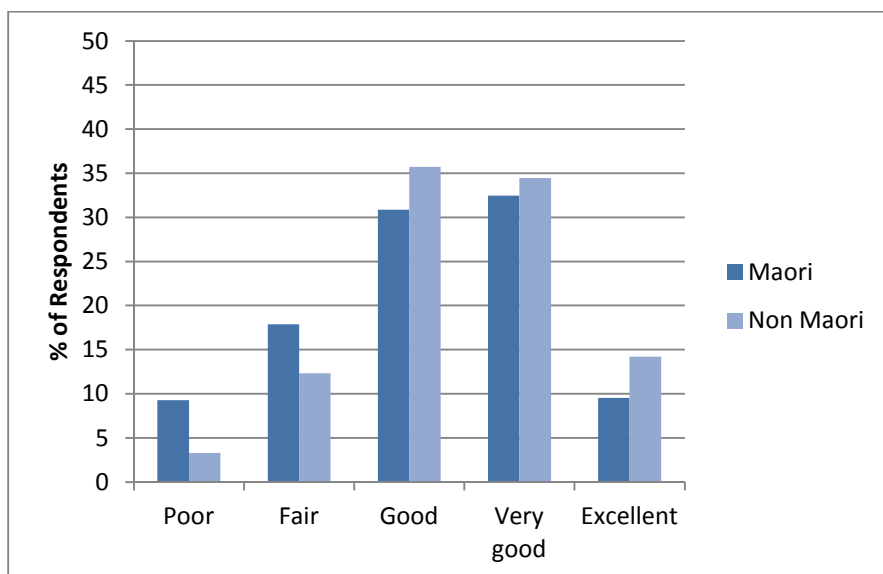
### Self-rating of health

Most participants (83%) rated their own health as 'Good', 'Very Good' or 'Excellent', with only 17% rating their health as either Poor (4%) or Fair (13%).

Maori (9%) were more likely to rate their health as 'Poor' than Non-Maori (3%).

Females (16%) were more likely to rate their health as 'Excellent' than males (11%) and participants living in areas of SES quintile 1 (21%) were more likely to do so than those in quintiles 3-4 (13%) or 5 (7%).

Figure 14: Self rating of health by ethnicity



### Self described weight and BMI

Participants were asked to describe their own weight and also asked for their height and weight from which their Body Mass Index (BMI) was calculated.

About half (51%) of all participants described themselves as 'about the right weight' although only 47% had a BMI within the 'normal' range of 18.5-24.9.

Over a third (37%) described themselves as 'slightly overweight' and the same number had an 'overweight' BMI of 25-29.9.

While only 5% described themselves as 'overweight or obese', 14% had an 'obese' BMI of 30+.

7% described themselves as 'slightly' or 'very' underweight but just 1% had an 'underweight' BMI of <18.5.

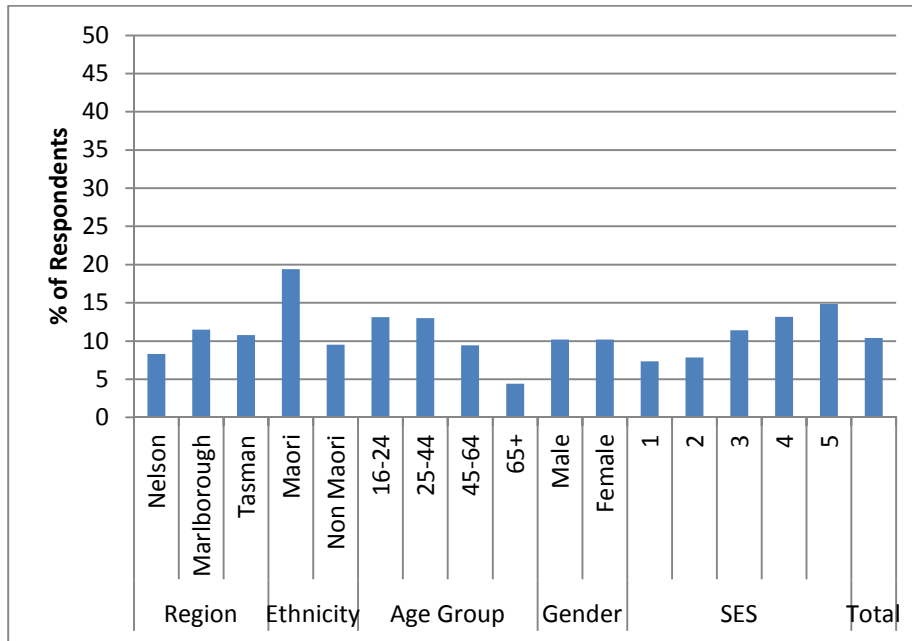
Maori (31%) were more likely than Non-Maori (13%) to have an obese BMI as were participants aged 25-65+ (15-16%) versus those aged 16-24 (4%).

Overall, 37% of participants reported that they were trying to lose weight; this was more likely for females (43%) than males (31%).

## Smoking

Overall 10% of participants reported that they smoke tobacco. This was more likely for Maori (19%) than Non-Maori (10%) and more likely among participants aged 16-44 (10-13%) than 65+ (4%).

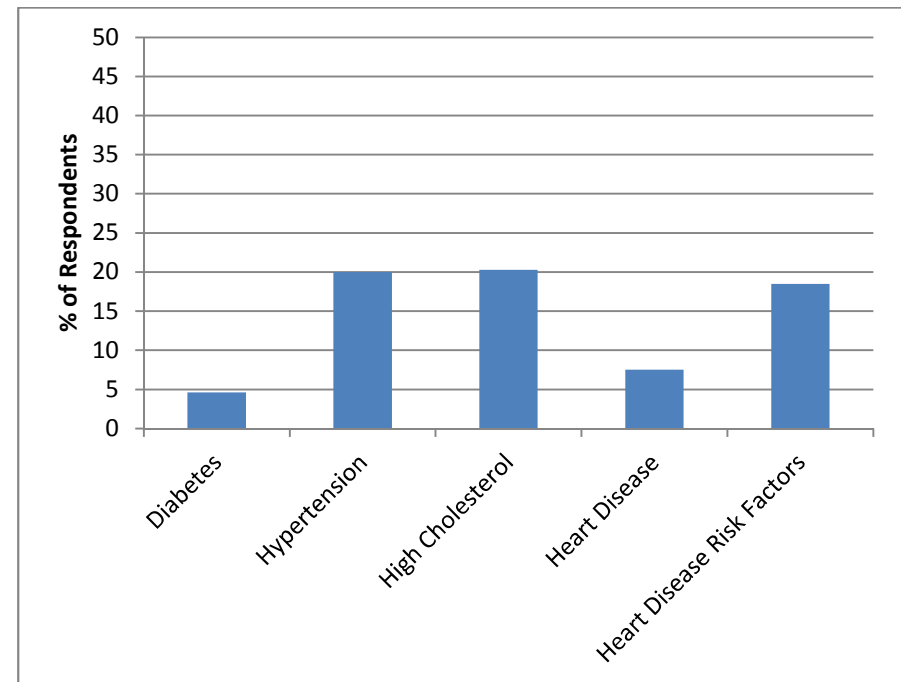
Figure 15: Smoking prevalence by sub-group



## Prevalence of major illness groups

The overall prevalence of diabetes (5%), hypertension (20%), high cholesterol (20%), heart disease (8%) and heart disease risk factors (19%) were differentiated in each case by age group - older participants being more likely than younger groups to report having each condition. In addition, males were more likely than females to report having high cholesterol (25% vs 18%), heart disease (10% vs 5%) and heart disease risk factors (21% vs 16%).

Figure 16: Overall prevalence of diabetes, hypertension, high cholesterol, heart disease and heart disease risk factors

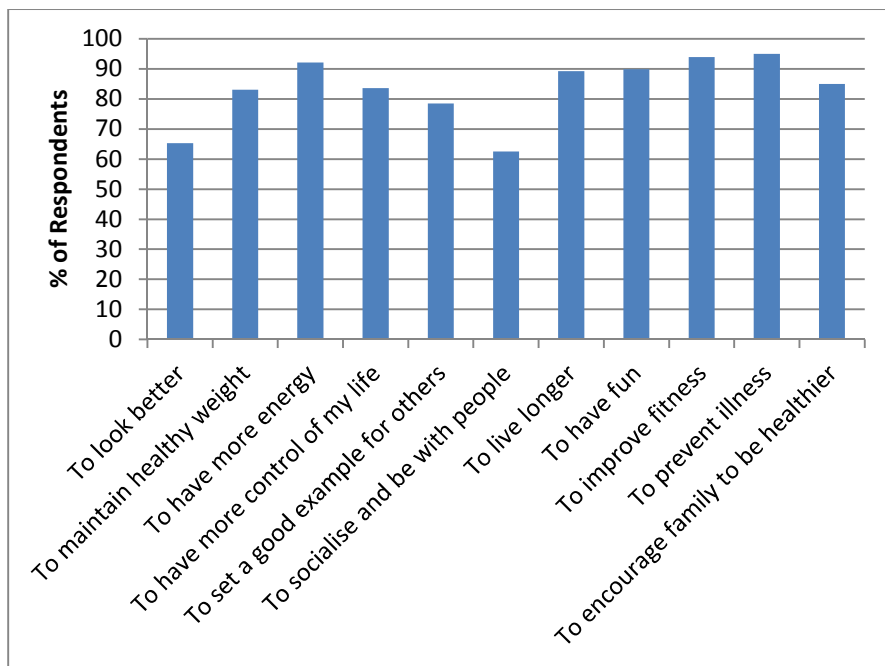


## Attitudes toward health

### Reasons for having a healthy lifestyle

Participants were asked how strongly they agreed with a number of potential reasons for trying to have a healthy lifestyle.

Figure 17: Reasons for trying to have a healthier lifestyle



Younger people were more likely to strongly/agree that having more control of your life, living longer and improving fitness were reasons for trying to have a healthy lifestyle. Older people were more likely to strongly/agree that preventing illness was a reason for trying to have a healthy lifestyle.

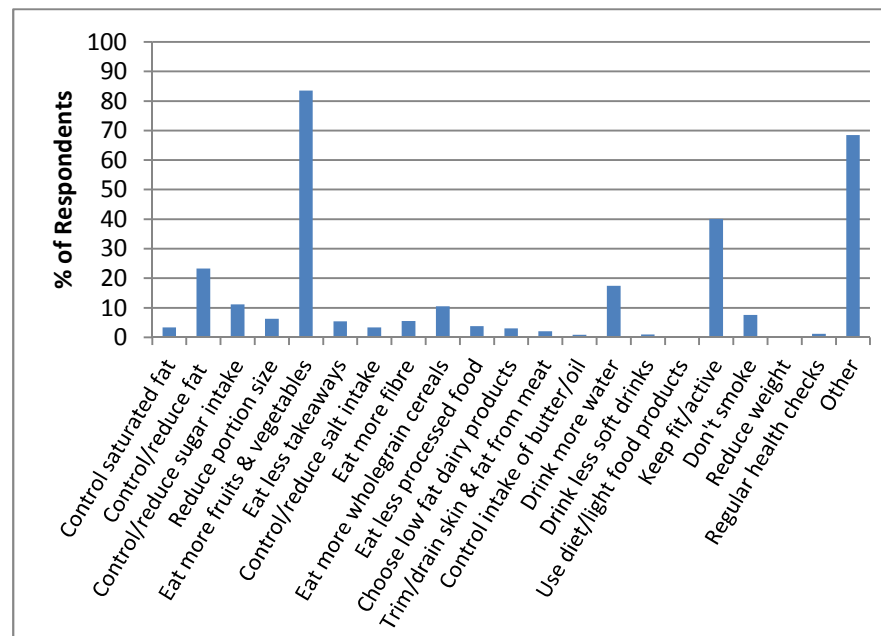
Females were more likely than males to strongly/agree that looking better, maintaining a healthy weight, having more energy and having fun were reasons for trying to have a healthy lifestyle.

Maori were more likely to strongly/agree that looking better was a reason for trying to have a healthy lifestyle.

### What to do to be healthy

Participants were asked, "If someone wants to be healthy, what are some of the things experts recommend they do?" The most commonly identified recommended actions were eating more fruits and vegetables (84%) and keeping fit and active (40%)

Figure 18: Actions to be healthy



## Primary health care

### Consultations with primary health care

Over three quarters (77%) of all participants reported that they had consulted a primary healthcare worker in the last 12 months. The likelihood of this increased with age and was also more likely for females (80%) than males (74%) and for Non-Maori (77%) than Maori (70%).

### Smoking cessation advice

Among those participants who were smokers and who had consulted a primary health care worker in the last 12 months, 63% had been given some advice about smoking cessation. This was more likely for residents in Tasman (81%) than Nelson (61%) and for participants aged 65+ (89%) than those aged 16-24 (33%).



## Primary care support for over-weight or obese patients

Among those participants who were overweight or obese and whom had consulted a primary health care worker within the last 12 months:

- 67% had been weighed
- 35% had received advice about health eating or weight and this was more likely for males (38%) than females (28%)
- 38% had received advice about physical activity and this was more likely for males (43%) than females (31%)
- 85% had had their blood pressure measured and this was more likely for Non-Maori (86%) than Maori (75%)
- 63% had had their cholesterol tested and this was more likely for males (70%) than females (55%)
- 50% had been tested for diabetes and this was more likely for males (55%) than females (46%)
- 26% had received advice about diabetes risk factors
- 42% had received advice about heart disease risk factors and this was more likely for males (48%) than females (35%)
- In addition, for each case above, the advice or testing was generally more likely for older than younger participants