

Which ethnic groups have the poorest health? Ethnic health inequalities 1991 to 2011

Summary

This briefing uses census data on limiting long-term illness to identify wide variations in health between ethnic groups in England and Wales. Ethnic health inequalities can be reduced by improvements in the social status and living conditions of disadvantaged groups.

- Persistent inequalities are seen in the health of Pakistani and Bangladeshi women. Their illness rates have both been 10% higher than White women in 1991, 2001 and 2011.
- The White Gypsy or Irish Traveller group, identified for the first time in the 2011 Census, has particularly poor health. Both men and women have twice the White British rates of limiting long-term illness, and at each age they are the group most likely to be ill.
- Ethnic inequalities in health are most pronounced at older ages:
 - 56% of all women aged 65 or older reported a limiting long-term illness, but over 70% of Pakistani, Bangladeshi and White Gypsy or Irish Traveller women at this age reported a limiting long-term illness.

- Arab and Indian older women also reported high percentages of limiting long-term illness (66% and 68% respectively).
- 50% of all men aged 65 or older reported a limiting long-term illness, but 69% of Bangladeshi and White Gypsy or Irish Traveller older men reported being ill.
- The Chinese group reported persistently better health in 1991, 2001 and 2011, half or under half the White illness rates for both men and women.
- Ethnic health inequalities in London in 2011 were more severe than elsewhere in England and Wales.

Health Inequalities

Poor health is caused by a wide range of factors, including biological determinants (age, sex, hereditary factors), and wider social determinants such as education, social position, income, local environment, and experiences of racism and racial discrimination.

The social determinants of health are unequally distributed across ethnic groups, leading to unjust and preventable

Figure 1: Ethnic inequalities in health for men in 2011.
Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, males 2011

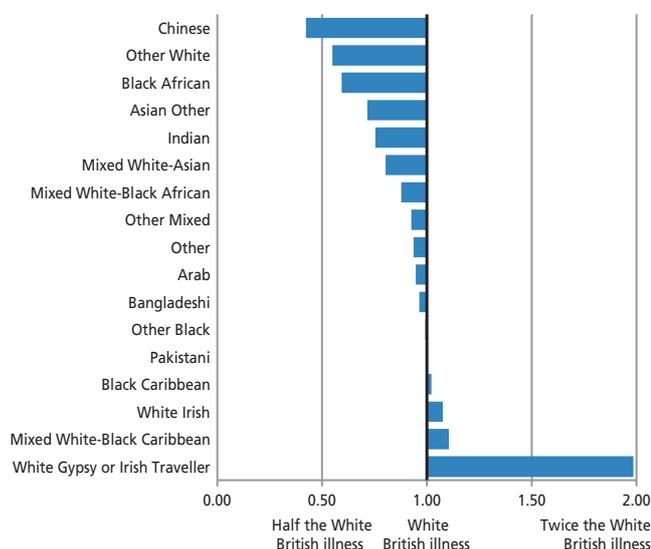
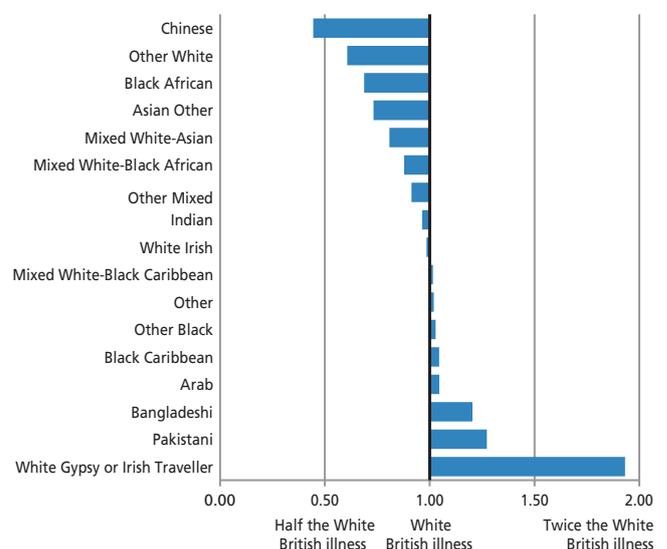


Figure 2: Ethnic inequalities in health for women in 2011.
Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, females 2011



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Which ethnic groups have the poorest health?

inequalities in health. As this briefing shows, ethnic groups have very different levels of ill health. The importance of the social over the biological determinants in patterning health across different groups in society is well documented,¹ including among studies comparing health across ethnic groups.² Addressing the social determinants of health is key to improving the health of the population of England and Wales, and to reducing ethnic health inequalities.

This Briefing uses *age standardised* illness rates to compare people of similar age, which avoids the misleading direct comparisons between populations with very different age structures (see box).

Ethnic inequalities in limiting long-term illness

Most ethnic minority groups have poorer health than the White British group, although ethnic health inequalities vary by gender.

As Figure 1 shows, in 2011 men from the White Gypsy or Irish Traveller, Mixed White-Black Caribbean, White Irish and Black Caribbean groups had higher rates of limiting long-term illness than White British men. Men in the White Gypsy or Irish Traveller ethnic group, identified for the first time in the Census, had almost twice the rate of having a limiting long-term illness than White British men.

Lower rates of limiting long-term illness as compared to White British are seen for men in some groups, such as Bangladeshi, Arab and Pakistani men. This health advantage is not observed in other outcomes including self-rated health that is also measured in the Census, where men from these ethnic groups report poorer health than White British men.

White British women had similar rates of illness as White British men, but had considerably better health than women of several ethnic minority groups (Figure 2). White Gypsy or Irish Traveller women had the highest rates of limiting long-term illness, almost twice the White British rate. Pakistani and Bangladeshi women also had worse health than the White British group.

Women from some ethnic groups, including Chinese, Other White and Black African groups, had lower rates of limiting long-term illness than White British women.

Ethnic health inequalities are substantially greater at older ages (Figures 3 and 4). 50% of all men aged 65 and over living in England and Wales reported a limiting long-term illness in 2011. White British older men report this average, but more illness is reported by White Gypsy or Irish Traveller (69%), Bangladeshi (69%) and Pakistani (64%) men. Among younger age groups the percentage of people from ethnic minority groups who have a limiting long-term illness is not very different compared to the England and Wales total (5% among men aged 0-15, and 12% among men aged 16 to 64). But the White Gypsy or Irish Traveller group stands out with much higher limiting long-term illness for all age groups (8% among boys aged 0-15, and 30% among men aged 16 to 64).

Measuring health

The 2011 Census included two measures of health: limiting long-term illness, and general self-rated health. Limiting long-term illness was measured by asking 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age' with responses 'Yes, limited a lot,' 'Yes, limited a little,' and 'No.' General self-rated health was measured by asking 'How is your health in general?' with the following options as responses: 'Very good', 'Good', 'Fair', 'Bad' or 'Very bad.'

These two measures are commonly used in health studies, as they are a predictor of mortality and health service use.³

In this briefing we have focused on limiting long-term illness, which allows us to compare across the three Census years, since it is the only health measure that was asked in 1991. The question on limiting long-term illness has been asked using slightly different wording across censuses. These changes in wording have important implications for how people interpret the question, and so comparisons across years have to be interpreted with caution. For this reason we have compared *inequalities* in each year, showing illness relative to the White British group, and the White group in 1991.

Why age-standardised ratios?

Older age is strongly associated with a decrease in health, and since most ethnic minority groups are younger than the White British group, the overall proportion of a group that is ill can be low even when their illness rates are high at each age. Figures here are produced with the indirect standardisation method, which calculates how much higher or lower the group's limiting long-term illness is compared to the average for England and Wales. For males and females separately, the calculation applies the England and Wales age-specific illness rates to the group's population to compute an 'expected' number ill. The age-standardised ratio is the observed number ill divided by the expected number ill. In order to compare the illness rates of ethnic minority groups to that of the White British group, we have divided the age-standardised illness rate of each ethnic group by the rate of the White British. A figure greater than 1 means more illness, and a figure lower than 1 means less illness than the White British population.

For women in 2011, the Pakistani, Bangladeshi and White Gypsy or Irish Traveller groups had a much higher percentage of their elderly populations with a limiting long-term illness (77%, 76% and 73% respectively, as compared to 56% among the total female population of England and Wales aged 65 and over). Older women in the Arab and Indian ethnic groups also reported high percentages of limiting long-term illness (66% and 68% respectively), whereas elderly Chinese women reported the lowest limiting long-term illness (47%).

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Figure 3: Percentage of males reporting Limiting Long-Term Illness in 2011, by age and ethnic group

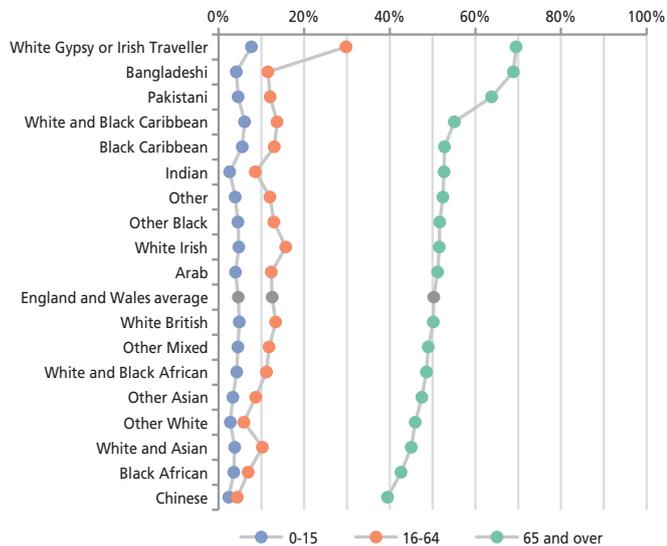
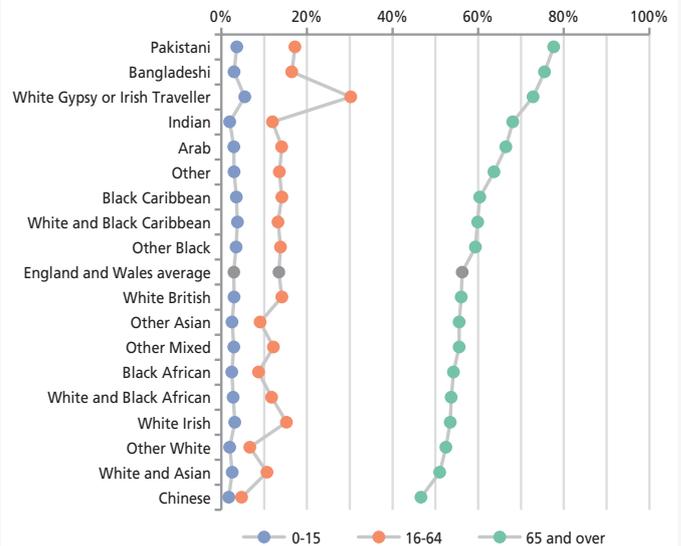


Figure 4: Percentage of females reporting Limiting Long-Term Illness in 2011, by age and ethnic group



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Women in some ethnic groups report limiting long-term illness considerably higher than the average across the whole age spectrum, not only in old age. For example, younger women of White Gypsy or Irish Traveller ethnic origin have high percentages of people reporting a limiting long-term illness as compared to the overall England and Wales population (5% among women aged 0 to 15 and 30% among women aged 16 to 64, as compared to 3% among all 0 to 15 year old women, and 13% among all 16 to 64 year old women in England and Wales).

Previous Censuses did not include the categories of White Gypsy or Irish Traveller and Arab, so we don't know from Census data whether the stark inequalities in rates of limiting long-term illness were present before 2011. We can, however, observe a persistent inequality in the illness rates of groups that are comparable in the 1991, 2001 and 2011 Censuses⁴. Figures 5-8 show the ratios of limiting long-term illness among males and females from ethnic minority groups, compared to the White British in 2001 and all White in 1991.

In 2001, the Pakistani, Bangladeshi, Black Caribbean, White Irish and Other Black groups have worse health than the White British group for both men and women.

Among women, the Indian group also reports high limiting long-term illness, and among men, the Mixed White-Black Caribbean group have a high rate similar to that of the Black Caribbean group.

For both genders, the rest of ethnic minority groups have lower rates of limiting long-term illness than the White British group. Rates of limiting long-term illness are particularly low for the Chinese group, which had almost half the rates of the White British group.

We can compare fewer ethnic minority groups to the White group in the 1991 Census, but we can still observe

persistent inequalities among the Pakistani, Bangladeshi and Black Caribbean groups (and among women, the Indian group) when compared to the illness rates of the White ethnic group (see Figures 7 and 8).

Wider ethnic health inequalities in London

There are clear regional health inequalities in England and Wales, where London and other regions in the South (South East, South West, and East of England) have a better health profile than the Northern regions. This North-South divide in health can be mostly explained by socioeconomic differences across regions, although there are also important socioeconomic differences *within* regions - London has high levels of socioeconomic inequalities, with some of the richest and poorest people in the country living in close proximity. London is also the most ethnically diverse region of England and Wales, which, together with its socioeconomic profile, creates a different pattern of ethnic health inequalities as compared to the other regions.

Ethnic health inequalities in London in 2011 were more severe than elsewhere in England and Wales. This is the case for most ethnic minority groups. Except for Other Mixed males and females, and Pakistani males, the minority disadvantage in London is greater than outside London, and for the groups with better illness than the White British group, the advantage is less.

Bangladeshi women were more than 30% more likely to have limiting long-term illness than White British women in London, compared to 15% more likely outside London. Arab men and women had considerably more limiting long-term illness in London than the White British group, but better health than the White British group outside London.⁵

Which ethnic groups have the poorest health?

Figure 5: Ethnic inequalities in health for men in 2001. Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, males 2001

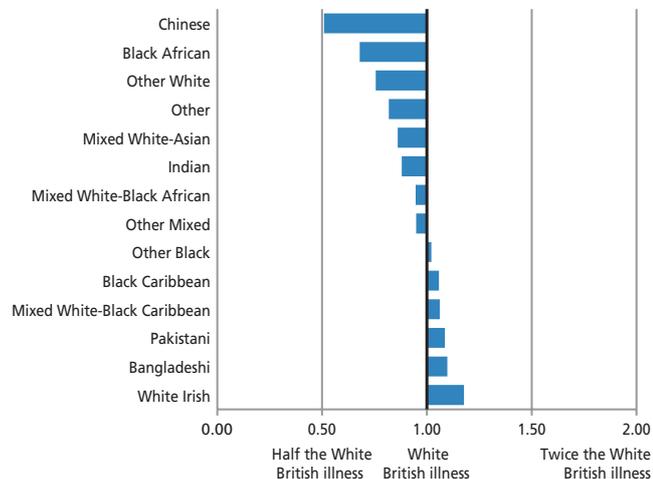
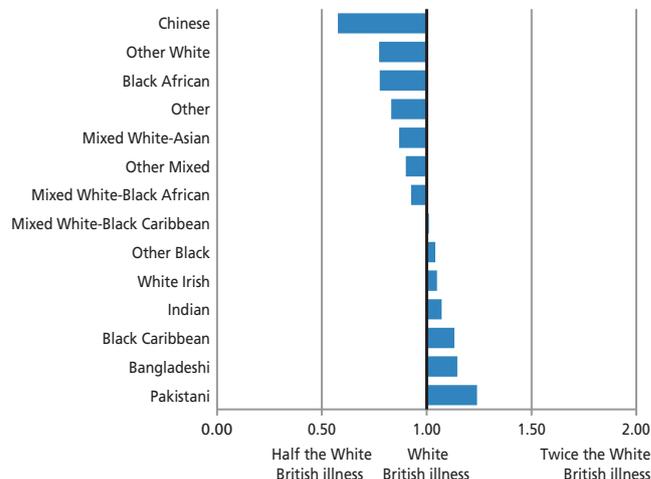


Figure 6: Ethnic inequalities in health for women in 2001. Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White British group, females 2001



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Figure 7: Ethnic inequalities in health for men in 1991. Age-standardised ratios of Limiting Long-Term Illness for ethnic minority groups, compared to the White group, males 1991

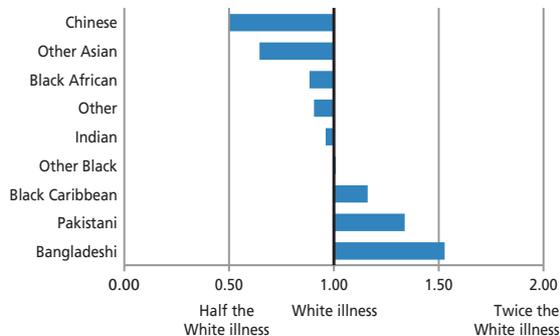
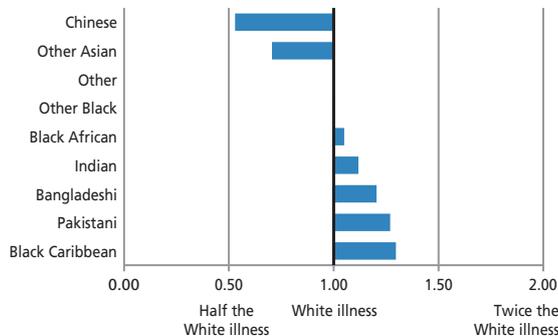


Figure 8: Ethnic inequalities in health for women in 1991. Age-standardised ratios of Limiting Long-term Illness for ethnic minority groups, compared to the White group, females 1991



[Click here for data in Excel](#)

¹ Acheson D. Independent inquiry into inequalities in health (the Acheson Report). London: HMSO, 1998.

² Nazroo, J. (2003). The structuring of ethnic inequalities in health: economic position, racial discrimination and racism. *American Journal of Public Health*, 93, 277-284.

³ Cohen, G., Forbes, J., Garraway, M., 1995. Interpreting self reported limiting long term illness. *British Medical Journal* 311, 722-724.

⁴ Comparable ethnic groups across Censuses [<http://www.ethnicity.ac.uk/census/comparability.html>]

⁵ The figures for London and the rest of England and Wales are available [here](#).

Sources: the 1991, 2001 and 2011 Censuses (Crown Copyright).

This briefing is one in a series, *The Dynamics of Diversity: evidence from the 2011 Census*.

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