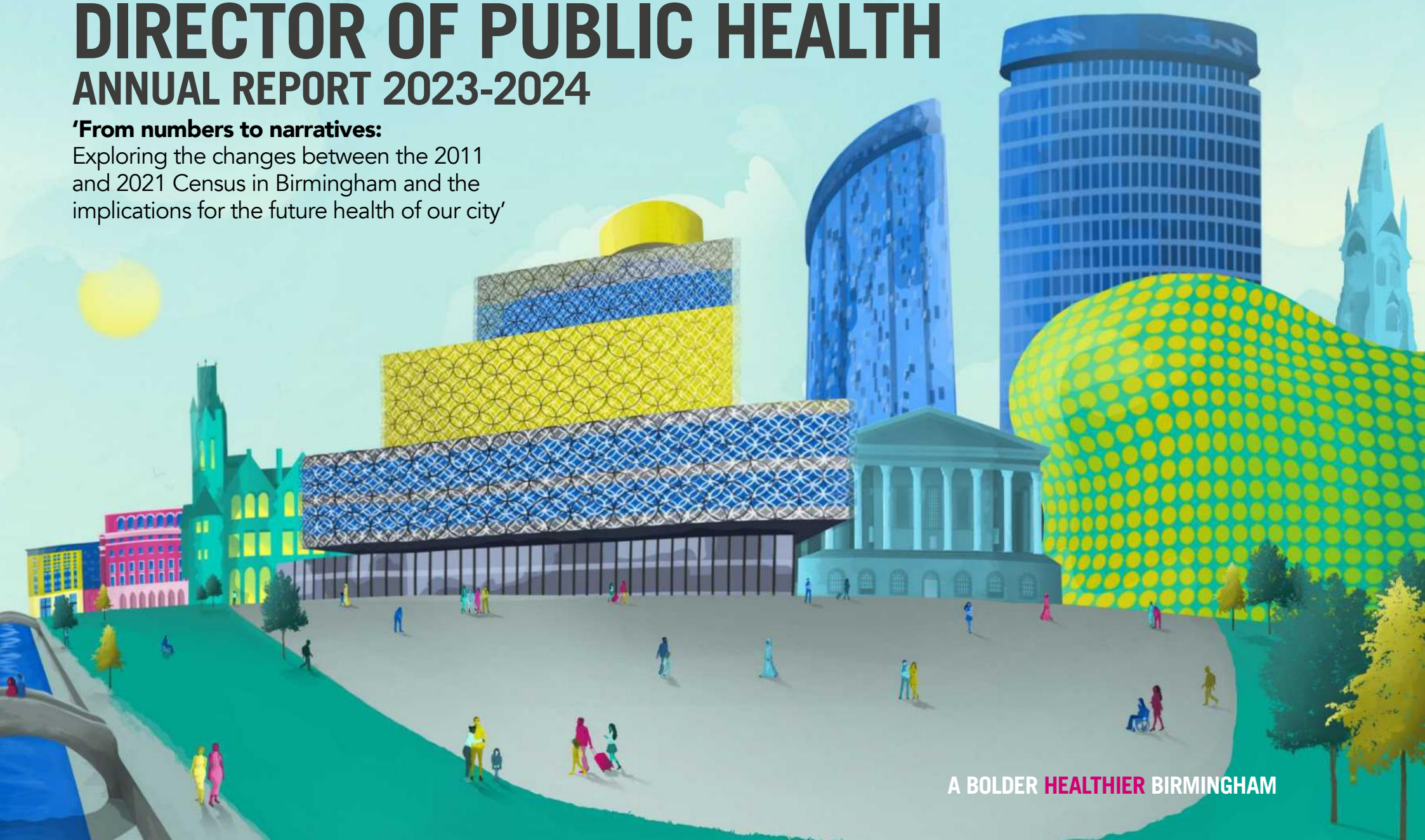
Birmingham City Council

DIRECTOR OF PUBLIC HEALTH

ANNUAL REPORT 2023-2024

'From numbers to narratives:
Exploring the changes between the 2011 and 2021 Census in Birmingham and the implications for the future health of our city'



A BOLDER HEALTHIER BIRMINGHAM

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FOREWORDS

Dr Justin Varney
Director of Public Health
Birmingham City Council

I am pleased to present this year’s Director of Public Health’s Annual Report, which explores some key demographic changes in our city.

Birmingham’s population is changing and will continue to change. Changes in demography bring opportunities to understand, learn from and engage with our diverse communities and citizens. A population with a different make-up has different needs, and by exploring how we are changing, the potential drivers and possible implications, we can collectively shape a healthier future for Birmingham.

Some of the changes we are experiencing reflect national trends, but some relate to our local history and shifts. Birmingham has changed significantly in previous decades and, in 2021, became a super-diverse city, meaning citizens from ethnic minorities make up more than half the population. Birmingham remains a young city, but it is still ageing with the rest of the country and will become older relative to the working-age population.

The report explores key areas through various sources, including census data. Once every ten years, the census allows us to build a detailed and comprehensive picture of Birmingham. The census was conducted in March 2021, during the extraordinary circumstances of the COVID-19 pandemic in our third national lockdown.

The census is not just another survey; it is much more than that because the information collected shapes the support available in our communities. As well as underpinning population estimates and projections that influence funding allocations, the census details population characteristics that help us tailor services to reflect Birmingham’s needs.

However, demographic change is more than statistical phenomena and the census. It is about people and communities, their stories, experiences and perspectives, and why we have included the voices of Birmingham’s citizens throughout this report. Many people have contributed to this report, and I am grateful for their insights and reflections.

We reflect on the past and look ahead to the future, but it is not all-seeing and all-knowing. Many things will change over time, so any glimpse into the future should be considered a ‘do nothing’ and ‘if nothing changes’ future.

This report is for everyone to use. I hope it inspires action across the city to understand our population further and enable our citizens to make choices that allow them to live long and healthy lives.

Cllr Rob Pocock
Acting Cabinet Member for Health and Social Care
Birmingham City Council

I am pleased to receive this year's annual report from the Director of Public Health, which focuses on the changing demography of Birmingham and how it might affect the health and wellbeing of Birmingham's citizens and communities.

There is no better time to look at our demography than now. Birmingham's population has changed significantly in recent years. This means we need to adapt our services and the ways they work to ensure they best align with the ever-wider range of expectations, needs and cultures of our city's changing population and engage with the diverse communities that live, work and learn in Birmingham. That's a pre-requisite for ensuring a thriving environment for all of Birmingham's citizens and communities.

As noted in the report, one of the most significant and unique changes for Birmingham is its super-diversity. This must become our distinctive asset, giving us an opportunity to celebrate and showcase our uniqueness, diversity and cultural heritage to the wider world. We can all be proud to be part of this wonderful city.

I was particularly interested in the report exploring how the different parts of our identities interact. It helps us understand that people may be disproportionately affected by a changing population because they face one or more inequalities relating to their identity. It also reinforced the challenges that we face as a council and a partner within the health and care system if we are to further reduce health inequalities with the city.

Trends and projections were explored, making it possible to predict the likelihood of the impacts of the demographic changes on health and wellbeing. It is time for us to come together, realising our strength, and taking advantage of the demographic changes while doing all we can to ensure that no one is negatively impacted, as we move forward in our collective aim of building a better Birmingham for the future.

INTRODUCTION

Purpose

All Directors of Public Health in England have a statutory duty to produce an annual report, usually on the health and wellbeing of their local community. In recent years, Birmingham has chosen to focus on a specific topic and to present the annual report as a 'discussion starter' on that topic. The focus of this year's annual report is on Birmingham's changing demography, as captured by the 2021 Census, and how these changes will affect the health and wellbeing of its residents in the future. This topic has been chosen because Birmingham's population has rapidly changed since the last census. In some respects, it has mirrored national trends, such as a gradually ageing population and shifts to homeworking. In others, it is more unique, such as through its ethnic superdiversity or migration profile. Moreover, the 2021 Census data gives us a rich and comprehensive understanding of the population by allowing us to combine all variables and see a more complete and more holistic picture.

The report predominantly uses data from the 2021 Census, along with supplementary data from other sources, and seeks to answer three questions for each chapter:

1. What does the data tell us?
2. What are the health and wellbeing implications?
3. What might this look like in the future?

The report is split into six chapters each focusing on a topic within the census that illustrates the changes in Birmingham's population and their implications for health and wellbeing. Within each chapter, there are several data headlines which summarise the greatest changes and trends and the headline health and wellbeing implications. There are also case studies from Birmingham residents on their perspectives of demographic change in the city and their outlook for the future. Finally, there are reflection statements on the data and discussion in each chapter from key leaders across the council, its partners and the community and voluntary sector in Birmingham.

Context

The census is a national survey completed by the whole population every ten years. It is undertaken by the Office for National Statistics (ONS) who then compile and release the data publicly.[1] The census provides vital insights into the population at the exact time it was conducted.
The 2021 Census was conducted on the 21st of March 2021 and was the first census to ever be completed digitally alongside paper booklets.[1]

The 2021 Census was also unique because it was conducted during the COVID-19 pandemic. At the time, Birmingham, alongside the rest of the United Kingdom, was still in a form of 'lockdown' and many regular activities were restricted to prevent the spread of the virus.[1]
As a result, some of the data collected was not representative of the usual circumstances that the population live, work, and socialise in. This means that it is harder to compare the data collected in 2021 to previous censuses and establish trends about the population. This issue will be explored later in the report.

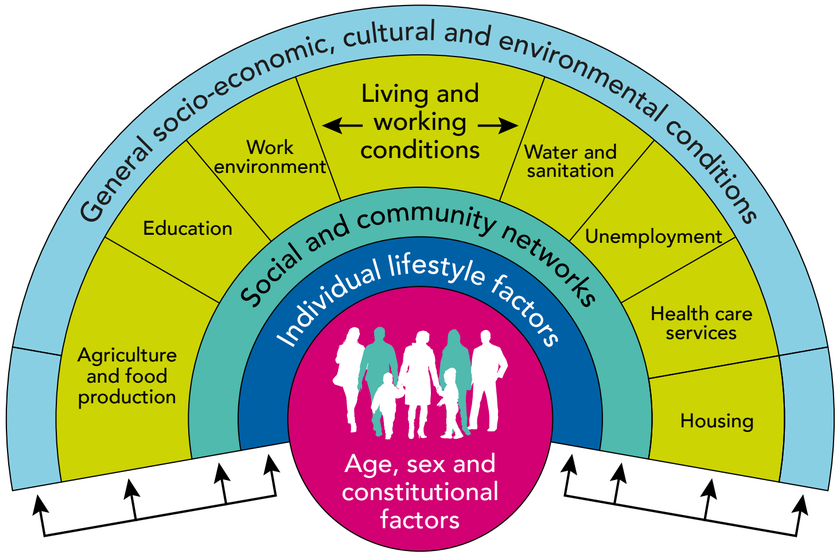
The rationale for the chapter topics is that each of them encapsulate an aspect of the Birmingham's population that has experienced major changes since the last census and can be part of a broader demographic trend. These chapter topics are:

1. Age
2. Ethnicity
3. Sexual Orientation & Gender Identity
4. International Immigration
5. Housing
6. Employment.

While these topics broadly align with those in the 2021 Census, they also have a clear relevancy to the health and wellbeing of the population. This can be shown through the Dahlgren and Whitehead Model of Health Determinants (Figure 1).

The model shows the influence that these determinants can have on health and wellbeing with the centre focused around physical or genetic factors and the next layers focusing on lifestyle, social networks, living conditions and environment. The topics chosen for the report coincide with several of the determinants identified in the model. Equally, the model emphasises that these determinants are interconnected and should be treated as such. While this report is split into chapters, we have explored how these determinants relate to each other. This will also present an intersectional understanding of the population's health needs.

Figure 1: Dahlgren and Whitehead's Model of Health Determinants[2]

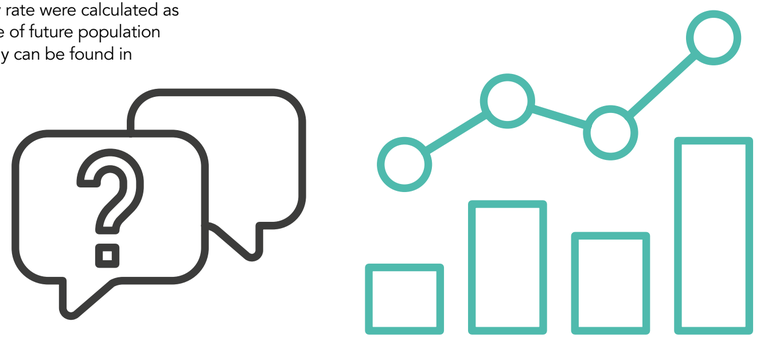


Our approach

This report has been developed through several stages, using a variety of primary and secondary sources to inform the insights and analysis. Initially, a research question was created to frame the direction of the report and the areas of the census to explore. Three sub-questions were then developed for each chapter to further explore the data and understand the potential implications for health and wellbeing.

Chapter topics were scoped by using the topics of the 2021 Census that highlighted the greatest changes for Birmingham. Under these topics, the relevant data was collated, and particular variables were chosen to best present the data through. Equally, for the topics where it was possible, population projections were produced to consider what the population might look like by the time of the next national census in 2031. These projections were developed using the current population figure and then factoring in the birth rate, death rate and migration trend for each subsequent year. To reduce the uncertainty with these rates, total fertility rate and age-dependent mortality rate were calculated as probabilistic. This allowed for a plausible range of future population numbers, as seen in Figure 3 (Full methodology can be found in Appendix 2).

Once the topics were agreed, an evidence review was conducted for each chapter to establish an understanding that could complement the census data through possible health and wellbeing implications. Further to this, a brief qualitative project was commissioned to gather the perspectives of Birmingham's residents on these changes. A selection of these perspectives has been presented as case studies and quotations in each chapter. Finally, a series of stakeholders have been engaged on each chapter topic to provide a 'system reflection' that includes both their response to the data and their local insight on how they may affect Birmingham in the future.



'Birmingham in 2021': A snapshot

AGE

THE AVERAGE (MEDIAN) AGE OF BIRMINGHAM INCREASED BY TWO YEARS FROM 32 TO **34** YEARS OF AGE

BIRMINGHAM HAD THE LOWEST AVERAGE (MEDIAN) AGE

in the West Midlands and a lower average (median) age than England **(40 years).**

THE NUMBER OF PEOPLE AGED 50 TO 64 YEARS ROSE BY JUST OVER 30,900

(an increase of 20.0%).

THE NUMBER OF PEOPLE AGED 4 YEARS AND UNDER FELL BY AROUND 6,900 (8.4% DECREASE).

ETHNICITY

BIRMINGHAM IS NOW A SUPER-DIVERSE CITY. THE CITY'S MINORITY ETHNIC GROUPS NOW REPRESENT MORE THAN HALF (51.4%) OF THE POPULATION.

31.0% OF BIRMINGHAM RESIDENTS IDENTIFIED THEIR ETHNIC GROUP AS ASIAN, ASIAN BRITISH

11.0% IDENTIFIED AS BLACK BLACK BRITISH BLACK WELSH CARIBBEAN OR AFRICAN

4.8% IDENTIFIED AS MIXED/MULTIPLE ETHNIC GROUPS

4.2% IDENTIFIED AS OTHER ETHNIC GROUP AND

48.6% IDENTIFIED AS WHITE

The greatest increases were for 'Pakistani' (an increase of **3.6%** on the proportion) and 'African' (an increase of **3.0%** on the proportion).

SEXUAL ORIENTATION AND GENDER IDENTITY

87.6% OF BIRMINGHAM RESIDENTS IDENTIFIED AS STRAIGHT OR HETEROSEXUAL

3.0% IDENTIFIED WITH AN LGB+ ORIENTATION

9.4% DID NOT ANSWER THE QUESTION ON SEXUAL ORIENTATION

90.8% ANSWERED THAT THEIR GENDER IDENTITY WAS THE SAME AS THEIR SEX REGISTERED AT BIRTH

0.9% answered that their gender identity was different from their sex registered at birth, and 8.4% did not answer the question on gender identity.

OF THOSE WHO IDENTIFY WITH AN LGB+ ORIENTATION

44.7% ARE GAY OR LESBIAN

42% ARE BISEXUAL

7.6% ARE AN OTHER SEXUAL ORIENTATION

INTERNATIONAL IMMIGRATION

AROUND **824,000** BIRMINGHAM RESIDENTS SAID THEY WERE BORN IN ENGLAND **(72.0%)**

PAKISTAN WAS THE NEXT MOST REPRESENTED WITH AROUND **67,400** BIRMINGHAM RESIDENTS REPORTING THIS **COUNTRY OF BIRTH (5.9%)**

This figure was up from around **55,900** in 2011, which at the time represented **5.2%** of the population of Birmingham.

PEOPLE WHO WERE BORN OUTSIDE OF THE UK BUT NOW LIVE IN BIRMINGHAM GENERALLY ARRIVE IN THE UK AT A **YOUNG AGE**

THE AGE GROUP WITH THE **HIGHEST** NUMBER IS **20-24 YEARS** (MALE AND FEMALE)

HOUSING

27.2% OF HOMES IN BIRMINGHAM WERE OWNED OUTRIGHT IN **2021**

MOST HOUSEHOLDS IN BIRMINGHAM HAVE **ONE PERSON** PER HOUSEHOLD

OVER HALF OF PEOPLE **AGED 85 YEARS AND ABOVE LIVE ALONE** IN BIRMINGHAM

22.6% OF HOUSEHOLDS IN BIRMINGHAM WERE RENTED PRIVATELY

UP FROM 17.9% IN 2011

JUST UNDER **ONE IN FOUR HOUSEHOLDS (23.5%)** lived in socially rented housing, compared with **24.2%** in 2011.

EMPLOYMENT

52.1% OF THE POPULATION WERE **ECONOMICALLY ACTIVE** WHILE 44.4% WERE **ECONOMICALLY INACTIVE**

3.5% WERE ECONOMICALLY ACTIVE WHILE FULL-TIME STUDENTS.

ECONOMIC INACTIVITY INCREASED BETWEEN 2011 AND 2021

The biggest reasons for this were 'retirement' **(15.6%)** and '16+ education' **(10.0%)**.

OF THOSE IN EMPLOYMENT REPORTED THAT THEY WORK MAINLY AT OR **FROM HOME**

THE MOST COMMON **METHOD OF** TRAVELLING TO WORK REMAINS **A CAR OR VAN (45.9%)**

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Figure 2: Population pyramid for Birmingham (2011 and 2021)[1]

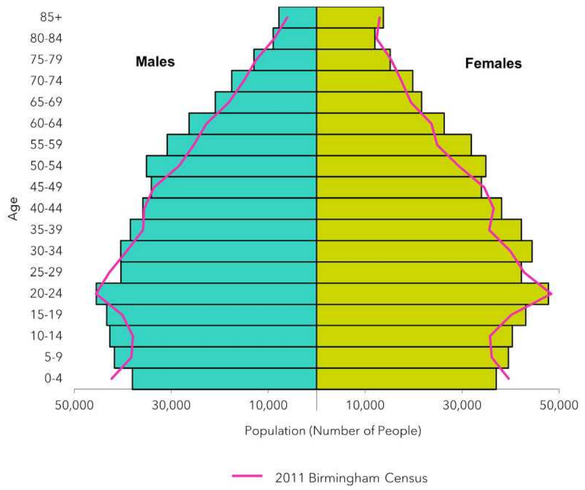


Figure 3: Population projection by all ages to 2031 in Birmingham.

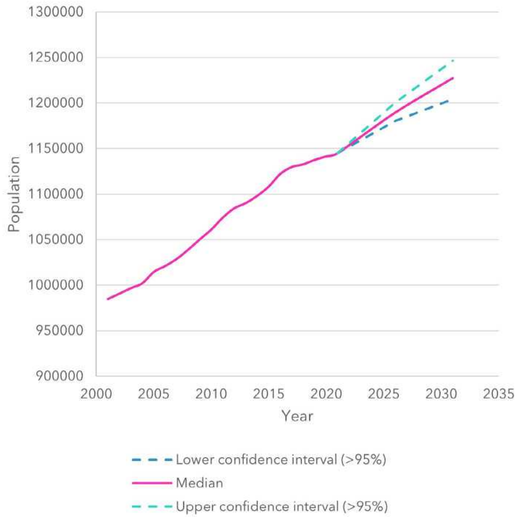


Figure 4: Life expectancy at birth for Birmingham and England (Females) (2001-2022)

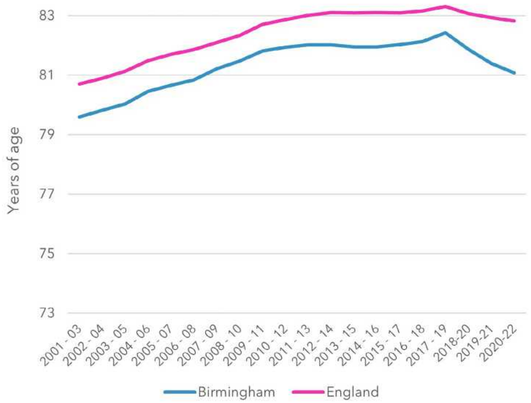
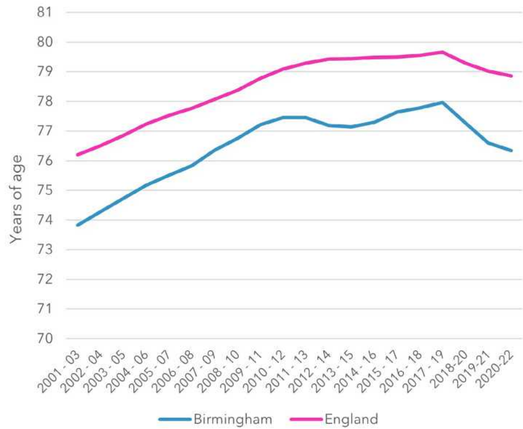
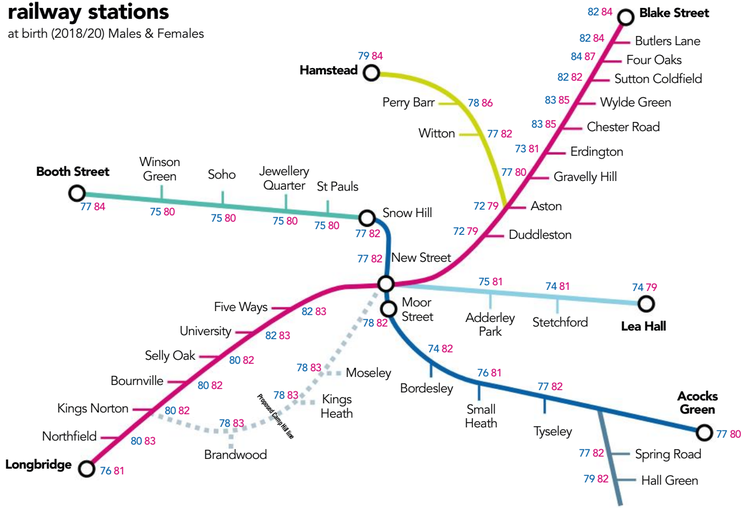


Figure 5: Life expectancy at birth for Birmingham and England (Males) (2001-2022)



Life Expectancy by Birmingham railway stations

at birth (2018/20) Males & Females



Average male life expectancy in Birmingham is **77.1 years** compared to **79.4 years** for England

With only **one stop** you can shave **ten years** off the average life expectancy of a male citizen

Average female life expectancy in Birmingham is **81.8 years** compared to **83.1 years** for England

With only **two stops** you can shave **five years** off the average life expectancy of a female citizen

Figure 6: Life expectancy at birth by Birmingham railway stations

Implications of demographic change for health and wellbeing

Age	Ethnicity	Sexual Orientation and Gender Identity
• Changes in birth rates and decreases in number of children mean there is increased uncertainty for planning to meet the needs for education and children-related services in the future, as well as uncertainty on planning for the complexity of the need. • As a greater number of Birmingham's population enters older age, there will be an associated rise in health and social care need. • Health and care needs associated with ageing will be geographically spread across the city, with higher proportion of older people in the north and southern areas of the city, and inequality bringing poor health to those in deprived areas at a younger age. • Whilst ageing is inevitable, aging in poor health is not. There is much that can be done to delay or prevent the decline in physical, mental, and emotional well-being and to enable older people to maintain independent lives.	• Ethnic minority groups tend to experience higher rates of conditions such as diabetes, obesity, asthma, heart disease, and cancer, and may also experience earlier onset. • Ethnicity impacts on health through different mechanisms: racism and discrimination, social determinants including income, education, employment and housing, cultural and lifestyle factors, health services and clinical factors and genetics such as sickle-cell disease. • The age-ethnicity profile in the city varies greatly, with the older age-group having a different ethnicity profile to the younger age-groups: there is a need for services to recognise this and respond to need appropriately and adapt over time. • With continued increase in ethnic minorities populations, specific diseases will see increases such as sickle cell disease which has an increased prevalence in African and Caribbean populations, and Type 2 diabetes which is higher in South Asian groups. • Ethnicity intersects with other characteristics, leading to worse health outcomes for example for older adults and people with learning disabilities from minority ethnic groups.	• The LGBTQ+ population is more likely to be affected by inequalities around mental health and wellbeing, substance misuse, and smoking rates. • They are also more likely to experience direct and indirect discrimination both when accessing health-related services and in wider society. • Those who identify as 'trans+' and seek to medically transition face additional barriers as there are no Gender Dysphoria Clinics in the West Midlands and long-waiting lists for referrals and treatment. • Future trends are difficult to determine as this was the first time LGB+ data have been collected in the Census, many possible reasons for non-reporting and uncertainty on whether greater identification of LBG+ in the younger population will continue as this population ages.

International Immigration	Employment	Housing
• Migrants often experience barriers in accessing health and social services, especially if they are undocumented. • Migrants may experience discrimination and are therefore vulnerable to physical and mental illness. • Those who migrated for employment, family and study reasons have better health than the UK-born, while those who migrated to seek asylum have worse health outcomes. • Those who migrate are more likely to be younger and are also less reliant on the health system. • Migrants who choose to migrate have better health than their host population, but there is a deterioration of health status the longer they reside in the host country.	• With increasing age, the proportion of economically inactive residents reporting long-term sickness or disability as the cause of their inactivity increases up to pre-retirement ages (50-64 years). • People who are economically inactive primarily because of their health tend to have increasingly complex health needs, the majority with more than one health barrier to them returning to the labour market. • Pre-pandemic there was a trend of increasing prevalence of poor health, and of poor health as a reason for economic inactivity. Further to the pandemic, economic inactivity for health reasons is likely to be exacerbated by conditions like long COVID and longer waiting lists for treatment, and the impact on the mental wellbeing.	• Housing is one of the key determinants of health and homelessness hugely impacts health and wellbeing. • Overcrowding can have negative effects on both physical and mental health and wellbeing and is associated with increased risk of infectious diseases such as COVID-19. • Living alone can be associated with unfavourable health outcomes such as anxiety, depression, and physical health conditions. • Owning a house can improve mental health, as this can provide a sense of emotional security: mental distress is more common in renters than homeowners.

AGE

AGE

Data Headlines

- Birmingham's birth rate has declined by 3.4% over the past decade and the number of 0-4 year olds has decreased by around 6,900 (8.4% decrease)
- The total population grew with the largest population increase seen in the pre-retirement age groups, with those aged between by 55-59 growing by 25% (12,400) since 2011.
- 50% of 65+ year olds in 2021 reported very good or good health compared to 41% in 2011.

Implications for Health and Wellbeing

- Changes in birth rates and decreases in number of children mean there is increased uncertainty for planning to meet the needs for education and children-related services in the future, as well as uncertainty on planning for the complexity of the need. .
- As a greater number of Birmingham's population enters older age, there will be an associated rise in health and social care need.
- Health and care needs associated with ageing will be geographically spread across the city, with higher proportion of older people in the north and southern areas of the city, and inequality bringing poor health to those in deprived areas at a younger age.
- Whilst ageing is inevitable, aging in poor health is not. There is much that can be done to delay or prevent the decline in physical, mental, and emotional well-being and to enable older people to maintain independent lives.

What does the data tell us about age in Birmingham?

Birmingham has a young demographic profile compared to the rest of the country.[3] Overall, the population of Birmingham has seen an increase of 6.7%, growing from around 1,073,000 in 2011 to 1,144,900 in 2021: approximately 255,300 (23.4%) of the population are aged under 16 years old, 686,500 (57.7%) are aged between 16 and 59 years old, and 203,100 (18.9%) are aged 60 years and above.[3] This is compared to England where the population is 18.6%, 57.3% and 24.2% in the same respective age groups.[1]

Whilst Birmingham remains a young city, the number of adults and older people has increased. Between the last two censuses, Birmingham's average (median) age increased by two years, from 32 to 34 years of age. This remains the lowest in the West Midlands and lower than the England average (40 years).[1]

The reasons behind these demographic changes in Birmingham's size and age structure include natural change, which refers to the difference between the number of births and deaths4 and international migration[5]. The city has been attracting individuals from around the world, contributing to its diverse and dynamic population[6] while Birmingham-born have also residents moved to other areas[7].

"I've seen a lot more young people around Birmingham, in town, and I think just in schools as well, because I was doing some work experience at my school and they normally have six form classes in secondary school, and they've had to add another one just because so many young people are coming in ...

Kabir 19, Male, Handsworth Wood

Birmingham's changing age profile also influences the health and care needs of the population. Whilst ageing is inevitable, ageing in better or worse health is more variable. With the greatest need and vulnerability in the youngest and oldest ages, a preventative approach to poor health can help the entire future population.

The birth rate across Birmingham has decreased since 2011 as has the number of under 5 year olds

Figure 7: Live Births and Total Fertility Rate in Birmingham (2021)[8]

Date	Live Births	Total Fertility Rate (TFR)	Percentage Change in births
2019	15,483	**1.78**	
2020	14,991	**1.74**	**-3.2%**
2021	14,477	**1.68**	**-3.4%**
2022	14,482	**1.66**	**0.0%**

Since 2011, Birmingham has experienced significant shifts in its birth rate.[3] The Total Fertility Rate (TFR), which represents the average number of children a woman would have, assuming that current age-specific birth rates remain constant throughout her childbearing years, decreased from 2.09 in 2011 to 1.74 in 2020.[8]

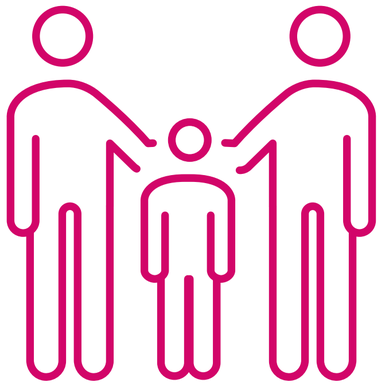
The ONS outlined potential factors contributing to the decline in total fertility rates[9]:

1. Increased accessibility to contraception.
2. Higher participation in higher education.
3. Postponing the formation of partnerships/marriages.
4. Prioritising longer careers before starting a family.
5. Uncertainties in the labour market.

Furthermore, between 2011 and 2021, the decline in the number of births in Birmingham was much steeper for UK-born mothers, with a decrease of 21%, compared to a modest 2.2% decrease for non-UK born mothers.[8]

"Pregnancy isn't all what people might make it out to be. It is like a very lonely time, and the people who are most closest to you are actually the people that you push away."

Nicola, 20, Female, Kingstanding



A significant reduction (9.2%) in the number of children aged 4 years and under was observed in 2021 compared to 2011 (Figure 8). This trend varied across the city as some wards experienced a percentage increase in this age group. The wards with the greatest proportion of the population aged 4 and under are in Central and East Birmingham (Figure 10): just under 10% of the population in Tyseley & Hay Mills are aged 4 and under. This is in contrast to Bournbrook & Selly Park where just over 2% of the population are aged 4 and under.[1]

Figure 8: Population change for those under 4 years old in Birmingham between 2011 and 2021 (2021)[1]

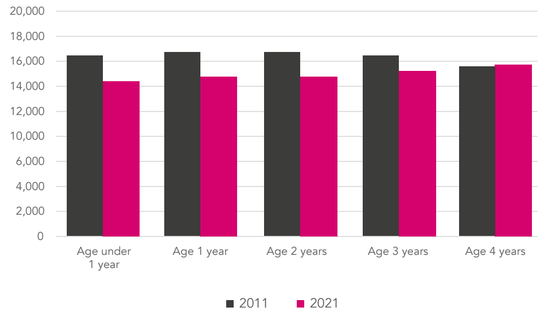


Figure 9: Ward map of Birmingham showing the largest percentage change in those aged 0-4 between 2011 and 2021[1]

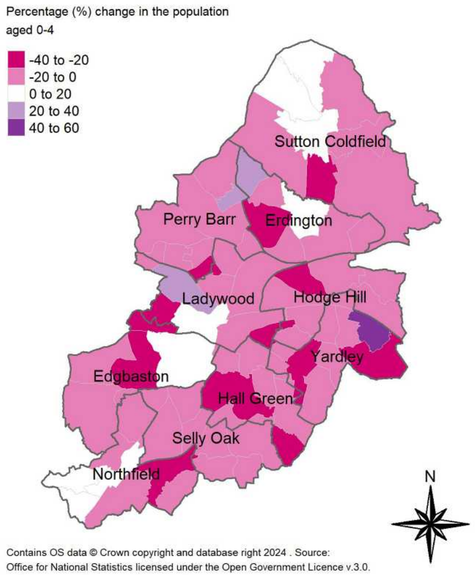
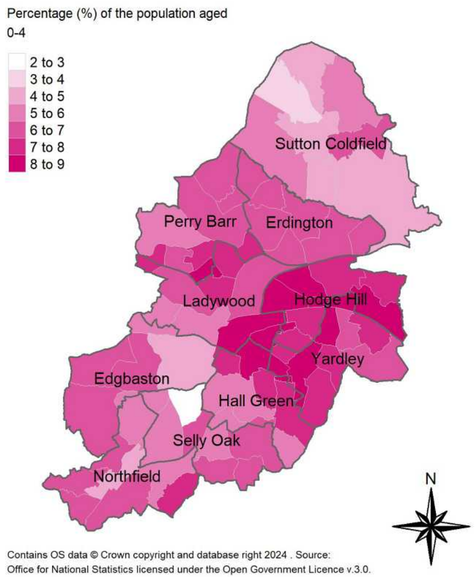


Figure 10: Ward map of Birmingham showing the percentage (%) of the ward aged 0-4 (2021)[1]



One of the main implications for a declining birth rate is the impact upon services for children, including education.[4] Many schools are state-funded on the basis of pupil numbers and uncertainty around future enrolment may impact on future funding allocations, potentially leading to increased competition among schools for children, especially urban and lower-rated ones.[10] As noted earlier, this trend varies across wards, so the pressure on schools and other services for children will be different in different wards.

Equally though, both internal and international migration have been shown to play an important role in maintaining the number of pupils in schools.[11] In January 2018, approximately 7% of children in state-funded primary schools and 10% in state-funded secondary schools in England were born outside the UK.[13] Similarly, migration data from the 2021 Census shows that the 'inflow' of children (aged 1 to 15) into Birmingham slightly exceeded the 'outflow' leaving the city.[12] While migration to some extent offsets the effects of a declining birth rates, there will still likely be a considerable impact on the number of children in the city in the long term.[13] Therefore, it is imperative for policymakers and education leaders to consider these trends and develop comprehensive strategies.

"As you say, the age has increased by two years. It looks to me a lot more than that... but maybe that's just the people I engage... obviously, I'm nearly 65, but everyone in the pub seems to be getting older as well..."

Terry, 65, Male, Sutton Walmley & Minworth

Largest increase in pre-retirement and retirement age groups by 20%

Figure 11: Population change (%) between 2011 and 2021 by age group[1]

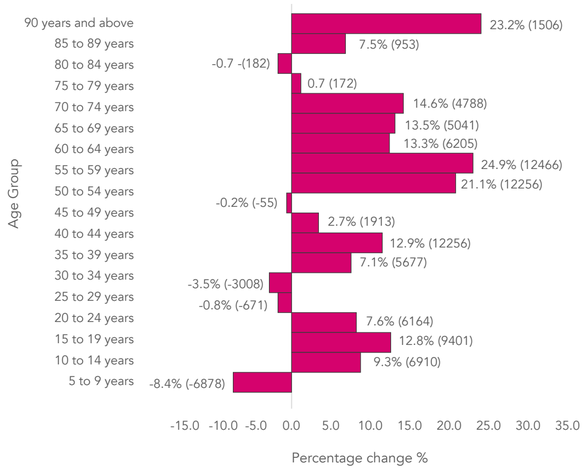


Figure 11 shows the population change by percentage and number within roughly 5 year age bands. The largest increases can be seen in the majority of age groups above and including 50 years. This is also where there has been the greatest increase in the actual number of people within the age group. Figures 11 and 12 (below) show the geographic distribution of those in the pre-retirement and retirement populations across the city. The majority of these populations live in the far north and far south of Birmingham, although it is clear that the 55-59 age group is more geographically spread. Figures 13 and 14 show where there has been the greatest percentage increase in these age groups on a ward level.

The pre-retirement age group in Birmingham, typically those aged 50 to 64, has seen a significant average increase of 19.8%, the highest among all age groups.[2] This is likely to be as a result of a cohort effect where there are a greater number of people within this age group, just as the 40 to 54 age group would have appeared in the 2011 Census. Locally, Newtown recorded the most significant percentage increase within the 55-59 years and 60+ age group.[1].

National forecasts predict an overall rise in the pensioner population.[3] As of 2020, there were 280 pensioners for every 1000 working-age individuals in England.[15] This ratio is expected to increase rapidly from the 2030s, reaching an unprecedented 393 pensioners per 1000 working-age people by 2070.[14] Birmingham's population of people aged 65 and over is expected to grow by 29% to 194,100 by 2040, up from 150,600 in 2020.[8]

Figure 12: Ward map of Birmingham showing the largest percentage change in those aged 55-59 between 2011 and 2021[1]

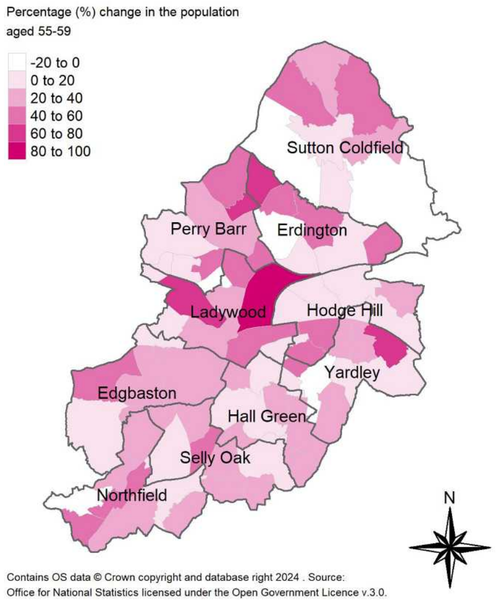


Figure 13: Ward map of Birmingham showing the largest percentage change in those aged 60 and older between 2011 and 2021[1]

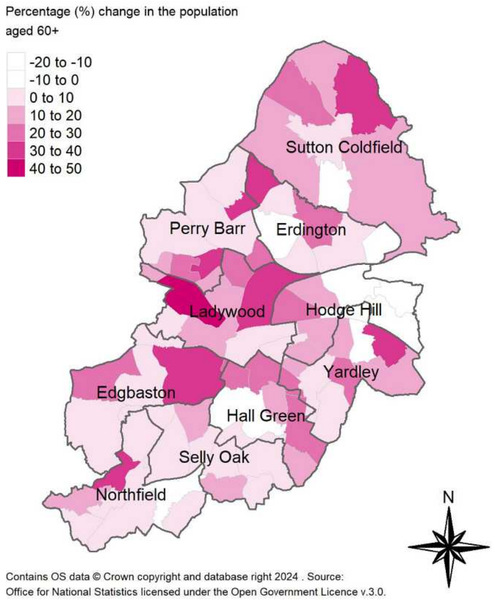


Figure 14: Ward map of Birmingham showing the percentage (%) of the ward aged 55-59 (2021)[1]

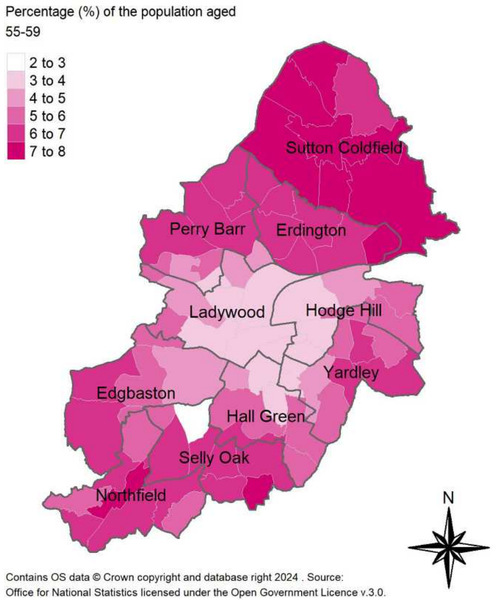
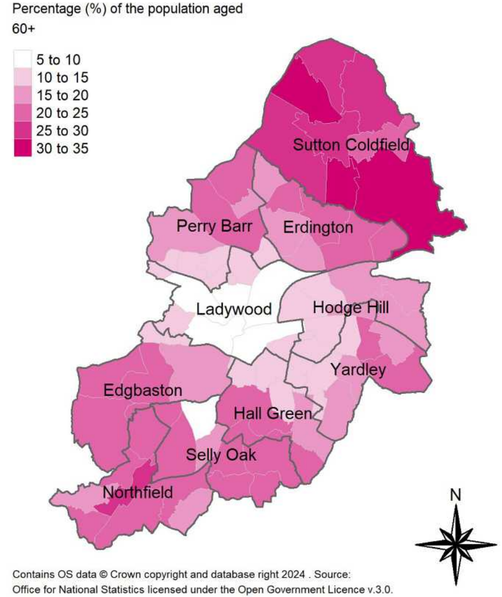


Figure 15: Ward map of Birmingham showing the percentage (%) of the ward aged 60 and older (2021)[1]



Case Study: Michelle

Ward:	King's Norton North	**Sexual Orientation:**	Heterosexual
Age:	58	**Gender & Gender Identity:**	Female
Ethnicity:	Black British	**Occupation:**	Hotel housekeeper
Faith:	Christian	**Living Arrangements:**	Homeowner with a mortgage or loan

Michelle has noticed the population increase, explaining that there are more cars around and longer wait times for NHS appointments. She recognises that there is an ageing population and thinks this is due to a mixture of people living longer and fewer children being born due to the cost of raising a child. Michelle believes the cost of living has significantly increased in recent years and questions the reasons why it has risen so drastically.

"[Fewer people under 4 years old] "It doesn't surprise me at all really. I think financially, people probably are having less children because they're so expensive. When I was growing up and all my friends of my age group have families with five or more in the family. Now you probably get two or three at the most in a family, because it's just the cost thing and people tend to have less children"

Michelle has always been fairly healthy and active. She goes to the gym regularly and her job requires her to walk a lot. She thinks that people are now more focused on their health and wellbeing, and are much more pro-active in looking after themselves.

She described an app offered at work that supports employees with their mental health. Although she doesn't use it herself, she feels that having support systems in place, such as apps and helplines, is important for those who may not have a strong support network like she does. Michelle has a strong friendship group who she sees regularly, which helps her mental health.

"I've always been pretty healthy, going to the gym and I'm working at a hotel and we do a lot of walking around the building."

"I think people focus more on their health and wellbeing now. Whereas you sort of just did it before, you didn't think, 'I've got to do this for my health or for my wellbeing.' It's now at the forefront."

Michelle is not overly concerned about her own future, as she appreciates her own financial security, however, she is worried about other family members, particularly her nieces and nephews, who she thinks will struggle to be able to ever afford their own property.

"I don't worry too much about my future. It's more my family's future and their health and wellbeing. I'm quite resilient and I'll just get on with it and I don't feel too worried about anything."

Michelle would like to see greater financial support to families with a single parent or those in low-income households. She suggested creating more job opportunities, encouraging people to work rather than relying on benefits. She believes these opportunities could involve the community, such as cleaning the streets or gardening.

"I think it's looking at ways of helping the single parents or people on low income, providing more jobs for people, getting them out, doing things, you know."

"There's so many people suffering at home claiming benefits, so I think could be out there working and doing more to help Birmingham. So then we can put more money for the people that are working, but on low income."

65+ year olds in 2021 report better health than those in 2011

Self-reported health of individuals aged 65 and over in Birmingham has seen a significant improvement over the past decade (Figure 16).[2] In 2021, 49.1% of individuals aged 65 and older described their health as either good or very good, compared to 41.2% in 2011.[2] There is a large disparity in self-reported health across the city, with those aged 65 years and over who report 'Very good or good health' concentrated in wards with lower levels of deprivation (Figure 17). Moreover, individuals in the more affluent parts of Birmingham can anticipate a life expectancy that is approximately five years longer after age 65 than their counterparts in the most deprived areas.[1]

Figure 16: Self-reported health status for 65-year-olds and above (2011 & 2021)[1]

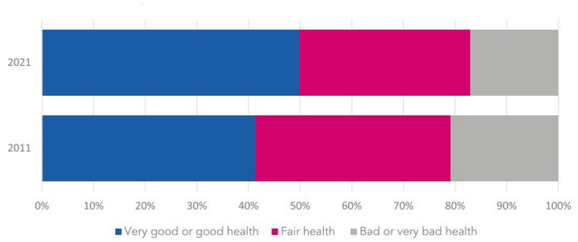
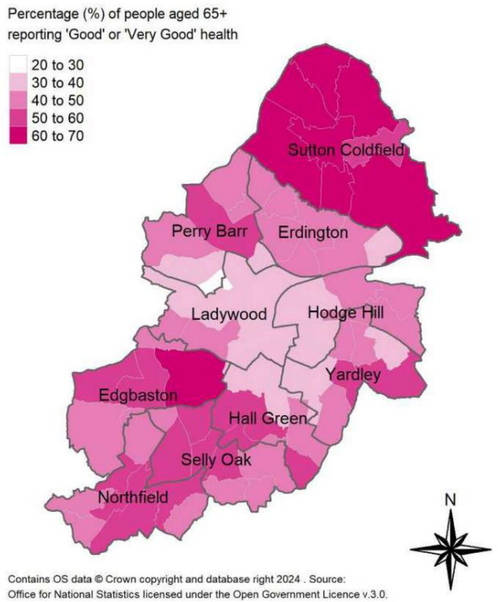


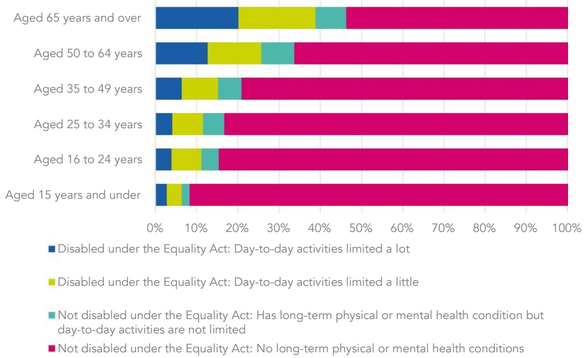
Figure 17: Geographic distribution of 65 years and above who report 'Very good or good health' (2021)[1]



While the data suggests an overall improvement in self-reported and a marginally smaller number of people reporting a disability, the prevalence of long-term conditions and disabilities impacting day-to-day activities will continue to increase with age (Figure 18).[15] In a more elderly population, you would expect more disability and poorer health, with higher levels of unpaid care and an increased demand for health and social care services. With advancing age, the likelihood of developing two or more chronic health conditions such as cardiovascular disease (CVD), cancer, respiratory ailments, diabetes and pain, significantly increases[15]. Additionally, dementia, frailty, recurring back issues and risk of falls becomes more prevalent, while poor mental health, isolation, and loneliness can affect those with diminishing social circle and limited opportunities for social interaction.[15]

Whilst ageing itself is inevitable, ageing in ill-health is not. There is much that can be done to delay or prevent the decline in physical, mental, and emotional well-being and to enable older people to maintain independent lives. Stopping smoking, maintaining healthy weight, reducing alcohol, increasing physical activity, healthy diet and nutrition all improve health in older age.[16] Supporting our older population (and future older population) to maintain a healthy lifestyle requires a supportive environment, such as access to green spaces and safe streets, as well as services and behavioural interventions. Early identification of disease and decline e.g. through screening programmes, recognition of sight or hearing loss, also extend the period that people can live in better health. For example, there is good evidence that addressing hearing loss in older people can help people remain socially active, reduce the risk of depression, and may reduce risk of dementia.[16,17]

Figure 18: Disability status by age group (2021)[1]



"I think you can see that the number of people aged between 50 and 64 has rapidly increased, basically. I think you can see that's in the amount of, like, nursing homes, retirement homes, like at assisted living and everything, like where I live, they're just popping up constantly."

Jack, 26, Male, Sutton Wylde Green

What might this look like in 2031?

The population of Birmingham is projected to continue growing increasing from 1,141,400 in 2018 to 1,186,000 (3.9%) in 2028 and 1,230,000 (7.8%) by 2038. Factors such as natural change (the difference between births and deaths) and international and national migration are likely to continue influencing Birmingham's population growth.

The age-structured projections for Birmingham's population indicate a shift in demographic trends over the next decade (Figures 18 -22). Key changes are:

- By 2031, Birmingham will have a projected 227,000 individuals under the age of 14 – a decrease from 239,350 in 2021. The number of children in each 5-year age-group (0-4, 5-9 and 10-14 years) is expected to decrease, although there is greatest uncertainty around the predictions for 0–4-year-olds (Figures 20 to 22).
- By 2031, Birmingham will have a projected 203,000 over 65-year-olds – an increase of approximately 30% increase on 2021 numbers.

These trends are largely attributed to the assumption that the Total Fertility Rate will remain at a lower level in the future, and migration patterns similar. It is these shifts in particular which will define Birmingham's population, and the city itself, in the future. If the fertility rate continues to fall then there will be less need for nursery provision but primary and secondary schools will be needed at current levels of provision. Whilst, an ageing population will see associated rises in health and care needs. For example, In 2023, the number of individuals aged 65 and older with dementia in Birmingham was 6,764 out of 168,779 within that age group[18] . With a projected population of 203,000 people aged 65 and older in Birmingham by 2031, the estimated dementia prevalence will rise by 1,350 to 8,070 in 2031[16].

Looking ahead, key challenges for Birmingham include ensuring the built environment and services are able to support the increasing population total and its changing demographic, for example with accommodation that enables the increasingly sizable population of older people to continue living independent and active lives, facilities and services for children that are in the right parts of the city, health services which can cope with the increasing multimorbidity of older adults.
A further challenge is the levels of deprivation seen in the city: 50% of the population live in areas that are amongst the 20% most deprived areas in the country. This means many of our residents face worse health outcomes than their counterparts in less deprived areas of the city and country throughout their life-course. Reducing these inequalities across our city is essential.

Figure 19: Population projection for ages 50-64 years by 2031 in Birmingham

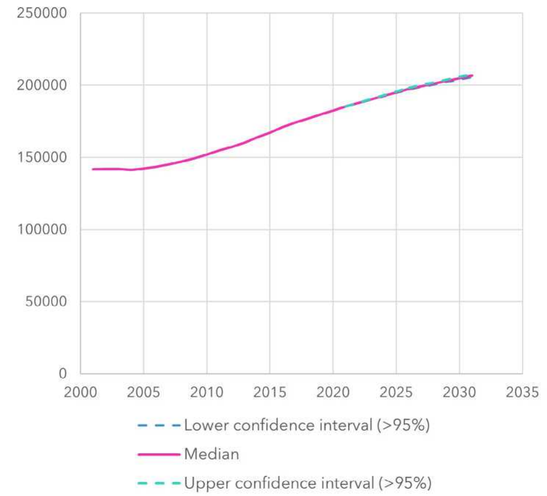


Figure 20: Population projection for 65+ years by 2031 in Birmingham

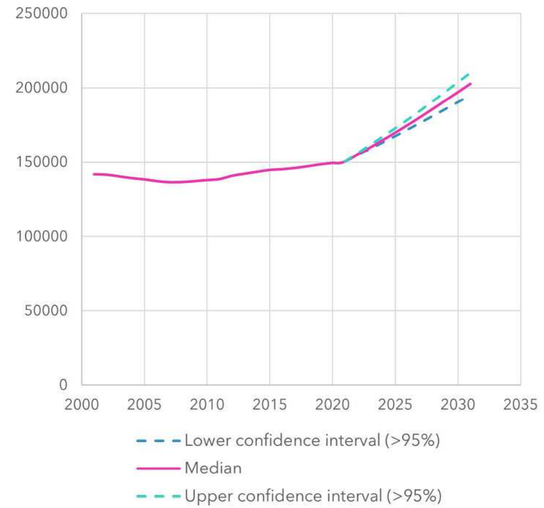


Figure 21: Population projection for age group 0-4 years by 2031 in Birmingham.

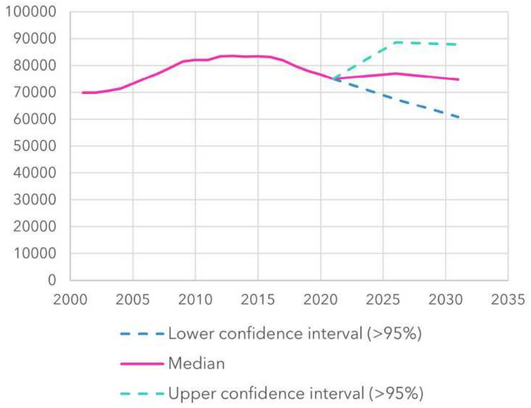


Figure 22: Population projection for age group 5-9 years by 2031 in Birmingham

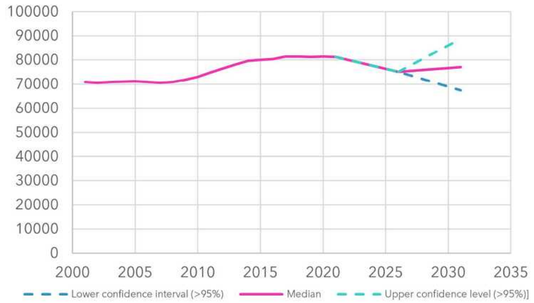
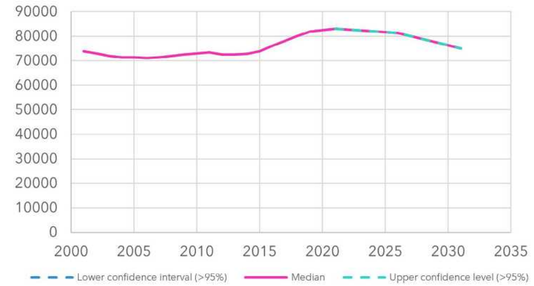


Figure 23: Population projection for age group 10-14 years by 2031 in Birmingham



System Reflections

Professor Graeme Betts
(Strategic Director of Adult Social Care, Birmingham City Council)

The report highlights the key areas of Birmingham's demographic changes. Adult social care can positively transform people's lives. It can support people to stay more independent, improve their wellbeing and continue to enjoy living in their communities Our goals are to support adults and older people so that they can be resilient, living independently whenever possible and exercising choice and control over their lives, and so enjoy good health and wellbeing.

It is a great achievement for society that more people are living for longer, especially those with complex needs. While Birmingham is one of the youngest cities in Europe, the older population is growing rapidly. An estimated 10,000 adults suffer dementia. Further, there are significant numbers of young adults who have disabilities or suffer from mental illness. Over the coming decades we will also see demographic change as the ethnic profile of the population continues to evolve. We need to ensure that our services keep pace with this, and offer culturally sensitive support. How we deliver and enable social care has an effect on people's health and wellbeing, including their mental health, and is of course intrinsically linked to the pressures on our partners in the NHS. The public rightly have higher expectations of the public sector, and standards are constantly rising thanks to the hard work and innovation by staff across the health and social care sector, and it is increasingly recognised that people want support to enable them to exercise independence, choice and control. In Birmingham we are focussing on early intervention and prevention, to ensure that wherever possible, people receive the support and guidance they need to stay healthy and independent.

Although adult social care can transform people's lives for the better, the quality and sustainability of the sector is at risk. As more people with increasingly complex needs rely on care and support, the cost of providing care is rising. Together with the government and our partners, we must work together to meet the challenges we face in recruiting and retaining good quality, dedicated care staff. In this city we are all part of a partnership, working together across social care, NHS, Public Health, Housing, the Voluntary Sector and others. We want this partnership to continue to grow, to continue our progress of making better use of our collective resources, and to improve the health, quality of life and independence for everyone living in Birmingham.

Ian Soars (Chief Exec of Spurgeons)

The demographic changes highlighted in this report are, at first glance, quite challenging. The trend of reduction in new births will lead to changes in the priorities of engaging with families as we track the "baby" bulge current working its way through the system. In this respect, Birmingham is in many ways ahead of the curve as we shift our focus from working only with the 0-5 age group through our children's centres and towards addressing the needs of the whole family from 0-19 (25 for SEND) as part of Birmingham's Family Hub strategy.

Seen in this light the change in the demographic profile of Birmingham's children presents an exciting opportunity. The Birmingham Forward Steps Partnership (of which Spurgeon's is a part) can carefully curate the resources invested in children to ensure a holistic approach (and a warm welcome) to all families that walk through our doors, regardless of the nature of the presenting issues, the ages of the children or indeed their ability to travel to one of our centres. It also means that we have more freedom to target health inequalities that have been deepened in the cost of living crisis.

This also means Spurgeon's and our partners can be more accessible, more holistic, more able to collaborate with faith groups and communities. Indeed, it invites the opportunity for real innovation in how we in Birmingham care for our families; to ensure that every family in need receives the care and expert support they deserve; to consider how we can shift our thinking away from the delivery of services and towards a measurable outcome of transforming children's lives.

Of course, just because the demographics point to this future we mustn't forget that the first 3 years of a child's life are arguably the most influential in determining outcomes for that child…and so Spurgeon's will continue to ensure laser focus on delivering care to the early years even as we look to expand how care across the age ranges.

ETHNICITY

ETHNICITY

Data Headlines

- Birmingham is the only core city in England and Wales to have more than half of the population (51.4% in 2021) from an ethnic minority background.
- Birmingham's superdiversity is higher in younger people, with 67% of those aged 0-15 being identified as from ethnic minority backgrounds.
- The largest ethnic group is still 'White', which comprised 48.6% of the total population.
  The number of people in this group decreased by 10.4%, from 621,636 in 2011 to 556,608 in 2021.
- The greatest increase in proportion was for the 'Pakistani' population, which made up 13.5% (144,627) of the population in 2011 and 17.0% (195,102) of the population in 2021 (3.5 percentage points*).
- The second largest increase in proportion was for the 'African' population, which made up 2.8% (29,991) of the population in 2011 and 5.8% (66,822) of the population in 2021 (3.0 percentage points*).

Implications for health and wellbeing

- Ethnic minority groups tend to experience higher rates of conditions such as diabetes, obesity, asthma, heart disease, and cancer and may also experience earlier onset.
- Ethnicity impacts health through different mechanisms: racism and discrimination, social determinants including income, education, employment and housing, cultural and lifestyle factors, health services and clinical factors and genetics such as sickle-cell disease.
- The age-ethnicity profile in the city varies greatly, with the older age-group having a different ethnicity profile than the younger age groups. There is a need for services to recognise this and respond to need appropriately and adapt over time.
- With a continued increase in ethnic minority populations, specific diseases will see increases, such as sickle cell disease, which has an increased prevalence in African and Caribbean populations, and Type 2 diabetes, which is higher in South Asian groups.
- Ethnicity intersects with other characteristics, leading to worse health outcomes, for example, for older adults and people with learning disabilities from minority ethnic groups.

* Percentage points describe the difference between percentages.19 Percentage point change is used in this chapter to show the difference between the 2011 and 2021 percentages.

What does the data tell us about ethnicity in Birmingham?

Collecting data on a person's ethnicity can be complex. Ethnicity is self-defined, subjectively meaningful and can change over time.[20] It is characterised by features such as a shared history, origins, language, and cultural traditions. As such, collecting data on a person's ethnicity can be complex. The first time an ethnicity question appeared in the British Census was in 1991 with 7 set answers and two enabling free text answers. It asked respondents to select one from the following categories: White, Black, Caribbean, Black, African, Black, Other (with description), Indian, Pakistani, Bangladeshi, Chinese, and Any other ethnic group (with description). Before 1991, censuses and surveys in the 1960s, 70s and 80s used proxy questions or estimates to understand ethnicity in the city and across the country. This included questions on nationality and the different 'Commonwealth' groups.[21] Following 1991, the question was refined in future Censuses to cover broad and specific ethnic groups.

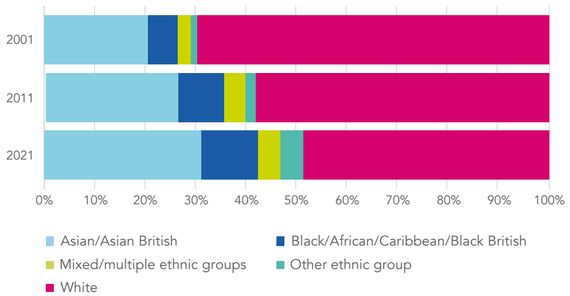
The 2021 Census question on ethnicity had two stages. Firstly, a person identified through one of the following five high-level ethnic groups: "Asian, Asian British", "Black, Black British, Caribbean or African", "Mixed or Multiple", "White"; or "Other ethnic group". In this report, these categories are termed "broad ethnic groups". Following this, a person identified through one of the 19 available response options (in this report termed "specific ethnic groups"). These included categories with write-in response options. In Birmingham, this captured 287 different ethnic identities (Figure 24).

Figure 24: A word cloud showing the 287 different ethnic identities in Birmingham (excluding White British)[11]

Birmingham is a ‘superdiverse’ city

In 2021, Birmingham officially became a super-diverse city. More than half of our population (51.4%) identify as belonging to an ethnic minority. This is higher than all other core cities in the UK and local authorities in the West Midlands. The changes in ethnicity in Birmingham can be seen to be a part of a longer term trend. This can be observed by looking at the changes in the proportion of broad ethnic groups (Figure 25) in current and preceding censuses. In 2021, the White ethnic group remains the largest single group despite decreasing relative to other groups (-9.3 percentage points) and decreasing overall numbers (-65,028). All of the other broad ethnic groups have increased in proportion and numbers.

Figure 25: Change in ethnic group proportion (%) between 2001, 2011 and 2021[1]



“You can quite clearly see since I’ve lived here that the diversity in the areas has increased. Especially in my area, which has always been predominantly an Asian area and I think now you’re starting to see not just Asians, but black and other ethnic minorities coming over or like just a bit more present... The changes have been very apparent and I think the data kind of does reflect what I’ve been seeing over the years.”

Ash, 26, Male, Sparkhill

Many factors contribute to the changing ethnic composition of Birmingham, such as topics explored in this report, including ageing, fertility, mortality, and migration. A key factor driving super-diversity is Birmingham’s history of welcoming people and its commitment to being a ‘City of Sanctuary’. This history is reflected in previous censuses and the age profile of the current population in Birmingham (explored later in this chapter). Many Irish people came to Birmingham looking for work, and the Windrush era saw people from the Caribbean help rebuild the country after the Second World War. Both communities have the highest proportion of adults aged 50 and older (69% of the White Irish community and 45% of the Caribbean community are aged 50+).

The largest increases were seen in the Pakistani and African ethnic groups

More recently, Birmingham has experienced change through the expansion of the European Union, as well as various conflicts and crises. Most recently, people seeking safety arrived from Afghanistan, Syria and Ukraine. The migration (international) chapter focuses on some significant changes from the previous Census (2011) and longer-term trends.

“There’s some people in my ethnic group, especially from Nigeria, from Africa, who have needed healthcare assistance, to reach the GP, and they are calling, calling, calling and the majority of them give up. I always try to let them know that you need to keep pushing and call again. They call twice, three times and no response and when the need is arrived next time, they don’t want to call again which will affect their health.”

Samuel, 35, Male, Yardley West and Stechford

Further to the broad ethnic group patterns, it is important to explore and explicitly consider differences between specific ethnic groups to enable greater understanding of the Birmingham population and inequalities. The largest population increases between the 2011 and 2021 censuses in specific ethnic groups were seen in the Pakistani and African ethnic groups, whilst the largest decrease was in the White British group.

Other specific ethnic groups, such as Bangladeshi, Other White and Any other ethnic group, also experienced notable increases. These changes are based on the proportion of the total population and are therefore shown as percentage point changes (Figure 26).

In 2011, the White (English, Welsh, Scottish, Northern Irish or British) population comprised 53.1% of the Birmingham population. In 2021, it was 42.9%, a decrease of 10.2 percentage points. The Pakistani population increased from 13.5% in 2011 to 17.1% in 2021, an increase of 3.6 percentage points. Some groups, such as the Indian population, increased in total population, but the proportion compared with other ethnic groups decreased slightly. Although there was an overall increase in those who identified within the “Black, Black British, Caribbean or African” group (11% of the total population compared with 9.0% the previous decade), there were notable differences within the group itself. The African group more than doubled in population numbers and increased by three percentage points. In contrast, the Caribbean population decreased by 0.5 percentage points.

These changes can also be observed geographically (Figure 27 and Figure 28). In comparison with 2011, the wards with the highest proportion of those identifying as African and those identifying as Pakistani remained similar. For example, Newtown remains the ward with the highest proportion of those identifying as African. However, this proportion has increased significantly from 16.2% of the ward identifying as African in 2011 to 42.3% in 2021. An increase is seen for those identifying as Pakistani in wards located towards the East of the city. Sparkhill is now the ward with the highest proportion of people identifying as Pakistani at 63.6%, which has increased from 56.9% in 2011.

Figure 26: Percentage point change in specific ethnic groups between 2011 and 2021[1]

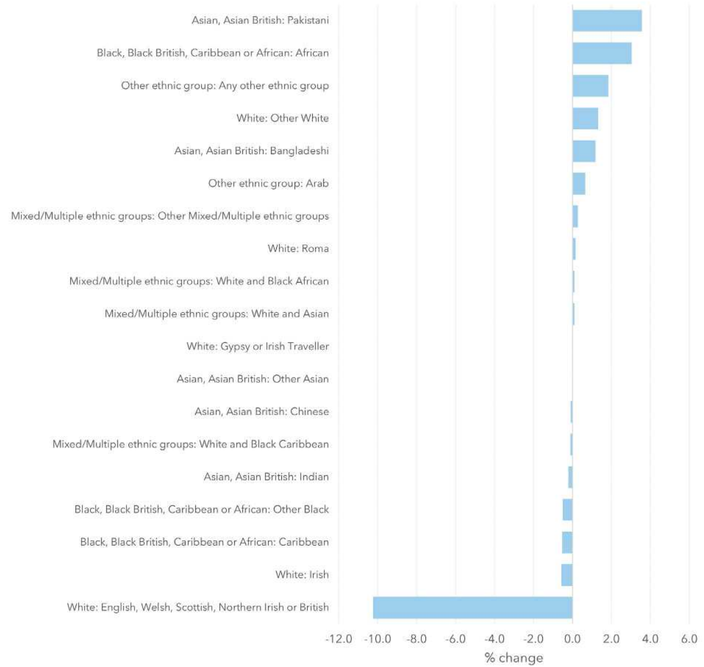


Figure 27: Map of African population by Birmingham ward (2021)[1]

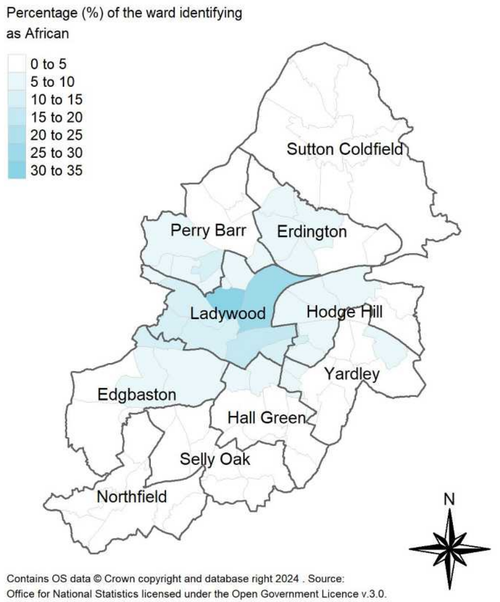
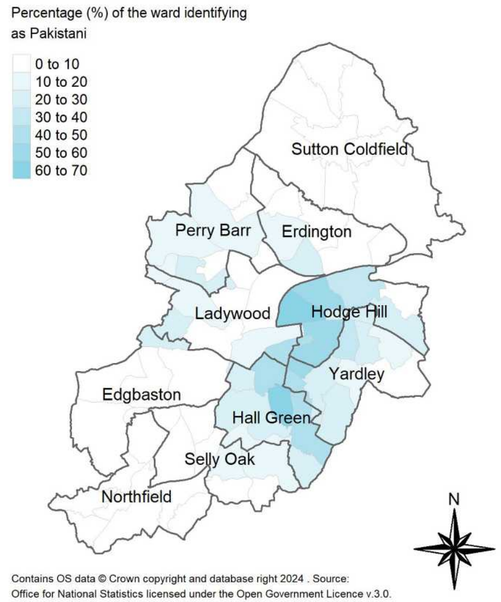
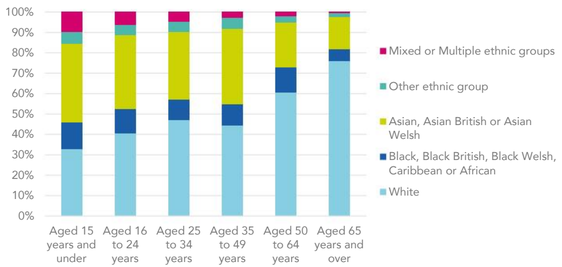


Figure 28: Map of Pakistani population by Birmingham ward (2021)[1]



There is greater ethnic diversity in younger age groups
Birmingham's super-diversity is particularly evident in the younger population, with 67% of those aged 0-15 being identified as from an ethnic minority. Around a third of people (aged 0-15) were in the White group (33.1%), less than the Asian or Asian British group (38.3%). For age groups 50 and above, the White group makes up over 50% of the population (67% of those aged 50 and above).

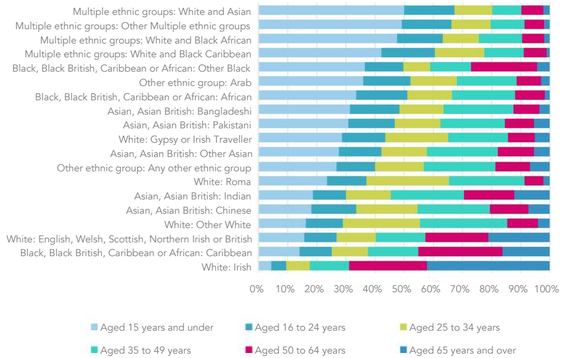
Figure 29: Usual residents in Birmingham by age group and ethnicity (broad group)[1]



However, there are differences within the specific groups which are not apparent in the broad ethnic groups' classifications (Figure 29). Whilst, the broad Black, Black British, Caribbean or African group is a young population, this is mainly due to the young African population with 55% of those who identified as Caribbean aged 50 and older. People with mixed ethnicities make up a small proportion of the total population but have the highest proportion of younger people within those groups.

Two ethnic groups have an older age profile than White British: Caribbean and Irish. Almost 70% of those who identified as White Irish were 50 and older. These age profiles and patterns reflect a city of historic and ongoing migration.

Figure 30: Usual residents in Birmingham by ethnicity (specific group) and age group [1]



There are differences in birth rates across different ethnic groups, but this report also shows that most people who migrate to the country are young. Studying is one of the main reasons people migrate to the UK, and the number of international students was 12,600 in 2021, the second highest of all local authorities in England.[22]

"A lot of people are coming to Birmingham, it attracts a lot of people, particularly with the university... people want to go to where they know people. People today want to migrate to these places so that they can seek help from their people, while black people also wanted to come to Birmingham, they know that the cost of living here is not the way it is in London."

Samual, 35, Male, Yardley and West Stechford

Health and ethnicity
Birmingham's super-diversity poses both challenges and opportunities for health and wellbeing. People from ethnic minority groups tend to experience higher rates of poor health and disease for a range of preventable and treatable conditions, such as diabetes, hypertension, obesity, asthma, heart disease and cancer.[23,24] The inequalities in health experienced by people from ethnic minority communities came to the forefront during the COVID-19 pandemic: people from ethnic minorities in Birmingham experienced higher rates of COVID-19 exposure, infection and mortality, caused largely by social determinants of health and existing health conditions.[25]

National evidence comprehensively shows health inequalities between ethnic minority and white groups and between different ethnic minority groups. The ONS used census data and death registrations to understand ethnic inequalities and differences in mortality from physical health conditions, such as cardiovascular disease or cancer. They show that some ethnic minority groups, such as the African community, have lower mortality from some conditions than the White British group. It also shows the differences between ethnic minority groups, including the South-Asian sub-groups. The Pakistani and Bangladeshi groups had the highest mortality rates for many individual conditions, including Covid-19 mortality. This was not seen in the Indian group (including Covid-19).[26,27]

Similar findings have been published by the Health Foundation but focused on morbidity (illness) rather than mortality (death). The Health Foundation linked primary care and hospital records to describe a more detailed picture of variations in diagnosed illnesses by ethnicity. They show that people from Pakistani and Bangladeshi ethnic backgrounds in England have more diagnosed chronic pain, diabetes, dementia and cardiovascular disease. The White British population have more diagnosed anxiety or depression, alcohol problems, atrial fibrillation and cancer.[28]

The causes of health disparities and inequalities for ethnic groups are complex but largely driven by the social determinants of health, such as income, education and housing. Health-related behaviours also play a role, as do other factors such as the 'healthy migrant effect'.29 Racism and discrimination play a crucial role, through wider determinants of health30 as well as influencing how people access health information, services and treatment.[23] People who experience racism and discrimination have poorer mental and physical health than those who do not.[31]

Diabetes is an example of a disease which is more common in people from ethnic backgrounds due to a complex interplay between biological, lifestyle, social, clinical and health system factors. [32] The risk

of developing type 2 diabetes is higher in South Asian groups than in white groups, and South Asian groups have higher mortality from the condition. The prevalence is also higher in Black groups than in the white population.[33]

There are also differences in health outcomes that do not necessarily relate to discrimination but to genetic conditions, such as sickle cell disease. As one of the most common genetic conditions in England, Sickle Cell Disease affects around 1 in every 2000 live births. It occurs predominantly in people of African and African-Caribbean origin, but also in countries with a history of malaria, or migration from a malarial area. Sickle cell trait or disease can protect people from malaria in endemic regions, and this has led to positive selection for the mutation of the sickle cell gene. [34]

Evidence has demonstrated worse health outcomes in minority ethnic groups for older adults[35] and people with learning disabilities compared to white counterparts.[36] Potential associations and suggested reasons for worse outcomes include increased prevalence of long-term conditions, poorer access to and experience of support, lower confidence in supporting their own health and higher levels of deprivation. [23,35,36]

Whilst there is considerable evidence that people from the African community and Pakistani community often experience higher rates of poor health and disease,[37] this was not consistently seen in self-reported health and disability. In the 2021 census, respondents from the African community had one of the highest proportions of people reporting 'good or very good health' (Figure 31) across different age groups. Three quarters (75%) of people who identified as African aged 50 and older reported 'good or very good health', the highest of any group. The Pakistani group had one of the lowest percentages of all communities in the 'Asian, Asian British' group across all ages. Similarly, the Pakistani and African groups had a greater percentage of people without a long-term physical or mental health condition than the White British group. These differences don't appear to be a result of the different age profiles of ethnic groups (Figure 30), as similar results are observed across different age groups (Figure 32). There may be other factors that impact, such as the 'healthy migrant effect', explored later in this report.[38] These measures are based on self-reporting and so might reflect differences between cultures. Self-reported measures of morbidity in Census data have been shown to positively correlate with routinely collected health records. However, there was an under-representation of ethnic minority groups in the linked healthcare data, which may reflect the likelihood of engaging with health services.[39]

Increasing ethnic diversity in younger people has important implications for health and wellbeing now and in the future. Birmingham's diversity and young population are strengths but may also pose challenges and increase the risk of health inequalities.[40] Inequalities based on ethnicity, as well as other factors explored in this report, have profound effects on young people and can persist into adulthood.[40] Issues that may affect young and diverse populations include areas such as sexual and reproductive health, substance misuse, mental health, obesity and nutrition. Similarly to those of all ages, racism is a key factor and determinant of a young person's health and can have a direct link to health outcomes.[41] The trend towards increasing diversity amongst Birmingham's young people is likely to continue.

Figure 31. Percentage of usual residents in Birmingham reporting as having 'good or very good health' by age[1]

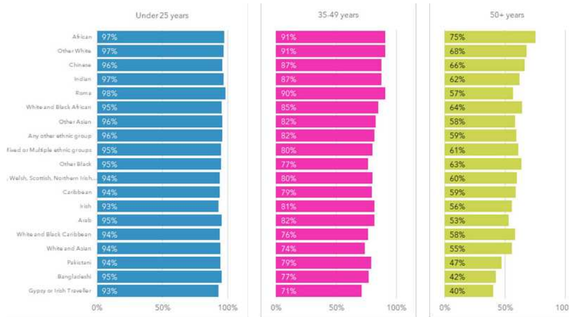
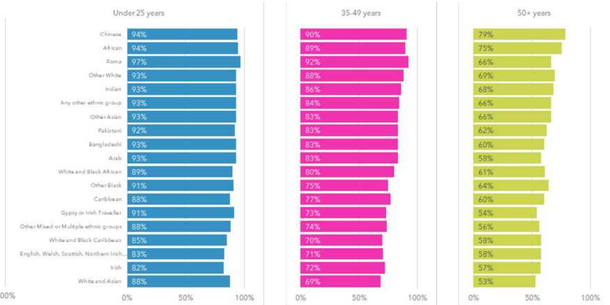


Figure 32. Percentage of each ethnic group in Birmingham reporting as having a no disability and no long term condition by age[1]



Case Study: Hamza

Ward:	Handsworth Wood	**Sexual Orientation:**	Heterosexual
Age:	57	**Gender & Gender Identity:**	Male
Ethnicity:	Asian British	**Occupation:**	Shop worker
Faith:	Hindu	**Living Arrangements:**	Owns with a mortgage or a loan

Hamza was born in Birmingham and has lived in the city most of his life. He has Pakistani heritage and lives in Birmingham with his wife and children. He thinks there has been an increase in the number of people from ethnic minorities living in Birmingham, particularly those from African, Indian and Pakistani backgrounds. He explained that at his temple, they have seen an increase in people from overseas attending, especially people from India. He is aware of quite a few Indian and Pakistani people who have moved to the UK on either student or skilled visas, which he sees as a positive thing for the economy. However, he feels that an increasing population will put pressure on resources and facilities. He is aware of overcrowding in houses – which he believes is due to high rental prices and the cost-of-living crisis.

"You can definitely notice that there's more ethnic minorities. I go to the Hindu temple... I've spoken to some of the people and those who run it, and they say there's definitely a lot more people coming from abroad… we used to only get like 50 or 60 or 70 people coming for the prayers but now we get about 300-400 people on a Sunday and a Tuesday."

Hamza described how the cost-of-living crisis has impacted his physical and mental health. He worries about his bills, and he is having to reduce his heating and how much he travels. He has noticed that many more people are having to rely on food banks and sharing free items through Facebook groups. Hamza explains that, like others, he has struggled to get a doctor's appointment. He believes this causes stress to many people throughout Birmingham.

"A lot more people are going to food banks, there's some food banks near us and you can see the people queuing up for them. And then I'm on a lot of the neighbourhood groups on Facebook and a lot of people are speaking and discussing their issues as well. And the problem they're having is, lots of people are asking if people have got free items available because they can't afford to buy them."

Hamza feels neutral about the future. He thinks there needs to be a balance in attracting more people to the city to boost the economy, without overwhelming resources. He believes it's particularly positive if skilled or healthcare workers move to the city. However, he feels that migration might create shortages in terms of housing and employment for those already living in Birmingham. He also thinks it could put additional pressures on the NHS, schools and local services.

"I think to boost the economy, we need more people in the area and also because if they are working and supporting the local economy. At the moment, Birmingham City Council's going through a crisis as well, so they need to have some more income coming into the economy."

Hamza recommended introducing more public areas, such as libraries and leisure centres, to improve people's mental health. He is particularly interested in seeing more youth support in the city. Hamza values the support a local gurdwara provides to the community. He appreciates this support and would like to see it continue, as well as more facilities like this open in other communities around Birmingham.

[Discussing a local gurdwara] "They've got their own health centre as well and wellbeing centre. They tend to be a lot of the older, older community… It's helping the community quite a bit, and they've got a centre as well where they have different courses, and they used to have a gym as well."

What might this look like in 2031?

The city's identity has changed over the decades and will continue to change. By 2031, if current trends continue in a linear way (Figure 33), Birmingham will continue to become more diverse over the next decade: the broad Asian/Asian British group would have a proportion similar to the White group (around 38%). Other ethnic groups, including those with mixed ethnicity, will also rise.

However, these trends are unlikely to occur linearly as there are many other factors at play, not least the heterogeneity in these broad groups and the difference in birth rates, mortality rates, overall age profiles, and migration patterns. When estimates of birth and mortality rates of age groups are added, more modest changes are predicted in the next ten years (Figure 34). In summary, whilst there is some uncertainty, we know Birmingham will remain a super diverse city and continue to change in the decades to come.

As we explore future change and the potential impact on health and wellbeing, it is important to remember the limitations on our discussion. Future trends are generally based on past data and as such cannot take account of policy shifts or world events which influence migration, nor can they easily predict the future of health of an ethnic group, given that generations within a group can have very different life experiences e.g. parents who were first-generation migrants, and their children and grand-children who have grown up in Birmingham. None-the-less, thinking about these potential futures is important because many of the inequalities discussed in this chapter could widen or increase without action.

Looking ahead to 2031 can help us understand the potential needs of communities in Birmingham. Some of this need may arise from differences in prevalence of inherited conditions. For example, sickle cell disease, which, as discussed, occurs predominantly in people of African and African-Caribbean origin. If current trends continue linearly (Figure 33), 14% of Birmingham's population will identify as Black, African, Caribbean or Black British. In numbers, 14% of the projected population for 2031 (1,227,323) is approximately 171,825 people. This would be an increase of almost 50,000 people from 125,760 in 2021. Given that approximately 8% of Black people carry the sickle cell gene[34], over 3,000 more people will be estimated to have the gene if population trends continue. According to the National Institute for Health and Care Excellence (NICE), the prevalence of the sickle cell gene is increasing in mixed race families[34]. This has implications for Birmingham, given that a high proportion of those with mixed or multiple ethnicities are younger (Figure 30), and this is likely to increase in the next decade.

Most differences in health outcomes however arise due to a complex interaction of differences in social determinants of health, such as income, education and housing; differences in individual health-related behaviours; differences in experience of and access to services; all impacted by racism and discrimination. In these circumstances, predicting the future rise of health outcomes is particularly challenging. However, there are some health outcomes that will undoubtedly have a future impact, and more so in Birmingham. For example, Type 2 diabetes, which has different risk in different ethnic groups, is expected to double globally over the next 30 years.[42] Modelled estimates for Birmingham, which takes into consideration the ethnicity, age, gender and deprivation of the city suggest that diabetes prevalence will rise to 11% of over 16 year olds by 2035 (110,000 people).[43] Intervention is strongly needed to prevent this rise – much of which is preventable - with its associated impact on people's lives as well as health and care costs.

Figure 33: Ethnic Group in Birmingham (Linear Forecast)

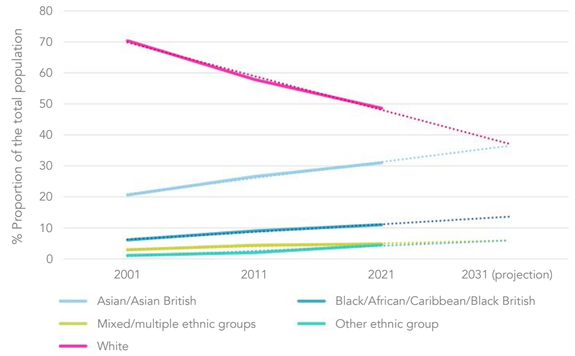
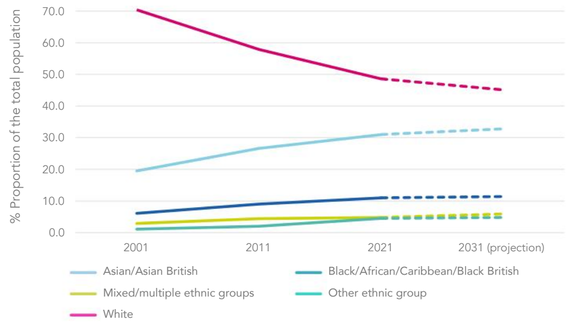
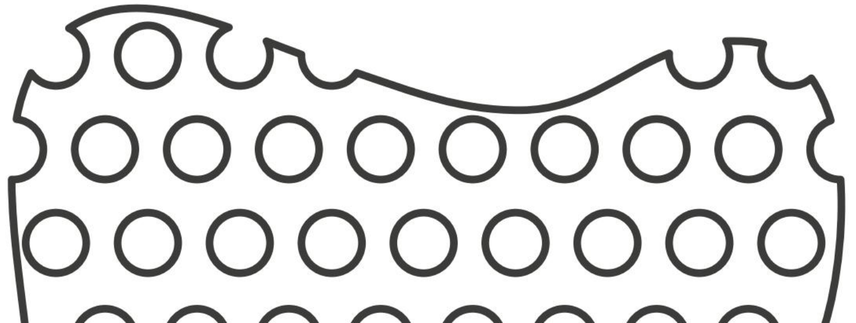


Figure 34: Ethnic Group in Birmingham (Bayesian Population Projections)





Despite the challenges of health inequalities facing different communities, it is important to recognise that increasing diversity can positively impact public health. Birmingham's super-diversity can foster social cohesion and cultural development. We must ensure that policies, services, and interventions are tailored and responsive to the needs and assets of different ethnic groups and involve them in the design, delivery, and evaluation. Moreover, the health and care system, as well as the wider workforce should reflect the diversity of the population it serves and develop the skills and knowledge to address the health issues of different ethnic communities.

The Census provides a rich data source for organisations and communities to understand our city better, and by accessing better data on ethnicity, more culturally informed care and support can be provided to people from different backgrounds. As a system, we need to move beyond the broad ethnic groups and explore how people identify in more detail, and by doing this, we can see some of the key changes in the previous decade. Locally, we are building on this national evidence through reviews going beyond the 19 ethnic groups in the Census. **The Community Health Profiles** explore the health needs and inequalities within specific communities discussed here, such as the Pakistani community as well as communities within Census categories, for example, recognising the significant heterogeneity in the African group, there are reviews on the Kenyan, Nigerian and Somalian communities in Birmingham. Additionally, these profiles and BLACHIR have identified gaps in data collection that are being addressed through local action. This includes the Birmingham Measurement Toolbox, which has built on the census question on ethnicity to collect better data to evaluate interventions trying to improve health and wellbeing in Birmingham.

"I have my own way of thinking and my contribution from Nigeria. Someone from Pakistan will have their own way of thinking and their own contribution. Someone from India and someone from Australia the same. When we come together, we see things from different perspectives, and it helps."

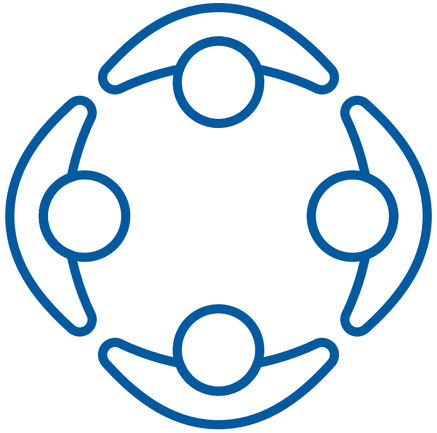
Abioye, 48, Female, Aston

System Reflections

Sal Naseem (Assistant Director;
Strategy, Equality and Partnerships, Birmingham City Council)

Reading the report shows how proud we are of the incredible diversity of our communities. Birmingham's super-diversity has been confirmed through UK Census 2021, with over 50% identifying with an ethnic minority heritage. Although this statistic does not truly capture the full diversity of our population, it does show that our city is significantly more ethnically diverse than it was ten years ago.

Ethnicity refers to a common group identity based on language, culture, religion or other social characteristics. People define their own ethnicity, and everyone (and not just those in minorities) has an ethnicity, and someone's ethnic identity may change over time. Health patterns differ significantly between ethnic minority groups, the white population, and different minority groups. We know that ethnicity and race have been shown to systematically influence health outcomes, socio-economic status and employment opportunities. Racial inequity continues to damage the lives and health of people, and COVID-19 disproportionately harmed some of our communities. If you are from an ethnic minority, you may already have had struggles to learn from, and maybe that lived experience has shaped you as a person and a leader. We must acknowledge that everyone has unique experiences of systematic inequality and consider everything and anything that can marginalise people. A person is not Pakistani on a Monday, a woman on a Tuesday and disabled on a Wednesday. They experience all of these things at once, and this is intersectionality. Our work in equality, diversity, and inclusion is about understanding people's experiences, becoming more self-aware and removing barriers. We will only tackle inequalities by understanding and acting to make real change.



Dr Nike Arowobusoye and Sola Afuape, BLACHIR Co-Chairs

In 2021, Birmingham was identified as one of the first 'super-diverse' cities in England and Wales and is the only core city, with over half of its total population from the global majority (often referred to as Black, Asian Minority Ethnic) communities, a 7% increase from the last Census. The DPH report also predicted population change over the next decade and noted further increases in populations from global majority communities, predicted partially using ethnicity breakdowns by age; 67% of residents in the city aged under 15 were from a global majority community compared with 33% of residents aged 50 and above. Positive and negative lived experiences and other intersectional factors of identity such as traditions, culture, country of birth, language, religion etc. can be impacted and shaped by an individual's ethnic background. In addition, descriptions of ethnic group and one's perspective on ethnicity, can be personal, complex and mainly subjective. I in 10 people in Birmingham (11%), described themselves as Black, Black British, Black Caribbean or African.

Birmingham's 1.1 million plus population is made up of 287 different ethnic identities. Therefore, it is essential to understand on a granular level, the heterogeneity of community groups under umbrella terms such as 'African' or 'Caribbean' in order to build a healthcare system which can appropriately and effectively reduce the experiences of health inequalities. The BLACHIR (Birmingham and Lewisham African and Caribbean Health Inequalities Review) report mirrors much of the data included in the DPH annual report. Both reports highlight that many aspects of health inequalities are often driven by both the social determinants of health and the influences of structural racism and discrimination. BLACHIR highlights that we must utilise this learning to address the root causes, as well as poor access, experiences of services and care, and outcomes. All of which result in poor health.

The BLACHIR report takes a whole system approach and provides seven key priority areas for action and 39 'opportunities' which are actionable next steps proposed for the Health and Wellbeing Board, BCC and the NHS Integrated Care Systems to act upon. This BLACHIR approach is underpinned by anti-racist terminology and focuses on understanding the evidence from the communities, racism, and the impact of the different ethnic backgrounds and cultures on health and wellbeing. The solution focussed approach has inherent within it community involvement and empowerment and partnership working with the wider health and social care system. In doing so, it aims to ensure that disparity in experience and health inequalities among Birmingham's super-diverse communities are reduced with improvements in overall health and wellbeing, lived experiences and receiving and accessing health care services. Achieving this in a culturally alert fashion is foundational to this body of work and is the unique added value for the residents of Birmingham. It remains vital to reflect on both the strengths and challenges associated with the rich diversity in Birmingham.

SEXUAL ORIENTATION & GENDER IDENTITY

SEXUAL ORIENTATION & GENDER IDENTITY

Data Headlines

- For the first time in the 2021 Census, voluntary questions were asked on sexual orientation and gender identity for respondents aged 16 years and over.
- 87.6% of Birmingham residents identified as straight or heterosexual, 3.0% identified with an LGB+ orientation, and 9.4% did not answer the question on sexual orientation.
- 90.8% answered that their gender identity was the same as their sex registered at birth, 0.9% answered that their gender identity was different from their sex registered at birth, and 8.4% did not answer the question on gender identity..

Implications for health and wellbeing

- The LGBTQ+ population is more likely to be affected by inequalities around mental health and wellbeing, substance misuse, and smoking rates.
- They are also more likely to experience direct and indirect discrimination both when accessing health-related services and in wider society.
- Those who identify as 'trans+' and seek to medically transition face additional barriers as there are no Gender Dysphoria Clinics in the West Midlands and long-waiting lists for referrals and treatment.
- Future trends are difficult to determine as this was the first time LGB+ data have been collected in the Census, many possible reasons for non-reporting and uncertainty on whether greater identification of LGB+ in the younger population will continue as this population ages.

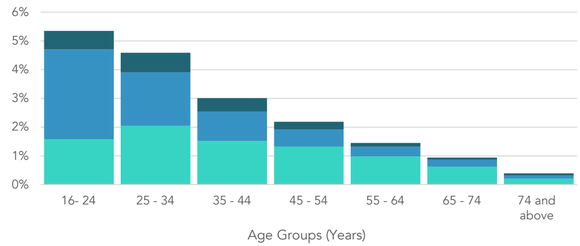
What does the data tell us about sexual orientation and gender identity in Birmingham?

For the 2021 Census, the ONS defined sexual orientation as "an umbrella term covering sexual identity, attraction, and behaviour". The ONS' definition of gender identity was "a person's sense of their gender, whether male, female, or another category such as non-binary".[45] The ONS use the term' trans(gender)' to describe all those whose gender identity was not the same as their sex registered at birth, including binary, non-binary, and non-gendered identities, although 'trans+' will be used for this chapter.[46]

According to the 2021 Census, 3% of Birmingham's population (aged 16 and above) identify with an LGB+ sexual orientation and 0.9% of the population (aged 16 years and above) identify with a gender identity that is different from their sex registered at birth. Related to this, 9.4% chose not to answer the question on sexual orientation while 8.4% chose not to answer for gender identity. Assuming that those who chose not to answer still reflect the population as a whole, there are approximately 13,100 people who identify as 'Gay or Lesbian', 12,300 who identify as 'Bisexual' and 4,000 who identify with an 'Other sexual orientation' in Birmingham. Similarly, there are 4,500 people who identify with a different gender identity from their sex registered at birth, but gave no specific identity, 1,500 who identify as a 'Trans Man', 1,350 who identify as a 'Trans Woman', and 900 who identify as 'Non-Binary' or another gender identity. When compared to the overall percentage proportions for England and Wales, Birmingham has a slightly smaller LGB+ population percentage and a slightly larger percentage of people with a different gender identity from their sex registered at birth.[1]

There is likely to be under-reporting of the total LGBTQ+ population as those under 16 years old are excluded and the Census was completed by one person on behalf of the household.[46] There may also have been those who identify as part of the LGBTQ+ population but did not wish to share this information on the Census.[46] Overall though, the Census is still the most comprehensive data source on sexual orientation and gender identity in Birmingham as previous estimates, such as one from ONS in 2015, showed a much smaller LGB+ population. [47]

Figure 35: Sexual Orientation by Age Group in Birmingham (excluding 'Straight/Heterosexual' or 'Not Answered') (2021)[1]



The Census shows differences in reported sexual orientation by age-group, with a greater percentage identifying as LGB+ in younger age groups and with younger LGB+ people more commonly identifying as bisexual, where older age-groups more commonly identified as gay or lesbian. Indeed, 1 in 3 (32.2%) LGB+ orientated individuals in Birmingham are aged between 16 and 24 years old (Figure 36). These differences by age are likely to reflect societal changes with individuals in younger age groups more comfortable identifying with LGB+ orientations,[45] whilst, those in older age-groups more likely to have experienced social, policy and legal discrimination in their lifetimes that may dissuade them openly identifying with an LGB+ sexual orientation.[48]

Figure 36: Percentage of LGB+ orientated individuals by age group (2021)[1]

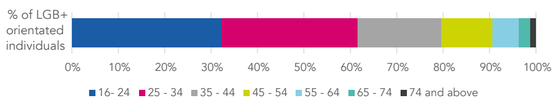
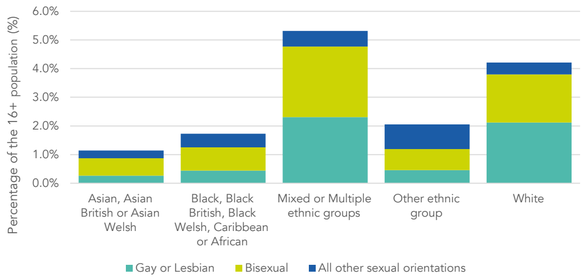


Figure 37: Sexual orientation by ethnic group (excluding 'Straight or Heterosexual' and 'Not answered') (2021)[1]



There are differences in the population identifying as LGB+ by ethnicity, some of which is likely to reflect the different age-structures of the ethnic groups (Figure 37) shows a similar breakdown of those who identify with an LGB+ orientation by ethnic group. For example, the higher proportion in the 'Mixed or Multiple' ethnic group corresponds to the age profile of this group with it being very young in comparison to other ethnic groups. It is also interesting to note that with the exception of the 'White' ethnic group (which has an older age-profile overall), the most common LGB+ orientation identified with is 'Bisexual'.

There are well-reported inequalities between those who identify as straight/heterosexual and those that identify with an LGB+ orientation. These include differences in risk behaviours such as higher smoking rates, alcohol consumption and substance misuse.[49,50,51] Furthermore, societal acts, including hate crime, sexual violence and causes of homelessness including parental rejection, disproportionately impact the LGB+ population.[52] There are also specific inequalities within the LGB+ population. For example, gay men and men who have sex with men (MSM) are more likely to engage in higher levels of drug use and have a higher risk of contracting certain sexually transmitted infections (STI).[53]

There are clear inequalities in mental health, with higher prevalence of mental health conditions seen amongst the LGB+ population. For example, Stonewall (UK-based LGBTQ+ charity) reported that in 2018 "half of LGBT people have experienced depression and three in five have suffered from anxiety, far exceeding estimates for the general population".[50] Prevalence is also greater among younger age groups, with a higher likelihood of engaging in health risk behaviours, such as self-harm and suicidal ideation.50[liv] For the LGB+ population in Birmingham, health needs relating to mental health and wellbeing are likely to be the most pressing as the age profile of this population is far younger than older.

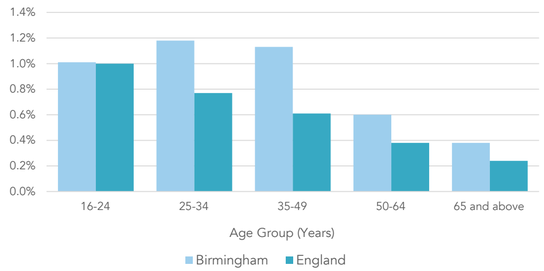
To meet the needs of the LGB+ population, Birmingham will require health and care services to be inclusive. In their 2018 report, Stonewall stated that 1 in 4 LGBT people had experienced a misunderstanding by healthcare staff of their specific health needs.[50] Research suggests that a lack of understanding is not always due to direct discrimination but health and care professionals feeling poorly equipped to respond to the needs of the LGB+ population.[50] Furthermore, "there is often an unhelpful conflation of LGBT communities in health and social care services".[50] The net result is that LGB+ oriented people may become more likely to avoid treatment or engagement with health and care services because they either expect or believe that they will face discrimination.[49,54] It will be crucial for the health and care system in Birmingham to acknowledge these barriers and develop inclusive approaches for the LGB+ population.

"I don't see much harm coming from inclusion and supporting people...I feel like that would have had a direct positive impact on the health and wellbeing of someone like me."

Mischa, 24, Female, Perry Barr

Compared to England, Birmingham has a higher proportion of residents who identify with gender identities different to their sex registered at birth

Figure 38: Gender Identity by Age Group (excluding 'same gender identity as registered at birth' and 'Not Answered') (2021)[1]



Birmingham has a greater proportion of people identifying as 'trans+' than seen in England and the differences are greater in those aged over 25 years (Figure 38). These figures may underestimate the true number s as there may be a proportion of people who identify as 'trans+' but did not disclose this in the Census. This may be indicative of the evidence that some are reluctant to share their identity for data collection purposes. [55]

People who identify as 'trans+' face inequalities in health and wellbeing outcomes. In particular, there is a higher prevalence for mental health conditions and self-harming behaviours, including attempted suicide.[50,56] There is also evidence that they are more likely to have a less healthy lifestyle and a higher rate of self-reported disability.[55] These inequalities are compounded by multiple barriers to accessing health services. In their 2018 report, Stonewall reported that around 40% of those who identified as transgender in their LGBT survey had "difficulty accessing healthcare due to their gender identity".[50] The most common issues were recorded as; expected or actual discrimination, lack of understanding, and lack of knowledge around specific treatment pathways.[56] As a result, similar to parts of the LGB+ population, individuals will avoid services, particularly primary care, in the expectation that they will not receive equal treatment.[50]

An additional issue for this population is accessing services related to medical transitioning. Whilst not all of those who identify as 'trans+' will seek to transition, of those that do, there are several barriers. To begin to medically transition, a person needs a gender dysphoria diagnosis which can only be obtained from clinicians at a Gender Dysphoria Clinic (GDC's).[56] There are no GDC's in the West Midlands.[56] Furthermore, there are long-waiting lists for any referral or treatment relating to gender-focused health services.[54] The current and future risk for the 'trans+' population in Birmingham is that these inequalities of access exacerbate inequalities related to health outcomes.

Case Study: Ajani

Ward:	Kingstanding	**Sexual Orientation:**	Heterosexual
Age:	28	**Gender & Gender Identity:**	Trans Male
Ethnicity:	Black/African/ Caribbean/Black British	**Occupation:**	Carer
Faith:	No religion	**Living Arrangements:**	Rents from a Local Authority

Ajani grew up in Birmingham, lived in London for a few years, before moving back to Birmingham where they have lived ever since. They live by themselves but are close to their family.

Ajani thinks that the percentage of people who do not identify as straight is actually greater than the figure taken from the census. They feel that some people lack the confidence to express their true identity, and that societal pressures to 'come out' can be overwhelming. They feel some might prefer to keep their identity hidden to avoid criticism and judgment.

They agree that a higher percentage of younger people identify as LGBT+, and that younger people are more likely to identify as bisexual, while those older might identify as gay or lesbian – they think this might be because this age group are still exploring their identity and experimenting with their sexuality.

"I would say a lot of people lack the confidence because there's this thing, and I've never understood it personally, about like having to come out and stuff like that… and that in itself puts pressure on the situation of having to come out or of having to just be yourself authentically."

Ajani has always struggled with their mental health. They had experienced a breakdown, which was caused by a bad housing experience when living in a rental property in London. Their health spiralled and they returned to Birmingham to live with their mum. Their experiences made them worried about getting another rental property, and they only felt comfortable moving out once they were able to get a council property.

They feel they had a unique transgender experience, having never felt comfortable in their own body – they did not have a journey of trying to feel comfortable, before then transitioning. Ajani describes the impact testosterone had on them, highlighting that it deepened their voice, making conversations easier as people no longer mistook them for female.

[Discussing testosterone] "It's just been a lot easier to hold a conversation with anybody, just for the simple fact that my testosterone has kicked in. Before, my voice was high and so obviously no matter how I dressed or how I looked, the moment someone will hear my voice instantly they'll call me female."

Ajani is concerned about being financially stable in the future. They feel that despite working full time, it is difficult to save, especially given increasing prices and the cost-of-living crisis. Equally though, they wanted to see more local community initiatives similar to the ones in their area, to help maintain public spaces and to support individuals within the community.

"To be fair where I live, we kind of have a little community of our own… because obviously we pay service charge for the Council to cut the grass, but it doesn't happen all the time. So, like every two weeks or so, we'll go out there and cut. We'll make sure everyone's OK."

The non-response rate was highest in the youngest and oldest age groups

Unlike most questions in the Census, the questions on sexual orientation and gender identity were voluntary. This meant that not answering the question (by leaving it blank) was captured as an answer and considered important data in itself. In Birmingham, the total non-response rate for the question on sexual orientation was 9.4%, and for gender identity was 8.4% (6% chose to not answer both).1 Both of these rates are higher than the total figures for the country; 7.5% and 6.0% respectively.[57]

Figure 39: Non-response rate for 'Sexual Orientation' question by age group (2021)[1]

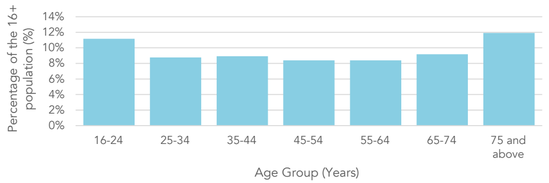


Figure 40: Non-response rate for 'Gender Identity' question by age group (2021)[1]

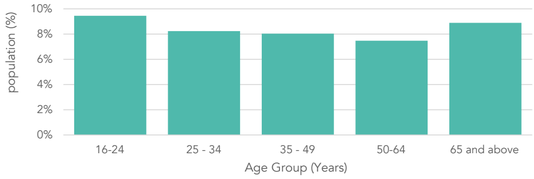
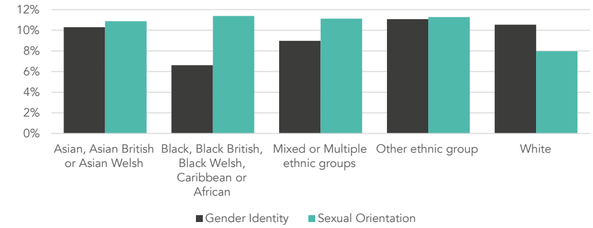


Figure 41: Non-response rates for questions on sexual orientation and gender identity by ethnic group (2021)[1]



Non-response rate was highest in the youngest and oldest age groups for both sexual orientation and gender identity (Figure 39,Figure 40). For the responses on sexual orientation in particular, over 10% of those in the '16-24' age group and '75 and above' age group provided no response. The reasons for non-response rates, and why these are highest in these age-groups, are not known and difficult to explain. No clear pattern was seen for non-response by ethnicity (Figure 41). There are many reasons as to why an individual may choose not to disclose this information. For example, even though the Census is a fully anonymous survey, some people may have been uncomfortable with sharing information that is very personal to them. [58] The implication for Birmingham is that the Census may have under-reported those who identify with an LGB+ sexual orientation or a 'trans' gender identity.

What might this look like in 2031?

As this is the first time this data has been captured comprehensively through a census, it is difficult to create a projection of how any trends might continue to 2031. For sexual orientation, it is likely that there will be an age-cohort effect where younger age groups continue to identify with LGB+ orientations at a higher level than preceding cohorts. The current 5% in the 16-24 age group is unlikely to decrease significantly as this cohort ages, although variation is possible as sexual fluidity is also more common in this group.lix Taking this into account, the expectation would be an overall flattening of the percentage across each age group. Therefore, there would be higher levels of LGB+ identification within the total population and a more even distribution across the age groups. This effect will also have implications for services that are more commonly associated with middle-age and older adults as those who identify with LGB+ orientations become more visible and present their own health needs.

A secondary trend which is difficult to predict is whether there will be further increases in the next cohort of 16-24 years olds in future years. In a 2022 survey from Stonewall on attraction and identity in Great Britain, 28% of respondents aged between 16-26 years old identified with an LGB+ sexual orientation.[60] While there is still a large difference between the census data for Birmingham and the estimates from Stonewall, which may be due to self-reporting methods, both suggest that levels of LGB+ identification are likely to increase in the population and across age groups. If the health and other needs of the LGB+ population, and the inequalities they face, are not recognised and addressed then the LGB+ population will continue to experience worse health outcomes and there will continue to be those that feel they have to hide their sexual orientation.

It is more difficult to suggest how levels of identification with different gender identities will change in the future as it does not fully mirror the same pattern as LGB+ identification in Birmingham. Generally, younger age groups have slightly higher proportions of those who identify as ‘trans+’. However, the lower proportion in the 16-24 age group, coupled with the higher non-response rate, indicates that there is no defined trend at this point. It is likely though that the ‘trans+’ population will increase in Birmingham over the next 10 years and health services and professionals will need to be aware of the stark inequalities experienced currently by this population. These services will need to adapt to accommodate greater diversity around gender identity and encourage better access for the ‘trans+’ population, particularly around gender-focused health services.

System Reflections

Bradley Yakoob
(Chair of LGBTQ+ & Allies Network, Birmingham City Council)
Inclusion! It may seem like an over exaggeration to use the word inclusion or to use an exclamation mark but there is a triumphant here. The census is rarely a major part of everyone’s wish list and is something we can often overlook in its importance, however for the first time since 1801, the LGBT+ population has been seen and included. Visibility is one of the foundations bricks behind the Pride movement, as for many decades the LGBT+ community fell victim to erasure and people were told to be ashamed or hide their most authentic self. In 2021, the UK Census allowed the LGBT+ community to seen and to be accounted for in one of the most powerful data sets in our land that informs decision making and service provision for the next 10 years.

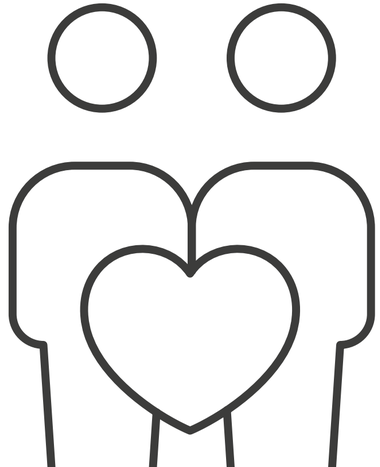
To read a quick insight into the 3% LGB+ and 0.9% Non-Cisgender Birmingham people and begin to see a glimpse of the LGBT+ community in our city. The growing LGBT+ community of the future with more young people (16-24) and younger adults (24-34) identifying as LGBT+ is testament to a changing and more inclusive future.

Conversely, it is important to recognise and reiterate that this is the first time these two questions relating to LGBT+ identity have been asked, and we have much to learn. This report identified that the non-response rate was highest in our youngest and oldest age groups – is this down to trust? Or maybe the fact that multiple generations are living in one household for longer than before? Or historic and current discrimination and societal aggression experienced? There are so many questions the census has unearthed but questions and challenges the LGBT+ community has highlighted many times before. Maybe the data and evidence that this census provides will enable leaders to hear and address these challenges.

The non-disclosure rate of both sexual orientation and gender identity in Birmingham was higher than the England average, our rates were higher in our youngest and oldest age groups, and our trends of disclosure in our non-white ethnic communities were low. These are all indicators of the change and action needed in our city. We need to ensure that every person in Birmingham feels safe and supported to be their most authentic self and be proud to be themselves. We need to do more as a city to ensure Birmingham citizens have the knowledge and resource to understand their experiences and feel safe to be open.

The service provision and consideration for the needs of the LGBT+ people in Birmingham is poor – with no dedicated gender confirming provision in the entire West Midlands even though we have a higher than England average for people who identify as Non-Cisgender, an under-funded LGBT+ Centre that supports Birmingham and the wider region, rising LGBT+ hate crime rates, and a lack of visibility of our city’s ally-led pride in our LGBTQ+ community outside of the Birmingham Pride weekend. If our city does not act now, we will see a rising number of people experience mental health challenges, substance misuse, victims of hate, and more health and social inequalities experience by LGBTQ+ people. Birmingham has the opportunity to be a vanguard of intersectional LGBTQ+ service provision and pride, with a population bursting with unique experiences, identities, and passion – it is time that our city, region, health and social care, and educational leaders do more to create a thriving LGBTQ+ city fit for the future. To slightly amend the opening of reflection: Inclusion, and now Action!

Mike Morgan
(Co-Founder, Alliance Network and Hays Pride Network)
There are some extremely interesting points in this data and as someone who works closely with internal and external networks in Birmingham, I was surprised that the largest identifying characteristic in all ethnic groups was Bisexuality. I feel this group of people lack support in Birmingham not only around healthcare but in around support networks where there are safe spaces to share experiences and seek support and advice. Given the data presented earlier in the report I am not surprised that Birmingham has a larger community of people identifying as LGB+ than the England standard as we have a much larger demographic of 16 – 24-year-olds than other areas in the UK. Whilst we know that these numbers are relatively accurate and probably underinflated, I would concur with the report that more work is needed now and certainly in the future to support these people given the number of young people identifying as LGB+ is likely to rise and also support for our trans community in the form of a specific West Midlands GDC.



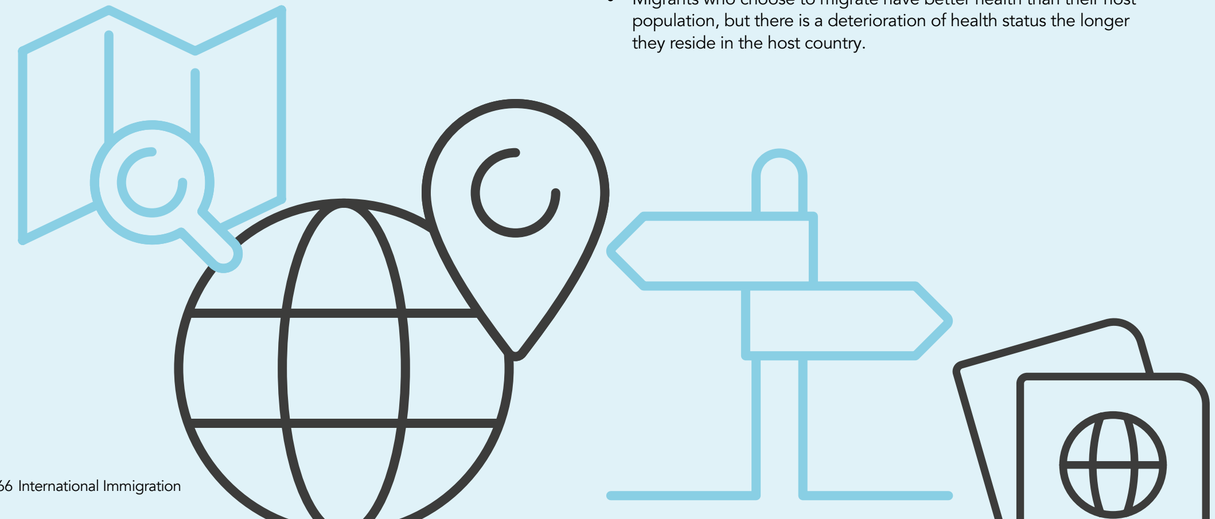
INTERNATIONAL IMMIGRATION

Data Headlines

- 73.3% of people (around 824,000) living in Birmingham were born in the UK, compared to 77.8% in 2011. Nearly two thirds of those who were born outside the UK have lived here for 10 years or more.
- Younger people contribute most to immigration: two-thirds (66.7%) of people who arrived in the UK in the previous decade, and were living in Birmingham in 2021, were under 30 when they arrived in the UK.
- GP registrations of migrated individuals increased in 2021.

Implications for Health and Wellbeing

- Migrants often experience barriers in accessing health and social services, especially if they are seeking asylum.
- Migrants may experience discrimination and are therefore vulnerable to physical and mental illness.
- Those who migrated for employment, family and study reasons have better health than the UK-born, while those who migrated to seek asylum have worse health outcomes.
- Those who migrate are more likely to be younger and are also less reliant on the health system.
- Migrants who choose to migrate have better health than their host population, but there is a deterioration of health status the longer they reside in the host country.



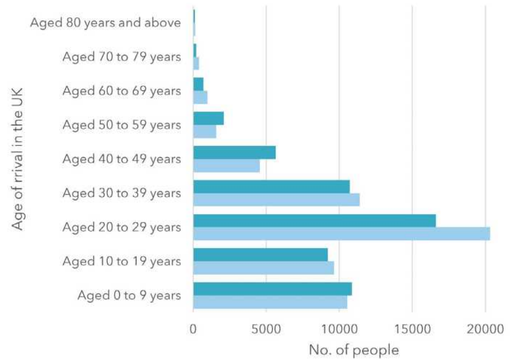
What does the data tell us about international immigration in Birmingham?

Migration is broadly defined as a change in a person's usual residence, it is an important contributory factor to population and social change. Migration can be divided into movement across national boundaries (international) and within a country (internal). Migrants in this report are defined as those born outside the UK, regardless of UK citizenship. Within the report international migration is discussed to understand health outcomes and is of the main drivers of population change in Birmingham.

Birmingham has a history of immigration during the 19th century, becoming an important destination for migrants seeking to settle and find work. Significant events include the following. Major immigration into the city from Ireland, following the Great Irish Famine (1845–1849). lxi Also, Jewish people fled religious discrimination in the 18th and 19th Centuries. In the decades following World War II, the ethnic make-up of Birmingham changed significantly, as immigration from the Commonwealth of Nations and beyond increased as employment opportunities increased during the 1950s-1960s.[61] The outcome of conflict around the world has led to many nationalities seeking asylum in Birmingham. Including residents from the Balkans, Somalia and East Africa, and later Iraq and Afghanistan during the 1990s. Following the Migration from the 'Accession Eight' or 'A8' East European Countries that joined the European Union (EU) in May 2004 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia).[61]

Two-thirds (66.7%) of people who arrived in the UK in the previous decade were under 30 when they arrived

Figure 42: Age of arrival in the UK by age group by sex (Arrived from 2011 to 2021)[1]

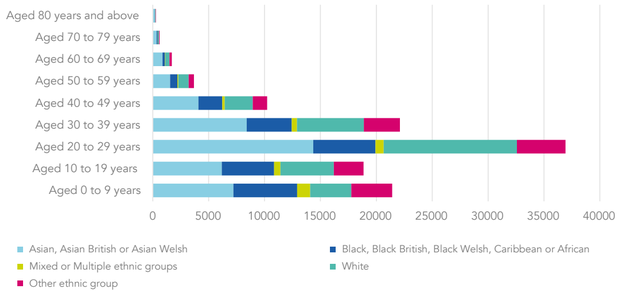


In Birmingham, in 2021, there were 298,730 people born outside of the UK (26.7% of the population). The data shows migrants who arrived in Birmingham are more likely to be female (52%) and aged 29 years old and younger.

International migration occurs when people leave their country of birth and stay in the host country for some length of time. The reason an individual chooses to leave their country of birth also can influence health outcomes. Health outcomes for migrants differ according to their reason for migration, country of birth, duration of stay in the UK and the type of work they undertake in the UK. Those who migrated for employment, family and study reasons have better health than the UK-born, while those who migrated to seek asylum have worse health outcomes.[63] Interestingly, after 15 years in the UK, non-born and UK-born populations report similar health outcomes across all age groups.[63]

The Census 2021 shows migrants who have arrived in Birmingham are more likely to be younger (Figure 42). Migrants tend to be young when they arrive, typically as young adults coming for work or study or as children accompanying their parents.

Figure 43: Age of arrival in the UK by ethnic group (Arrived between 2011 and 2021)[1]



The increasing population of migrant women in the United Kingdom has implications for the provision of healthcare and healthcare experiences. Research has shown that ethnic minority and migrant women are disproportionately affected by existing barriers to access to healthcare and have poorer maternal health outcomes. Migrant women are at increased risk for complications related to pregnancy and childbirth, possibly due to inadequate access to and utilisation of healthcare. The impact on Birmingham's health may need to consider migrant women as a vulnerable group who may experience challenges in adapting to a new country.

"I'm on regular medication, so I was lucky recently because I have my annual asthma check, and it's a hard chance to get an appointment with my GP. It's like a fortress."

Lena, 44, Female, Aston

62% of Birmingham residents who were born outside the UK have lived in the UK for 10 years or more

Figure 44: Age of arrival in the UK by length of residency (2021)[1]

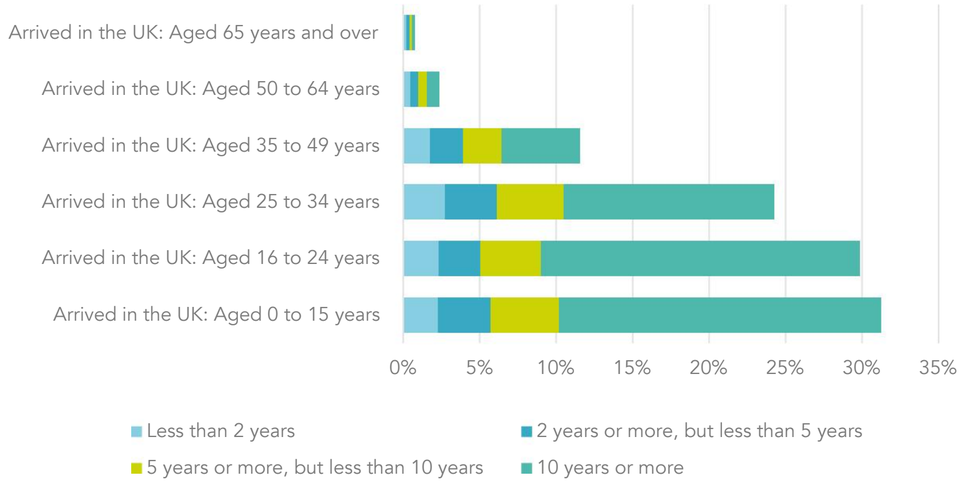


Figure 44 shows the age of a person who has arrived and the length they have stayed. The length of residence in the UK is the date that a person most recently arrived to live in the UK. The data shows those who are arriving are younger (aged 0-15 years) and are also staying in the UK for a significant length of time (10 years or more).

The 'healthy migrant effect' refers to observations that migrants have been found to have a better health status at migration than the other population in their country of birth and to some extent also better health status than the population in the host country.[62] This difference is in part explained by the fact that non-UK born are on average younger.[62]

But even within the same age groups, the non-UK-born are healthier than the UK-born, at least among the population below age [50.63] People who were born in the UK reported lower levels of 'good or very good health' than several other groups who were not born in the UK (Figure 45). In adults aged 35-49, 79% of people born in the UK reported 'good or very good health'. For the same age group, 90% of people born in Africa, and 81% of people born in the Middle East and Asia reported 'good or very good health'. Greater disparity is seen in older adults which may have implications for the next decade as this population increases.

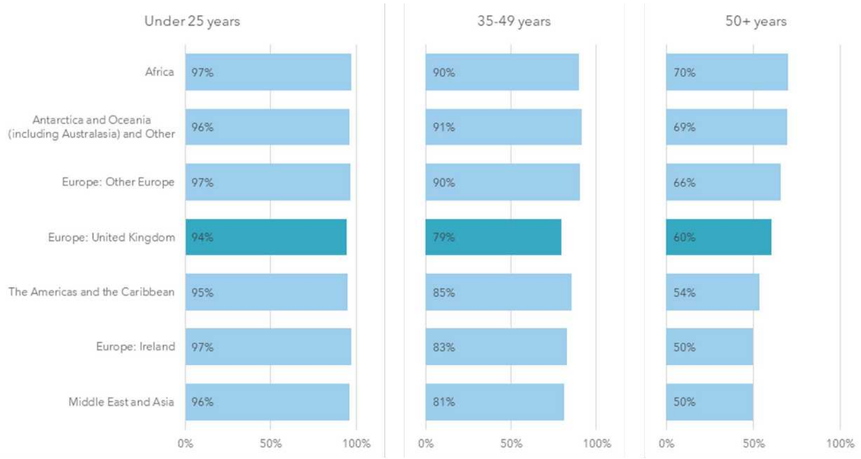
The health implications for Birmingham may see migrants who arrive in the UK, are more likely to be younger. Therefore, younger age groups are less likely to be diagnosed with age-related diseases and are less likely to be dependent on the healthcare systems.[64]

Migrants have been reported to make a positive contribution to the UK health service.[65] Migrants contribute through tax, tend to use fewer health services compared to others and provide vital services through working in the NHS.[65] However, work in manual or lower-skilled jobs and may therefore be more exposed to work-related risks and more vulnerable to work-related diseases.[66] Moreover, a few studies show that migrants' health advantage diminishes over time and their health status becomes equal to or worse than the host population's within 10-15 years after migration.[62] Length of stay in the UK increases with migrants who arrive younger (seen in figure 39).

"I'm still not very confident using NHS...I'm going through the process for the ADHD medication and I'm not feeling like I'm very taken care of...I never actually speak to anyone in person...and they don't explain it."

Agne, 27, Female, Ladywood

Figure 45: Percentage of usual residents in Birmingham reporting as having 'good or very good health' by age and country of birth[1]



Case study - Kamran

Ward:	Harborne	**Sexual Orientation:**	Heterosexual
Age:	54	**Gender & Gender Identity:**	Male
Ethnicity:	Iranian	**Occupation:**	Film writer and director
Faith:	Christian	**Living Arrangements:**	Temporary Council accommodation

Kamran migrated from Iran to the UK with refugee status 4 years ago, and two months after arriving to the country, he moved to Birmingham. After spending 8 months in a hotel, he now lives in temporary accommodation provided by the Council. As he does not speak English well, his son often acts as a translator for him.

Kamran believes Birmingham is a hugely diverse city, but he feels there is a lack of social cohesion and that there are tensions between different ethnicities. He thinks racism is on the rise, and that often these tensions are fuelled by the government – whether it's through the language they use or via their policies.

He thinks that some ethnicities are treated differently. For example, he feels Ukrainian refugees were able to find accommodation and employment much quicker than Afghan or Iranian refugees.

Kamran and his family were given temporary accommodation in a hotel when he first moved to Birmingham. The room was dirty and there were bed bugs and cockroaches. He later moved into a council property, which he described as being in poor condition. However, he did not complain as he had been warned by others in a similar situation that this would be the case. Instead, he sought help from his church, who were able to make his home a nice place to live. During his stay in a hotel, he met many families who had experienced homelessness due to rising living costs or difficult landlords. Kamran has a heart condition, which prevents him from working full time. However, he knows that his church has supported other Iranian refugees to find employment. Nevertheless, he explained that the employer had treated these Iranian employees differently compared to British ones.

"I think it's very diverse and that's something I enjoy about the UK… it's very deeply ingrained, and I feel like it makes my position as an immigrant easier to fit in. People are used to hearing people speak with accents. There is a bit of like, oh, where are you from? And like a bit of, you know, trying to put people in boxes, but generally I think it's not as big of an issue, people accept that you can be, I don't know, Asian and British or, you know from any country. I feel like I don't have to constantly prove my right to exist in this country as much as I did in Denmark. And to me, I think that comes [from] the fact that there's so many different people from so many different places."

"I get quite a lot of my healthcare done back home. So I go, you know, see a dentist, do my glasses there because it's cheaper, but also because I have more trust and I go to the same dentist, like, I went to as a child, and I don't like it's very difficult for me to know which dentist to trust even if I were able to pay for it here. I go back. I interact with those doctors differently. I can demand what, you know – how [a] GP sometimes would go in and you have to tell them what you want and you have to demand it. And you have to be like, no, I want this service, and I'm way more assertive and confident in doing that in my own country than I would be here."

2021 saw the greatest number of migrant GP registrations in Birmingham

Figure 46: GP registrations of migrants in Birmingham by year and sex[1]

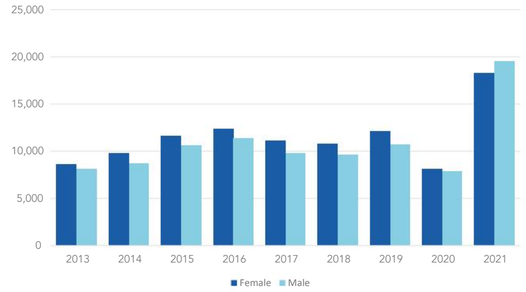


Figure 46 shows the data that GP registrations for migrants are increasing and vary year to year between genders. The greatest number of migrant GP registrations was seen in 2021 (female: 18,317 and male: 19,534). We can assume the low figures in 2020 could be a result of a lack of movement between countries in 2020 due to the COVID-19 pandemic. The increase in registration in 2021 may have been associated with the recovery from the pandemic and the NHS vaccination rollout programme as GP registration is one of the most effective ways of enabling access to the COVID-19 vaccine.

Vulnerable migrants are susceptible to multiple barriers to access to healthcare with impacts on short and long-term health outcomes.[68] The evidence defined main barriers to 'vulnerable migrants' receiving good quality primary care are language and administration barriers.[68] Themes included access to primary care, mental health, use of interpreters, post-migration stressors and cultural competency[68]

Vulnerable migrants perceived high levels of discrimination and reported the value of a respectful attitude from health professionals.[68] Those without documents were perceived as burdensome, and/or moral judgements were made about their deservedness for resources.[69] Lower proficiency in English makes it difficult for people to access suitable healthcare, which may have a longer-term impact on health.[70] There was also a more rapid decline in good health by age among people who were less proficient in English.[70]

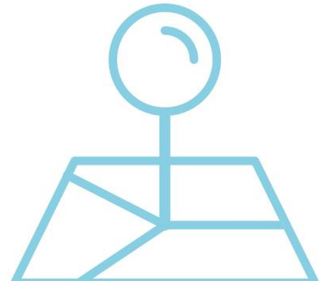
Due focus on 'the language problem' has meant little attention is paid to diversity within and between migrant populations.[71] It has been highlighted through the evidence migrants are less likely to use the National Health Service (NHS) than the general UK population.[64] This is partly because people who move to the UK tend to be young and healthy. General practice has played a key role in efforts to tackle health inequities among migrant populations but they are still a marginalised group who experience barriers to access services.[72] Migrants including refugees, asylum seekers, and undocumented migrants may experience health inequities due to social exclusion, discrimination, language barriers, and, for some, restricted entitlement to health care due to their immigration status.[72]

What might this look like in 2031?

It is difficult to predict migration demographic trends as the likelihood of migrants coming to, and staying in, the UK varies over time in response to national and international policy and events, for example post-Brexit restrictions on EU migration and the Ukraine war. That said, from the Census 2021, if Birmingham demographic trends continue, we would expect the migrant population to continue to be a substantial proportion of the population, with a relatively young age profile.

"I can see great people living in Birmingham, they're very helpful. I moved to Birmingham, I met a lot of people who were from different charities and they're always helpful, they're trying to help. They understand your situation, that you are a migrant. You have some difficulties. So, they're trying their best to help you."

Lena, 44, Female, Aston



System Reflections

Arten Llazari (Chief Executive of the Refugee and Migrant Centre)

In 2021, 27% of the Birmingham population were born in a foreign country, 0.15% of the Birmingham population are asylum seekers.[73,74] Migrants are less likely to use the NHS, and to be less of a financial burden on the NHS, than the UK born population (though interestingly, they are more likely than the overall UK population to work in the NHS [64]).

By far the most needed support which impacts on the health and wellbeing of the 14,000 new arrivals attending RMC's services each year, is immigration advice. Once this is addressed, holistic support around all the other wider determinants of health becomes a priority, including improving, stabilising and protecting physical and mental health and wellbeing.

Health literacy: 'the ability, skill and capacity to communicate, process and understand basic health information and make appropriate healthcare decisions'[75] is closely linked to happiness and therefore wellbeing.[76]

New arrivals continually express their need for such education, information and awareness raising around NHS provision. They don't know what is 'normal' in the UK. This training needs to be combined with support for those lacking confidence and those for whom language is a barrier. Equally, new arrivals request that health professionals are trained in: diversity and equity, active listening skills and cultural humility, and that primary care access is improved. There is good evidence[77] that if all of these measures are in place, the current high need for mental health support will be reduced and physical health will improve.

Dr Clara Day
(Chief Medical Officer, Birmingham & Solihull Integrated Care System)

Birmingham is an incredibly vibrant and diverse city, and international migration plays a significant role in enriching our communities. It also plays a huge part in shaping health outcomes for our populations. This not only brings additional challenges, but opportunities too to help enhance our health and care provision.

One of the key challenges we continue to face is our workforce and resourcing this provision. We are proud to have a large number of international staff in our employment across the NHS, and we want to ensure that these staff are supported in their roles and provided with equal opportunities, regardless of background or level.

To help with this, we've launched Our Open Conversation which invites staff to share their thoughts and feedback on how the system is set up to support individual development and needs. The insights we're collecting from this process means we can start to bring online additional initiatives to provide all staff with the best possible conditions to achieve the best possible outcomes for themselves, their teams and our patients and communities.

International migration can also influence the demand we're seeing for health and care services. Data in this report sets out that migrants born outside of the UK tend to arrive at a younger age, and some may be healthier than those born in the UK. However, the circumstances in which people arrive will greatly influence their health and social care needs. Those seeking employment or education will require difference support than refugees and those seeking asylum. More vulnerable people may face more barriers, such as language. We must address these barriers and wider inequalities to ensure all of our population receives equitable care and care live their best possible life.

In line with our 10 year master plan and Joint Forward Plan, services in Birmingham and Solihull are being designed to fit the unique needs of our diverse population, and ensuring culturally competent care. A key priority for us is reducing the stark health inequalities we're continuing to see across the breadth of our services and communities. We are doing this through initiatives such as the Fairer Futures Fund, which supports community-based projects to improve health and care outcomes for vulnerable groups, including new migrants, refugees and asylum seekers. We remain firm in our commitment to providing compassionate, inclusive and culturally competent care, recognising the valuable contributions of international migrants, the unique and unacceptable inequalities they

HOUSING

HOUSING

Data Headlines

- Overcrowding is higher amongst ethnic minority groups, in central and eastern wards and for young people.
- 31.5% of households in Birmingham are 1 person per households. Over half of people aged 85 years and above live alone.
- The biggest increase since 2011 has been in private rented tenure (from 17.9 to 22.6%) and is now similar to the proportion living in socially rented housing (23.5%).

Implications for Health and Wellbeing

- Housing is one of the key determinants of health. In the extreme, homelessness severely impacts health and wellbeing.
- Overcrowding can have negative effects on both physical and mental health and wellbeing, and is associated with increased risk of infectious diseases such as COVID-19.
- Living alone can be associated with unfavourable health outcomes such as anxiety, depression, and physical health conditions.
- Owning a house can improve mental health, as this can provide a sense of emotional security: mental distress is more common in renters than homeowners.

What does the data tell us about housing in Birmingham?

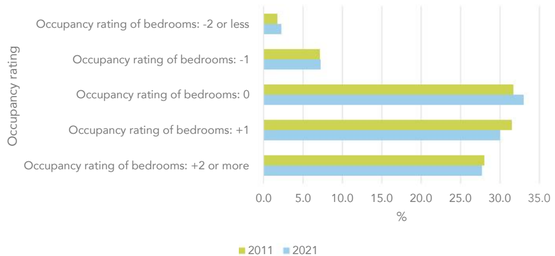
Housing is a key determinant of health across the life course. Good quality housing can save more lives, improve quality of life, reduce disease burden and reduce poverty whilst also assisting in combating climate change[78]. Poor quality housing or a lack of housing can produce negative short and long-term effects on both the physical and mental health and wellbeing of its inhabitants[79]. As a determinant of health, housing has the potential to improve or sustain health inequalities.

There are 423,456 households in Birmingham, nearly one-third of which are one-person households, and over half of people aged 85 years and above live alone. The percentage of Birmingham households who own their homes outright or with a loan or mortgage decreased from 55.2% in 2011 to 52.7% in 2021 and there was a 4.7 percentage point increase in private renting in this time (from 17.9% to 22.6%). Whilst most households (over 90%) in Birmingham have sufficient bedrooms for their size, overcrowding is common in central and east areas of the city and is higher amongst Asian, Asian British or Asian Welsh ethnic group.

* Percentage points describe the difference between percentages.19 Percentage point change is used in this chapter to show the difference between the 2011 and 2021 percentages.

Overcrowding is disproportionately affecting households in the central and east areas, and those from Asian/Asian British, Black/Black British and Other ethnic groups

Figure 47: Occupancy rating for bedrooms in Birmingham in 2011 and 2021 (2021) [1]



There are two measures of occupancy ratings in the Census: the occupancy rating for rooms and the occupancy rating for bedrooms. Each measure considers whether the number of bedrooms is adequate in respect of the household structure (e.g. one bedroom would be considered appropriate for a married/co-habiting couple but not for a single parent with a child) and the rooms rating also requires a minimum of two common rooms, in addition to the bedroom requirement. For both ratings, the value is then used to describe the occupancy level for the household: -1 or less implies there are fewer rooms than required (overcrowded); +1 or more implies there are more rooms than required (under-occupied); and 0 suggests there is an ideal number of rooms. Due to the differences between census methods, comparison between 2011 and 2021 can only be made for the occupancy rating for bedrooms.

Comparing the census year 2011 with 2021, there has been a small increase in proportion of households with over-occupancy (0.5%) and ideal occupancy (1.3%) in Birmingham overall. However, as shown in Figure 48, there are large differences across the city, from 43.8% of households considered overcrowded in Alum Rock compared to 2.5% in Sutton Wylde Green. There are also difference by ethnicity and age-group. Under-occupancy and ideal occupancy by bedroom rating are more prevalent among the White ethnic group, while over-occupancy is more prevalent among the Asian, Asian British or Asian Welsh ethnic group, Other ethnic group, Black, Black British, Black Welsh, and Caribbean or African (Figure 49).

Over-occupancy also much more commonly affects children and young people, with over a quarter of under 25-year-olds living in a household with over-occupancy by the bedroom rating. Whilst, under-occupancy of bedrooms was commonly seen among the older age groups, especially aged 65 years and above (Figure 50).w

Figure 48: Ward map of Birmingham displaying wards with the most over-occupied households (2021) [1]

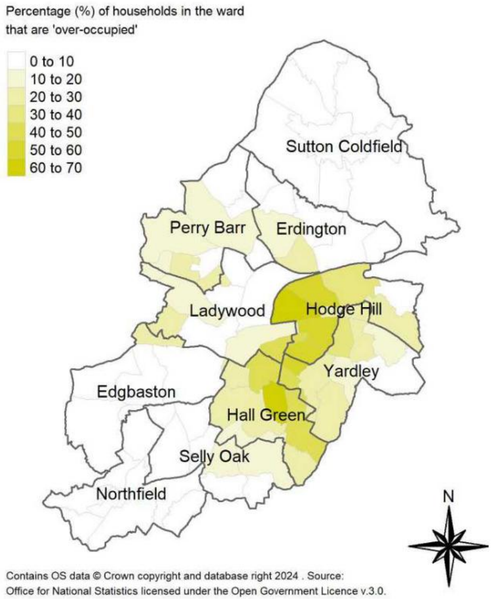
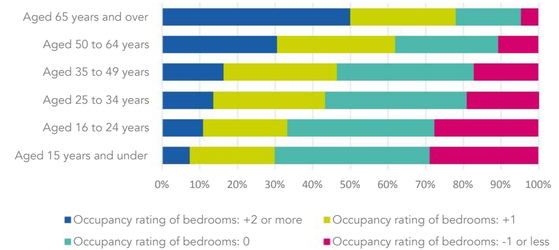


Figure 49: Occupancy rating of bedrooms by ethnic group in Birmingham (2021)[1]

Figure 50: Occupancy rating of bedrooms by age group in Birmingham (2021)[1]



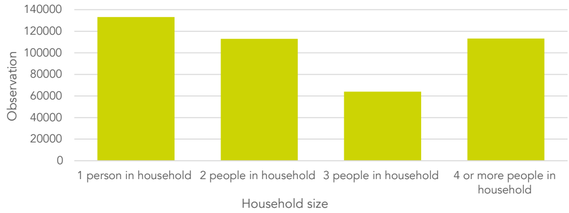
Overcrowded accommodation can have negative impacts on both physical and mental health and wellbeing. Chronic respiratory conditions, poor psychological conditions, and easy spread of bacterial and viral infections are some of the negative health effects associated with overcrowded accommodations. Living in a crowded accommodation has been shown to be associated with psychological stress among women between the ages of 25–45 in London, while living in temporary accommodation has been demonstrated to cause behavioural problems among children[80]. Overcrowding has been described as a risk factor for hospital admission with acute respiratory infection[81], and there is increasing evidence on the association between COVID-19 and overcrowding[82].

"There's loads of people living in sort of like one house and things like that, and a lot of overcrowding. Obviously, that could affect people's health because disease and illnesses and things will travel a lot quicker. I just think we'll see more sort of overcrowding. I think Birmingham is becoming quite overcrowded now."

Jack, 26, Male, Sutton Wylde Green.

1 in 3 households in Birmingham are one-person households

Figure 51: Household size in Birmingham (2021)1



Household size refers to the number of people usually resident in the household. The total number of households in Birmingham in 2021, was 423,456 an increase of 12,719 from 2011. Most people in Birmingham live in a household with other people, but approximately 1 in 3 people (31.5%) live in a one-person household (the number of single-person households has increased since 2011, however, there is reduction in percentage point by 0.4 due to increase in population) (Figure 51). However, this pattern changes during the life-course, with very few under 25 year olds living alone, then approximately 10% of each age-group from 25 years up to 45 years living alone, followed by a steady rise in the proportion from about 12% in 45-49 year olds to over 50% of those 85 years and over (100,662 over 85 year olds living alone) (Figure 52).

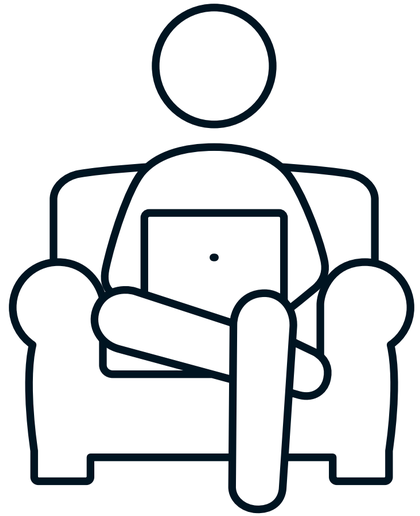


Figure 52: Household size by age group (2021)[1]

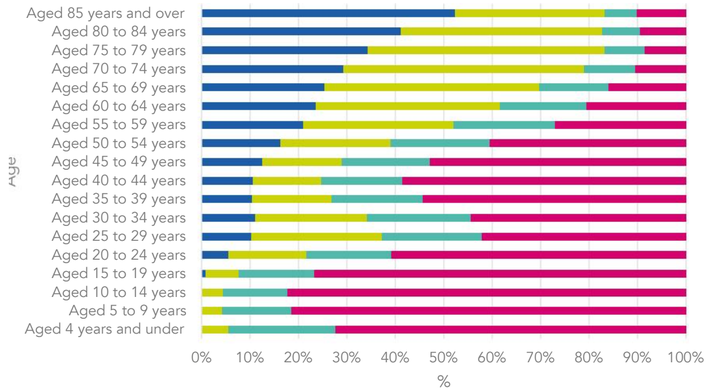
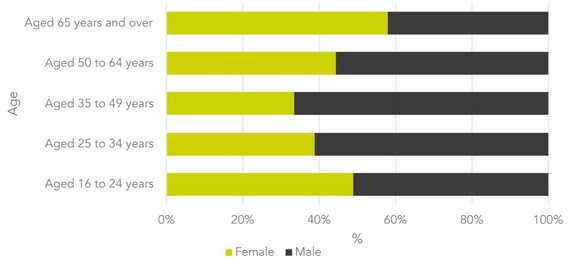


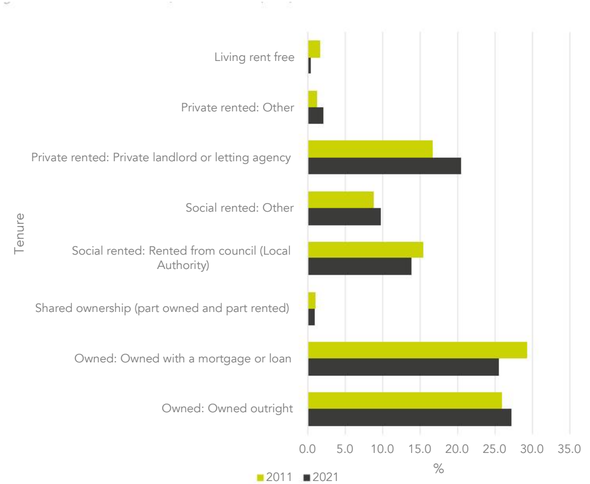
Figure 53: Percentage of single person households by age group and sex (2021)[1]



Loneliness can impact older adults and their health and wellbeing, and living alone has been associated with 32% increased likelihood for early mortality.[83] Living alone can lead to social isolation, which can be associated with unfavourable health outcomes such as anxiety, depression, and other mental health outcomes. The absence of social support in households can make coping with emotional stressors challenging for an individual that lives alone. In addition, in an emergency that involves older people who live alone, having access to immediate health support may be challenging. Older people who live alone have increased risk of hospital admissions from fall and respiratory disease.[84] This population group are susceptible to slips, trips, and falls, and adverse health outcomes, and living alone could reduce their quality of life.

Over half the homes in Birmingham are owned outright or with a mortgage but private renting has seen the greatest increase since 2011.

Figure 54: Tenure of households in 2011 and 2021 (2021)[1]



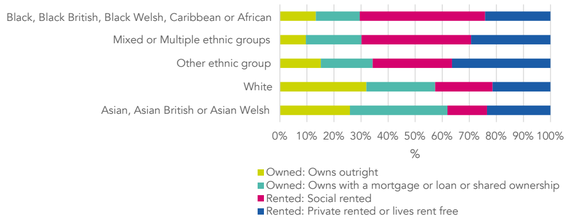
Tenure describes whether a household owns or rents the accommodation that it occupies. Accommodation options involve ownership, whether through full ownership, a mortgage or loan arrangement, or partial ownership through a shared ownership scheme and renting, either through a private rental arrangement, or through social rental scheme provided by a local council or housing association.

There was an increase of 1.2 percentage point for households that were owned outright in Birmingham between 2011 and 2021 census, however, there was a decrease of 3.7 percentage points for households own with mortgage or loan (Figure 54). Homes that were owned outright were commonly seen among White ethnic group (which also has an older age-profile), while homes that were owned with a mortgage or loan or shared ownership were common among the Asian, Asian British or Asian Welsh population. Social rented accommodation was prevalent among the Black, Black British, Black Welsh, Caribbean or African community, while private rented or lives rent free accommodation were more common among other ethnic group (Figure 55).

Tenure describes whether a household owns or rents the accommodation that it occupies. Accommodation options involve ownership, whether through full ownership, a mortgage or loan arrangement, or partial ownership through a shared ownership scheme and renting, either through a private rental arrangement, or through social rental scheme provided by a local council or housing association.

Research in the UK has shown that type of housing tenure (owns outright, or owns with a mortgage or loan, or through social or private renting) is associated with morbidity and mortality[85]. In a study where renters were compared to homeowners using twelve indicators (from sleep loss to impeded social life), it was found that renters exhibit more mental distress on all the indicators than homeowners[86]. For example, the percentage of homeowners who reported they had been losing sleep was 2% compared to 6% of renters who reported that they had been losing sleep.[86] According to a UK study by the National Child Development, children at age 7 and 23 living in homes that were owned outright had better health than those living in social rented accommodation, based on the following health metrics: height, `malaise', self-reported health, hospital admissions and psychiatric morbidity[85]. The conditions of the homes and the tenure both have effect on mental health because homeownership can essentially provide a sense of emotional security for homeowners, and this is beneficial for mental health[87].

Figure 55: Tenure of households by ethnic group (2021)[1]



Although, homelessness cannot be measured through the Census, inability to secure or continue to afford housing as result of financial constraints can ultimately lead to homelessness which has deleterious effects on health and wellbeing. Even without such significant event, higher mortgage and rental costs relative to income may result in economic stress, which may impede the ability of households to afford healthy living conditions and healthy lifestyles, as well as putting the household under stress[88].

"I would say that there's more people renting now than has bought a house or can afford to buy a house"

Yvonne, Female, 32, Handsworth

Although, homelessness cannot be measured through the Census, inability to secure or continue to afford housing as result of financial constraints can ultimately lead to homelessness which has deleterious effects on health and wellbeing. Even without such significant event, higher mortgage and rental costs relative to income may result in economic stress, which may impede the ability of households to afford healthy living conditions and healthy lifestyles, as well as putting the household under stress[88].

Case study - Liam

Ward:	Moseley	**Sexual Orientation:**	Gay
Age:	36	**Gender & Gender Identity:**	Male
Ethnicity:	White British	**Occupation:**	Primary school teacher
Faith:	Other religion	**Living Arrangements:**	Rents from private landlord

Liam has lived in Birmingham for 11 years and is currently trying to save up to buy his own house in the city. Liam explains that many of his friends and colleagues in Birmingham rent instead of buying homes due to high housing prices. He finds it frustrating to be continually saving while the cost of housing keeps increasing, and also while competing against property investors.
"I think within Birmingham in particular, I think there's a lot of people selling properties that are selling them to investors. It's not so helpful for people that are not on the property ladder because you're competing against people that are buying a chain of properties purely for profit reasons…"

He has noticed the population fluctuating in size within his school, which has seen an increase in refugees from Ukraine and Hong Kong. He thinks Birmingham is diverse in terms of ethnicity, which he sees as hugely positive, believing it enriches the city. Liam thinks there has been an increase in the number of residents identifying as LGBTQ+, particularly among younger people. He doesn't believe this is specific to Birmingham, but instead reflects an overall increased awareness in the UK and the Western world more widely. However, he also knows people in the LGBTQ+ community who choose not to report their sexual and gender identity in the public census, as they are pessimistic about the future and fear discrimination based on how they identify.

Liam feels like he has good physical and mental health. However, he acknowledged that many people are struggling – and were particularly during Covid-19, when there were limited opportunities to exercise and socialise. He explained that the cost-of-living crisis is having an impact on people's mental health across the city. He feels that increasing rents and mortgage rates can negatively impact their wellbeing.

"Obviously rent is increasing and obviously the cost of lots of other things are increasing as well. So, it's just the strain potentially of balancing those demands and kind of budgeting around it. But it's something I'm managing with at the moment."

He thinks that for some people being economically inactive would also negatively impact their mental health as it might affect their self-worth. However, he also noted that flexibility around work has positively impacted some people's lives, as they are able to create a better work-life balance, are able to exercise and see more of their friends and family. Liam is concerned about elderly people who live by themselves, as he thinks that isolation can negatively impact mental health.

[Discussing elderly people living on their own] "I think it can be quite lonely. My grandma is still alive, but she used to live alone and she found it a really lonely experience. And in terms of her mental health, I think she really struggled."

Liam feels pessimistic about housing and thinks that the current situation is disheartening – he believes that for many people, no matter how much they save, housing prices continue to rise and remain out of reach. He is concerned about whether public services will be able to keep up with the increasing population, especially the NHS and schools.

"The main thing is private renting, you're putting money aside each month, but you're not actually gaining anything from it. I think the longer you're in that situation, the more frustrating it's going to be, particularly if you're saving for a house, a housing deposit and the interest rates and things like that continue to rise, you're almost chasing a never-ending goal."

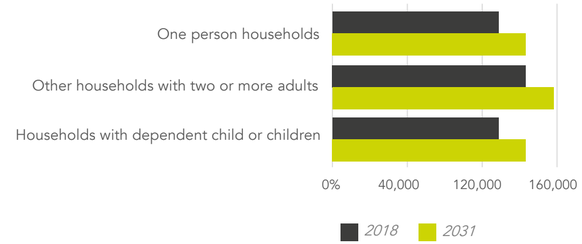
What might this look like in 2031?

The total population and number of households in Birmingham have grown in the previous 10 years and are predicted to continue to grow, whilst the cost of somewhere to live (rent, mortgage and property costs) have all increased. The pressure on families and households in terms of accommodation costs are therefore considerable, and national and international economic conditions do not suggest that costs will be significantly eased in the short term.

Health and wellbeing can be impacted by tenure (which is linked to security of housing, costs and standard of accommodation), overcrowding and single-person households (linked to loneliness). Whilst there are many factors at play, each of these could reasonably be expected to increase in impact over the next 10 years for the most affected in Birmingham.

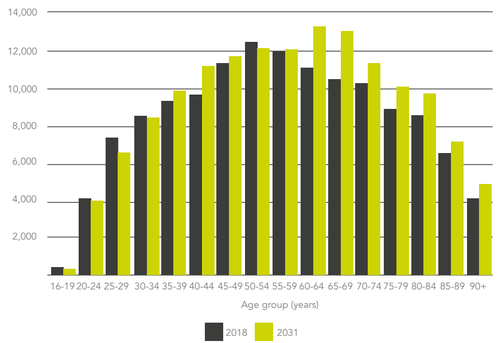
Demographic change is driving trends in the make-up of households. According to ONS, most of the projected household growth will come from one-person and multiple adult households without dependent children (referred to as "other households with two or more adults") (Figure 56). Between 2018 and 2031, the number of households with dependent children is projected to increase by approximately 5,500 (3.8%). One-person households are projected to increase by approximately 12,500 (8.7%). Similarly, the number of other households with two or more adults (without dependent children) is expected to increase by 11,500 (8.6%).

Figure 56: Projected change in the number of households by household type in Birmingham between 2018



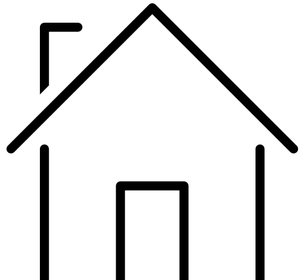
The predicted growth in the number of one-person households and other households with two or more adults is driven by increases at older ages (Figure 57). The largest projected growth for one-person households in the 13 years to 2031 (from 2018) is where the household reference person (HRP)* is aged between 65-69, which increased by 20% (from approximately 10,500 households to 13,000 households).

Figure 57: Projected change in the number of one-person households and age of household reference person (HRP) between 2018 and 2031



Homelessness has a terrible impact on health and wellbeing, with homeless people dying 30 years earlier than general population89. Although, homelessness and housing insecurity were not captured in the Census, these are important areas we cannot ignore when talking about housing. Some of the factors that could lead to homelessness include poverty, high accommodation costs, low income, housing shortage, poor health or disability, unemployment, and domestic abuse. According to homeless link, the two main reasons people cited as the cause of their homelessness were family and friends were unable to accommodate them, and the end of a private rented Assured Shorthold Tenancy90. Thus, over-crowding and increasing private rentals are a risk to homelessness in Birmingham.

Based on the recent census data (2021) and contrasting it with data from the 2011 census, it is evident that there has been an increase in the proportion in privately rented accommodation. If the trends persist in Birmingham, it is likely that people may shift from owning houses to renting houses. This may put people at risk of becoming homeless. Also, if the changes continue in similar directions in Birmingham, it may widen the health inequality gap as a result of the unfavourable health outcomes associated with overcrowding and solitary living (social isolation).



System Reflections

Paul Langford
(Strategic Director of City Housing, Birmingham City Council)
This report highlights that 9.4% or 39,804 of the 423,456 households in Birmingham are overcrowded whilst 57.7% of households under occupy accommodation. White households are much less likely to live in overcrowded conditions. Approximately 30% of Black, Asian and other ethnic groups are overcrowded, this is true for less than 10% of white households. Another issue identified through this report is the high prevalence of black and mixed ethnic minority groups who are dependent on social housing. In the households we see becoming homeless, some communities are significantly over-represented. Through our new homeless prevention strategy and other city wide strategies such as Everyone's Battle Everyone's Business we have demonstrated a commitment to working with partners to reduce racial and housing inequality to improve life chances and outcomes for all Birmingham residents.

The reason as to why greater numbers of white ethnic groups under occupy accommodation might be explained by the fact that trends in ethnic make-up in Birmingham differ hugely by age group. More than 80% of households aged 70+ in Birmingham consist of two or less people and more than 50% of those aged 85 and over live alone which indicates a good proportion may be socially isolated and at greater risk of serious harm due to slips and falls. Older people are also more likely to own their property outright as a result of paying off their mortgages meaning that a significant proportion of family sized accommodation is unavailable for use by larger households. This suggests a need for more attractive and affordable retirement and older peoples supported accommodation as a means of freeing up larger properties for those that truly need the space.

Overcrowding and under occupancy places significant strain on statutory homelessness services and social housing. 14,810 households are currently on the Council's Housing Register as a result of being overcrowded and in the last financial year 1,253 households were accepted as homeless by Birmingham City Council because friends and family were unwilling to accommodate them. The majority of those made homeless were single female parents who would also be owed a temporary accommodation duty. Owing to current socio-economic conditions, a lack of suitable affordable housing, and the cost of living crisis, such households are likely to struggle to find an affordable accommodation solution in Birmingham and therefore are likely to become long term statutorily homeless dependent upon temporary accommodation at which point the wider emotional and practical support needs (including mental and physical health) of all household members are likely to increase.

Our Housing Strategy 2023-2028 aims to increase the supply of affordable housing in Birmingham and some significant achievements have been made, particularly in relation to encouraging third party development across the city but the fruits of this labour are unlikely to have an immediate impact on overall numbers. Therefore it is important that we seek widen the geographical scope of suitable and affordable accommodation offers in discharge of homelessness duties for those households who might wish to resettle out of area with support.

Jean Templeton (Chief Executive, St Basil's)

There are significant pressures on housing supply, affordability, quality and accessibility as a result of a number of factors cumulative over many years. Lack of investment in social housing, freezing of local housing allowance by national government, significant reduction in funding for supported housing, and rising poverty have led to increased levels of homelessness for families and single people with many more living in temporary, insecure accommodation. This disproportionately affects some people and communities more than others.

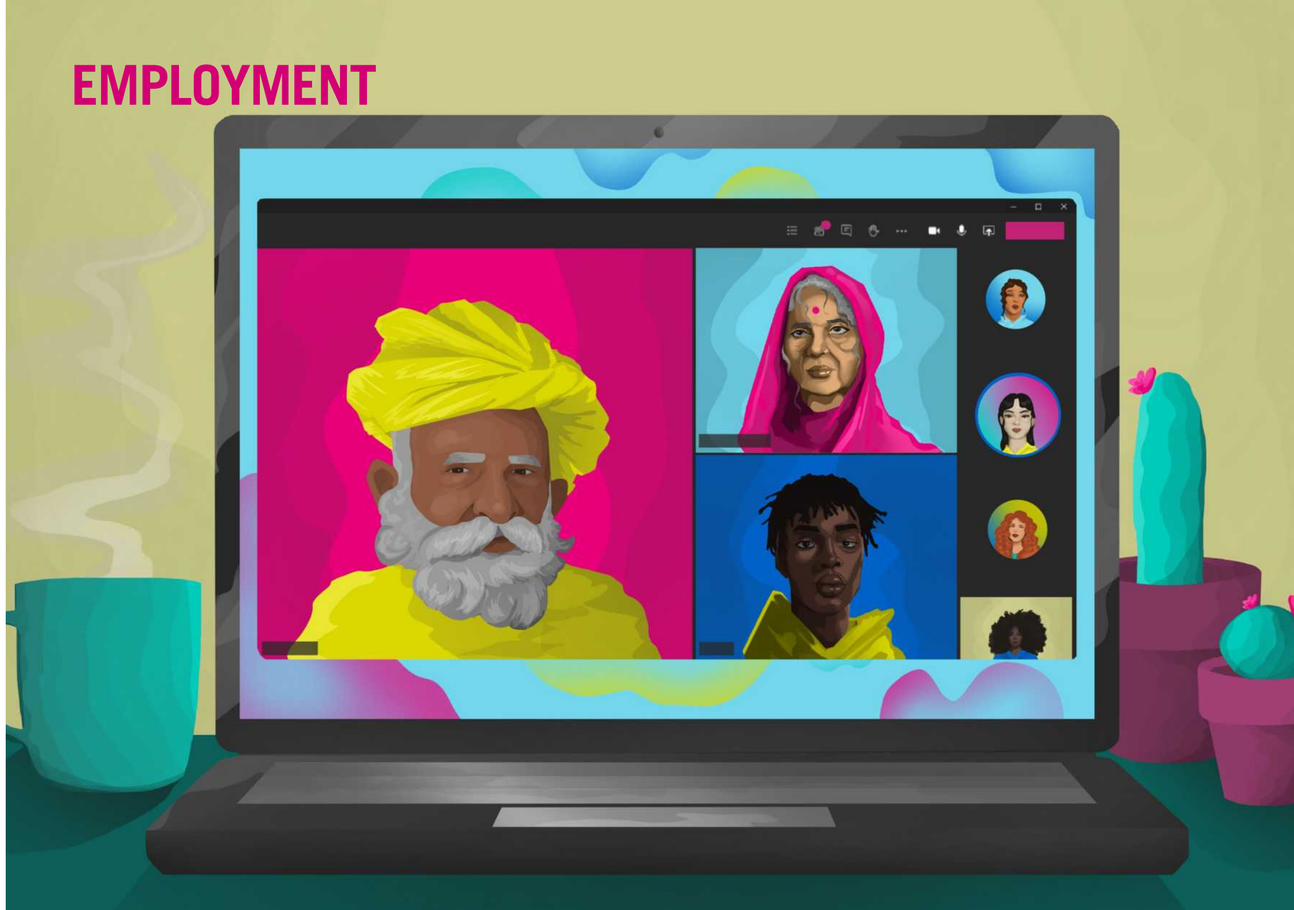
Rent levels in the private rented sector have increased significantly, whilst assistance with housing costs have not. Zoopla data for September 2022 shows that those requiring assistance through local Housing Allowance are only able to access some 5% of private rented accommodation in the city. Some private landlords, unable to let at Local Housing Allowance, have left the sector, some moving into the exempt sector or other types of short-term lets. Sustainable, affordable homes are therefore increasingly difficult to access for many people.

The 2023 Destitution in the UK study by Joseph Rowntree Foundation reveals approximately 3.8million people experienced destitution in 2022 including around 1 million children. This is almost two and a half times the number of people in 2017, and nearly triple the number of children.[91]

The health consequences of housing insecurity are significant and require a cross government, long term Housing and Inclusion Strategy and implementation plan. In the meantime, health services need to consider the health needs of those in precarious housing, those who are homeless or at risk and ensure that their services are bespoke, accessible, inclusive and psychologically informed.

Homelessness is the ultimate exclusion and is therefore everybody's business. Good health, a secure, safe and affordable home, sufficient income to live, and people who care about you, are the fundamentals which enable any of us to thrive. Achieving those, requires all of us to play our part.

EMPLOYMENT



Employment

Data Headlines

- 42,000 of the working age population are economically inactive due to long term sickness or disability
- Almost 50,000 people are economically active and providing unpaid care, with carers more likely to be older and female.
- Most common method (60%) of travel for journeys less than 5km was by car or van.

Implications for health and wellbeing

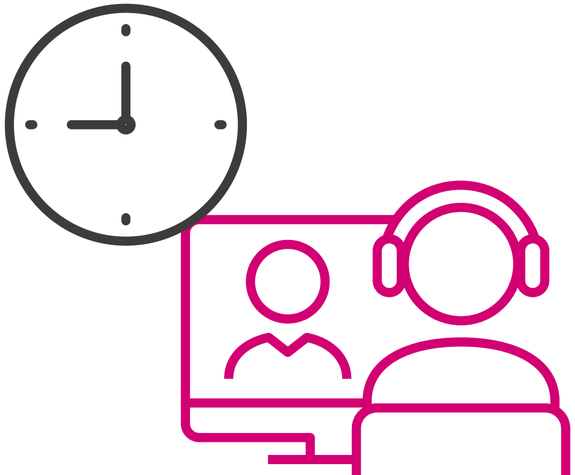
- With increasing age, the proportion of economically inactive residents reporting long-term sickness or disability as the cause of their inactivity increases up to pre-retirement ages (50-64 years).
- People who are economically inactive primarily because of their health tend to have increasingly complex health needs, the majority with more than one health barrier to them returning to the labour market.
- Pre-pandemic there was a trend of increasing prevalence of poor health, and of poor health as a reason for economic inactivity. Further to the pandemic, economic inactivity for health reasons is likely to be exacerbated by conditions like long COVID and longer waiting lists for treatment, and the impact on the mental wellbeing.
- Evidence shows that working carers can experience a range of difficulties including lack of time, excessive stress and resulting health problems, and financial pressures. Active travel, especially for short, routine journeys, can create a positive health effect for both individuals (more physical activity) and the wider population (improved air quality from less vehicle-based pollution).

What does the data tell us about employment in Birmingham?

Income and employment are key determinants of health and drivers of health inequalities.92 The greater one's income, the less likelihood of disease and premature death93 and being in "good work" improves health and wellbeing across the life-course, and protects against social exclusion[93], whilst unemployment is associated with increased risk of ill-health and dying. The Census is a useful tool for understanding employment in Birmingham and associated self-reported health of those working and not working.

The Census asked those aged 16 years and above a series of questions on their employment, including their economic activity status. The ONS defines a person as economically active if they are working (employed) or looking to start work within two weeks (unemployed) and economically inactive if they were not looking for work or couldn't work (e.g. retired, looking after family, student not looking for work).[95] Unemployment is therefore not the same as economic inactivity. The Census also asked about the method that people use to get to work and the distance these journeys take. While impacted by the COVID-19 pandemic, the changes to methods of travelling to work (particularly the increase [80] in home-working) illustrate the future of work and how health and wellbeing can be better emphasised in good working practices.

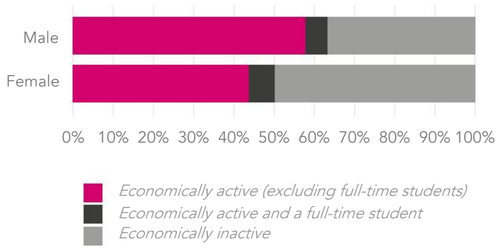
The ONS recognise that the Census 2021 data and employment information in particular may have been affected by the unique situation of the COVID-19 pandemic and the measures in place to control the pandemic, including advice against use of public transport and the 'furlough' scheme , which is not easily captured as a work status on the Census.[95] The effects of some changes brought on, or accelerated by, the pandemic have clearly remained, including for example, increased levels of working from home however, others have returned to pre-pandemic levels (e.g. levels of cycling have broadly returned to pre-pandemic levels as conventional traffic has increased on the roads) .[94]



42,000 of the working age population are economically inactive due to long term sickness or disability

Figure 58: Economic activity status by age group (2021)[1]

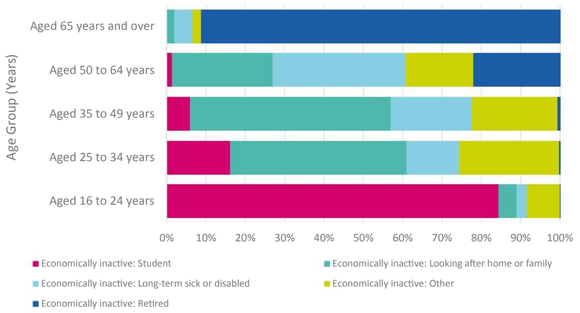
Figure 59: Economic activity status by sex (2021)[1]



Just over half (52.1%; 463,304) of Birmingham residents were economically active (excluding full time students), 44.4% (394,873) were economically inactive and 3.5% (31,316) were economically active full-time students. Figures 57 and 58 show how the economic activity status of the 16+ population breaks down by sex and age group. The division of activity to inactivity follows generally established trends in age group, and overall, a greater proportion of females are economically inactive than males.

The reason for changes to economic inactivity over the life-course are as expected, with the most common reasons being studying for 16–24-year-olds, looking after home or family for 25–50-year-olds, long-term sick/disabled for 50–64-year-olds and retirement for those 65 years and older (Figure 60). The ONS have noted that there may have been more people responding 'Other' than expected due to the working restrictions caused by the COVID-19 pandemic. xcv Overall, 4.7% (42,143) of the working age population (16–64-year-olds) report they are economically inactive due to long term sickness or disability.

Figure 60: Reasons for economic inactivity by age groups in Birmingham (2021)[1]



Just over half (52.1%; 463,304) of Birmingham residents were economically active (excluding full time students), 44.4% (394,873) were economically inactive and 3.5% (31,316) were economically active full-time students. Figures 57 and 58 show how the economic activity status of the 16+ population breaks down by sex and age group. The division of activity to inactivity follows generally established trends in age group, and overall, a greater proportion of females are economically inactive than males.

The reason for changes to economic inactivity over the life-course are as expected, with the most common reasons being studying for 16–24-year-olds, looking after home or family for 25–50-year-olds, long-term sick/disabled for 50–64-year-olds and retirement for those 65 years and older (Figure 60). The ONS have noted that there may have been more people responding 'Other' than expected due to the working restrictions caused by the COVID-19 pandemic. [95] Overall, 4.7% (42,143) of the working age population (16–64-year-olds) report they are economically inactive due to long term sickness or disability.

Figure 61: Rates of economic inactivity ('Long-term sick or disabled') by age group (2001 to 2021)[1]

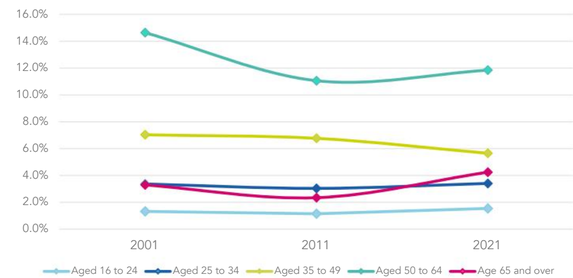


Figure 62: Rates of economic inactivity ('Looking after family or home') by age group (2001 to 2021)1

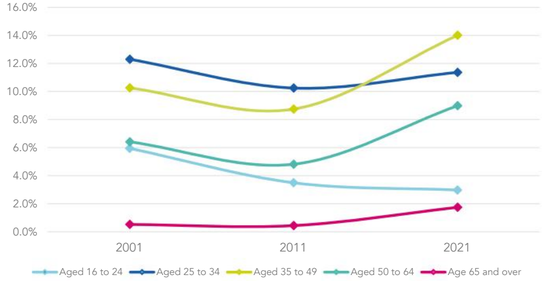
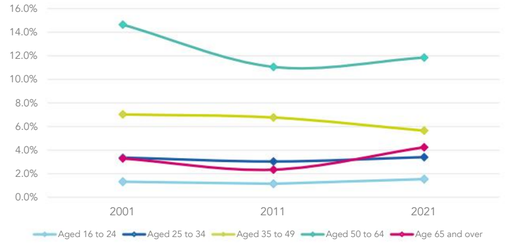
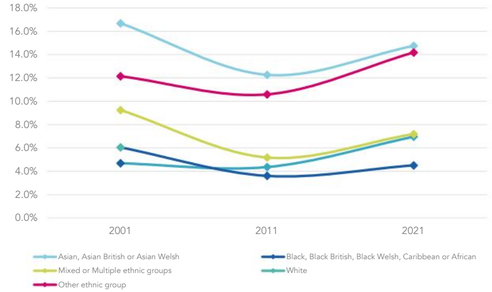


Figure 63: Rates of economic inactivity ('Long-term sick or disabled') by ethnic group (2001 to 2021)[1]



Trends over time for economic inactivity due to sickness or disability and due to looking after family or home, by age group are given in Figures 60 and 61. For the most part, the percentage reporting that they are not working due to sickness or disability remained fairly constant for each age-band between 2011 and 2021, but this was a change from the downward trend seen for 50-64 year olds between 2001 and 2011. Similarly, the downward trend seen across age-groups of economic inactivity due to looking after family or home between 2001 and 2011 was reversed in 2021, with rates increasing particularly in the 35-49- and 50-64-year age-groups.

Figure 64: Rates of economic inactivity ('Looking after home or family') by ethnic group (2001 to 2021) [1]



Figures 62 and 63 show a more nuanced picture on economic inactivity, through the lens of ethnic group. Long-term sickness or disability has increased within the 'White' and Mixed or Multiple' ethnic groups while decreasing slightly or remaining roughly the same within the 'Asian/Asian British', 'Black/Black British' and 'Other' ethnic groups. 'Looking after the home or family' has increased in all ethnic groups since 2011 but the increase has been greatest in the 'Asian/Asian British' and 'Other' ethnic groups.

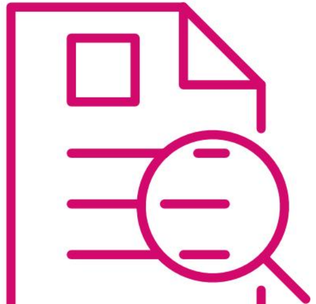
The relationship between health and economic activity works both ways: economic activity can lead to better health and better health leads to economic activity. Lack of good health is a determinant of economic inactivity across different age groups, albeit of greater prevalence in older, pre-retirement age-groups.[96] The likelihood of returning to work is lower at older ages and particularly for those also with poor health.[101] Equally, there are well-documented inequalities in access to work across ethnicity, sexual orientation, gender identity, and sex.[97,98] These in turn can impact upon health and wellbeing as they present a barrier to becoming economically active.

People who are economically inactive primarily because of their health tend to have increasingly complex health needs, the majority with more than one health barrier to them returning to the labour market.99,100 The Office for National Statistics reported between 2019 and 2023, the number of people inactive because of long-term sickness who reported depression, bad nerves or anxiety rose by 386,000 (40%).[99] Most of this increase was from people reporting it as a secondary health condition (increased 50% over the same period), whereas it only increased by 14% as a main health condition.[99] Moreover, people can have multiple concurrent reasons (sickness, retirement and/or looking after the family or home) for not engaging in the labour market,[101] and they may have a preference to report one or identify more strongly with one as the primary reason for example, preferring to report themselves to be economically inactive due to retirement rather than long terms sickness over the age of [65.101]

Factors that may have driven the recent rise in people reporting economic inactivity due to poor health include long COVID and long waiting lists for treatment.[99] However, these contributing factors have been exacerbated by a pre-pandemic trend of increasing prevalence of poor health, and of poor health as a reason for economic inactivity.[102]

"I'm 58 now, but for the last 18 years I've been disabled, and I needed a hip replacement over 10 years ago... if they'd repaired that hip 10 years ago, I'd still be a working person today"

Sally, 58, Female, Edgbaston



Case study - Caroline

Ward:	Longbridge & West Heath	**Sexual Orientation:**	Straight/Heterosexual
Age:	53	**Gender & Gender Identity:**	Female
Ethnicity:	White British Caribbean/Black British	**Occupation:**	Homemaker
Faith:	No religion	**Living Arrangements:**	Homeowner with a mortgage or loan

Caroline is a 53-year-old mother of several children, who recently lost her husband during the pandemic. She used to work in a school but has been at home for the last few years. She has noticed changes in employment, particularly Covid-related changes and believes that more people are working from home or are enrolled in colleges. She has also noticed that more people are only working 15 hours per week. She felt this was so they do not lose their benefits, as the costs of childcare are so expensive that it negates earnings over that amount. This was the experience of some of the other parents she used to work with.

"When I worked a few years ago, people only work the 15 hours because they didn't want their benefits affected, and for child care… it's just so expensive to get children into childcare, it's not really worth them working full time"

Caroline feels crime has increased in the city, making her concerned for the safety of her children – and making her more wary of letting them leave the house. This is exacerbated by her belief that the number of police on the streets has decreased – she used to find police presence reassuring. Not working also had a negative impact on her mental health and social wellbeing, as it had been a considerable source of human connection for her, particularly amongst people of her own age. She feels that since she has stopped working her life has become more monotonous, and she is less able to see her friends, who all work full time. She still feels able to go out for exercise and feels positive about the parks and council-run gyms in West Heath. Previously, she had been able to attend a local gym for free, though she was not sure if this was still being offered.

"I'll try and walk a lot. I've got dogs and walk a lot, which helps me. I've got loads of nice places in Birmingham that you can go, lots of parks." Caroline is generally concerned for the future due to the increased cost of living and the impact she expects this to have on crime and homelessness.

"I think suicide's going to go really high. I think the mental state's going to just go high. I think crime is very ridiculous because people can't afford to live."

Caroline feels that education on health and wellbeing, in schools and in workplaces, could be improved, as some people are not aware of what resources are available to them. She was also positive about her community and felt they were good at checking in and looking out for each other. She also feels that free activities for children after school would help parents who can't afford after-school clubs for their children

"Just put things in place to educate people more about it. Because a lot of people don't know or don't know that this thing's out there, that they can access… it doesn't have to be school. It could go to the workplace. Just to promote all these things in half an hour, just something like that. Just to tell them what's out there."

"Our community where we are, we're quite good. We spend a lot of time looking out for each other."

Almost 50,000 people are economically active and providing unpaid care

Figure 65: Economic activity status by provision of unpaid care (excluding those who provide no unpaid care) (2021)[1]

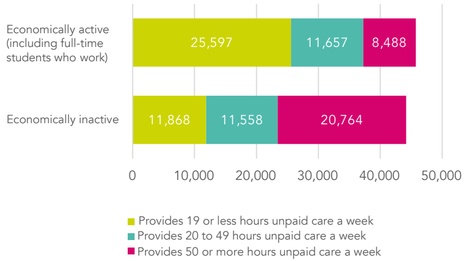
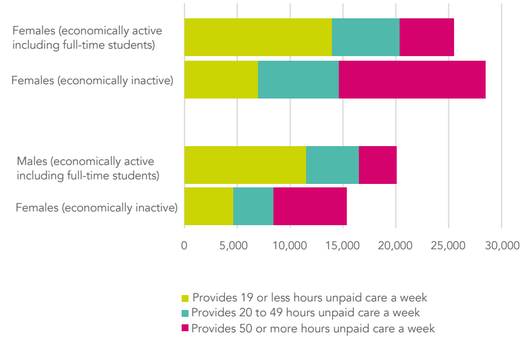


Figure 66: Provision of unpaid care by sex (excluding those who provide no unpaid care) (2021) [1]



Almost 90,000 Birmingham residents provide unpaid care, with approximately 29,000 residents providing more than 50 hours a week. Figure 58 shows the economic activity status of those who provide some form of unpaid care at the time of the Census. It shows that just under 10% of all economically active individuals are providing at least 1 hour of unpaid care a week. Within this, the majority provide between 1 and 19 hours of care a week, although approximately 2% (8,488) of the economically active population in Birmingham are also providing 50 or more hours of care a week.

Unpaid care was already known to have both a gender and an age gap, and the 2021 census confirms that economically active individuals who provide unpaid care broadly follow this pattern.ciii Figure 65 shows that both economically active and inactive females provide more unpaid care than their male counterparts. Those aged 35 to 49 and 50 to 64 contributed the most unpaid care of those who were economically active and providing care (Figure 66).

A person is a provider of unpaid care if they look after or give help or support to family members, friends, neighbours or others (excluding children aged under 18 years) because of long-term physical or mental ill-health or disability, or problems related to old age.[104] The number of people who combine work and unpaid care is slowly increasing as more people need care, public and private care systems are progressively under pressure and more people are required to work for longer. [105] cv Without adequate support, these working carers may experience detrimental effects on their well-being.[105] Evidence shows that working carers can experience a range of difficulties including lack of time, excessive stress and resulting health problems, and financial pressures. Health problems might have already existed before they started caring or developed because of chronic physical and emotional exhaustion.[106]

Positive effects of caring include improvements in psychological well-being, personal fulfilment and physical health.[104] However, in general, research shows that providing unpaid care is associated with negative impacts on carers' education, employment, household finances, health and wellbeing, and personal and social relationships.[104] Carers' health, physical and mental, has been shown to have a big impact on their ability to work and care.[106] Unpaid work is an important aspect of economic activity and the well-being of individuals.[104]

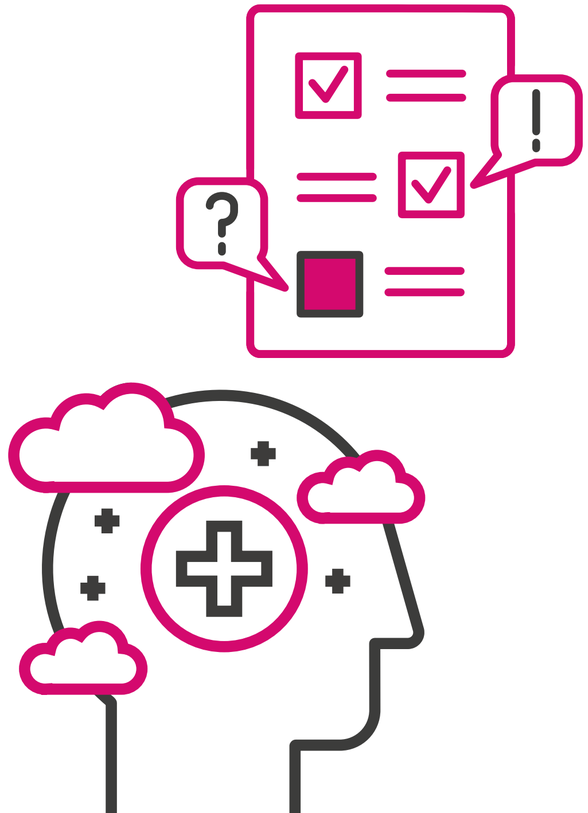
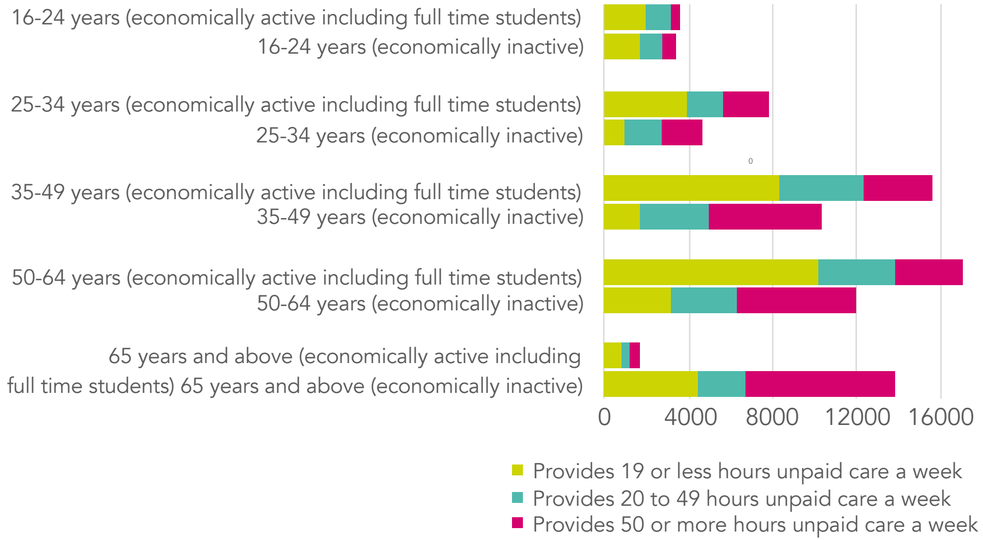


Figure 67: Provision of unpaid care by age group (excluding those who provide no unpaid care) (2021) [1]



Most common method (60%) of travel for journeys less than 5km was by car or van

Figure 68: Method used to travel to work (all distances) (2021)[1]

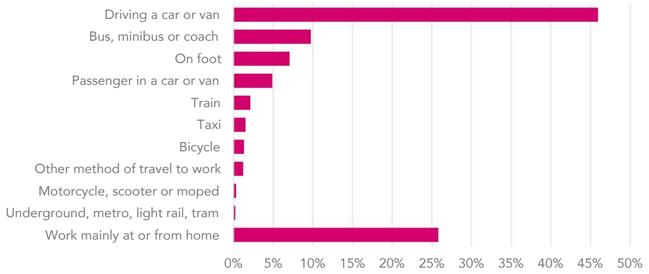
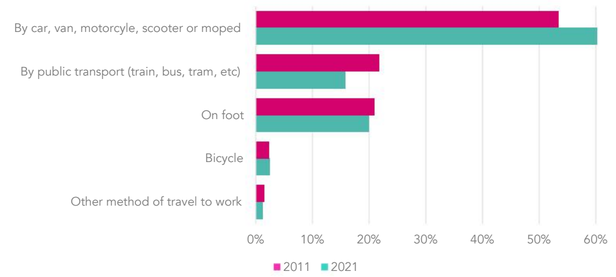
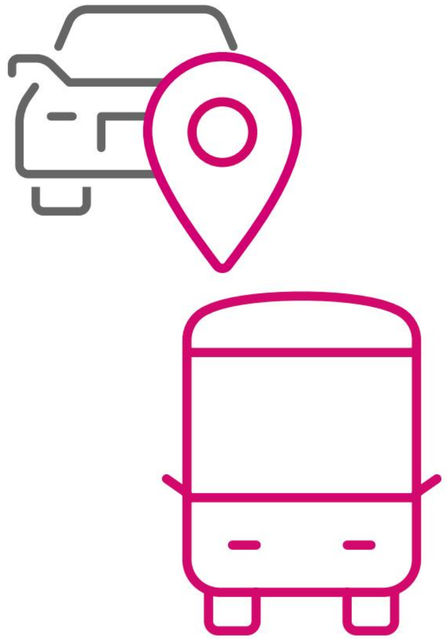


Figure 69: Method used to travel to work by those who travel less than 5km (2011 & 2021) [1]





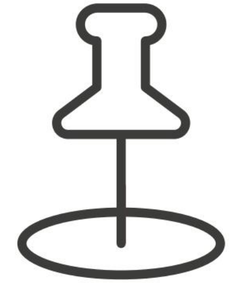
The COVID-19 pandemic resulted in a large shift in the place of work, with considerable increases in working from home which have continued post-pandemic restrictions.107 [1]In 2021, 25.8% of people reported working 'mainly at or from home'. The ONS acknowledge this and note that the shift to working from home may not fully reflect past-pandemic behaviours.108 UK government guidance at the time discouraged unnecessary the use of public transport.[108]

As in previous years, Figure 68 shows that the most common method of travel to work was 'driving a car or van'.[1] Furthermore, short journeys were also most commonly undertaken by car or van (Figure 69 shows the methods of travel to work for journeys less than 5km, as reported in 2011 and 2021). For 2021, journeys 'less than 5km' comprised 44.3% of all journeys to work.[1] There is an opportunity to target these journeys to encourage active travel to workplaces.

Active travel means making journeys in physically active ways, particularly walking and cycling.[109] There is strong evidence that physical activity benefits many aspects of physical and mental health and well-being.[110] Physical activity is associated with many improvements in health and wellbeing, including lower premature death rates, and lower risk of heart problems and depression. It benefits people of all ages, ranging from helping children maintain a healthy weight to reducing conditions such as hip fractures in frail older people.[111] Active travel can contribute positively towards mental health in comparison to commuting by car.111 Cycling to work reduces the relative risk of mortality by almost 40% by reducing the risk of cardiovascular disease, obesity and general health improvement, and results in lower absenteeism.[112,113]

During lockdown many people turned to active travel, especially walking and cycling for local exercise and shopping.[114] However now the rise of private motorised transport and at the same time a reduction in walking and cycling has reduced everyday opportunities for physically active lifestyles through travel.[114] Many people now spend long periods inactive at work, and only a large minority choose a significant amount of active recreation. This means physical activity has fallen for many of us in day-to-day life.[114] Equally, while 'passive commuting' (by train, bus, metro, car passenger) is less impactful on local air quality and congestion, there are still issues with longer commute times being associated with increased stress, higher blood pressure and BMI.[115]

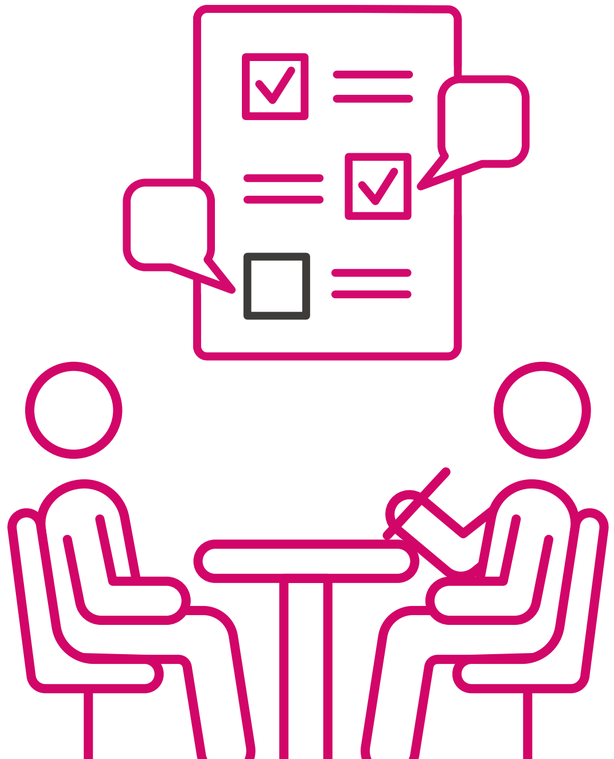
Therefore, the implication is that if cars and vans continue to be used as the primary method of traveling to work, the negative health impacts associated with them will continue. However, there is an opportunity with the change to conventional working patterns to boost active travel, particularly for short and necessary journeys to the workplace.



What might this look like in 2031?

A key concern for the future of employment in Birmingham will be if economic inactivity continues to increase, particularly from the impact of long-term sickness and disability . Interestingly, further analysis of labour force data for the West Midlands, found an increase in the number of people in the West Midlands citing long-term sickness between 2021 and 2022. This analysis also showed difference by employment type, with professionals aged 60-65 years much less likely to leave the labour market due to ill-health than those working in elementary or as operatives.[116] There are also differences in economic inactivity levels by ethnicity and gender. It is likely therefore that economic inactivity will continue to rise in the city. With an increasing number of older people in the city and increasing rates of long-term conditions such as diabetes[117], the proportion of economically active people who also provide unpaid care may also be expected to increase as their family members, become less independent.

The challenge of encouraging active travel for shorter distance journeys, such as to work, is likely to continue over the next 10 years. Active travel requires effective infrastructure as well as behaviour change. Whilst the pandemic supported some aspects of this, with fewer cars on the road and in many places social distancing measures which supported active travel e.g., temporarily wider pavements, the long-term infrastructure changes take time and remain limited so far.



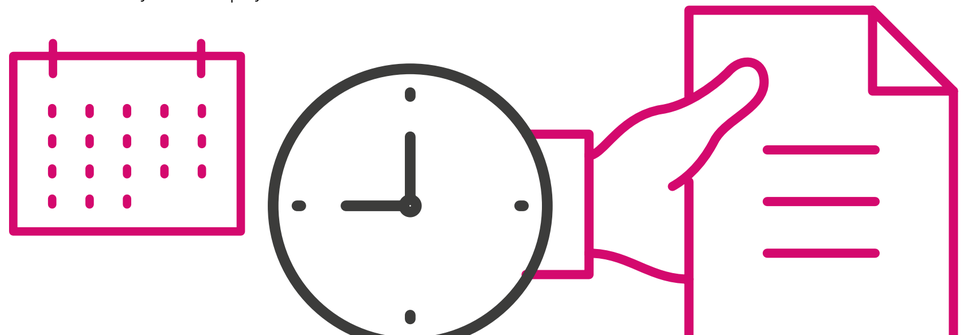
System Reflections

Paul Kitson (Strategic Director of Places, Prosperity and Sustainability, Birmingham City Council)
Birmingham has undergone and is continuing to undergo a huge physical and economic transformation. The city's economy, workforce and business base have all grown strongly in recent years as the city recovers from the pandemic. However, the city still suffers from persistently high levels of deprivation and too many of our residents have low or no qualifications and are not in work or in poorly paid employment. This results in more families living in low-income households, in poorer housing, with poorer health outcomes. These issues are concentrated in certain parts of the city and disproportionately impact some communities.

Resident employment rates in the city (66.9%) are well below the UK level (75.7%) and the second lowest out of the Core Cities. Increasing resident employment rates is key to improving living standards for our residents and tackling poverty and inequality. The changing demography of the city over the next decade will, however, make increasing resident employment rates and reducing economic inactivity and unemployment rates even more challenging.

Birmingham's population is set to grow strongly with an ageing population and faster population growth within more deprived communities. More residents will need to move into work to simply maintain the city's employment rate as the population grows. To really move the dial on the low employment rates in the city and to drive up household income and help tackle high levels of poverty and deprivation we must ensure that our future growth is more inclusive, and more residents, especially those from the most deprived areas and communities' benefit from the significant development and investment planned in the city over the coming decade.

The city has a number of key strategic documents that aim to shape the spatial and economic development of the city in the coming decades to ensure that levelling up and inclusive growth are at the heart of the city's ongoing transformation: Our Future City Plan, The Birmingham Plan, East Birmingham Inclusive Growth Strategy, and Birmingham Transport Plan 2031.



Raj Kandola (Director of External Affairs, Birmingham Chamber of Commerce)
The economic circumstances of the last few years have been uniquely challenging and precipitated long-term changes in the way that many of us live and work in the city-region. However, what hasn't changed is the clear relationship between access to meaningful employment and personal wellbeing.

The significant number of people out of employment due to long-term illness is something that we have picked up on at the GBCC and have lobbied the Government to introduce tax breaks to encourage firms to offer Occupational Health support that can help keep people in work. Occupational health services should be made a non-taxable benefit in kind.

In last year's Birmingham Economic Review, our annual publication written by the University of Birmingham City-REDI in partnership with the GBCC, we found that whilst the analysis of health conditions linked to economic inactivity are still unclear, there are two consistent causes: musculoskeletal health and mental health causes. Musculoskeletal health remains the most common health condition reported by those no longer working- in over 70% of cases it is listed as a cause.

With all of this in mind, the Chambers are proud to work with partners across the city region, including Birmingham City Council, as well as national government, to try and ensure that local residents who want to access local employment opportunities are supported and enabled to do so.

DISCUSSION AND IMPLICATIONS

This report has explored how demographic change in Birmingham may impact population health and wellbeing now and in the future. It serves as an evidence base for understanding our population and how it is changing. Several key changes in the city's population have occurred in the past ten years, including its size, structure, and characteristics. Evidence suggests that demographic changes impact health and wellbeing in a number of ways. Various sources, including census data and the perspective of Birmingham citizens have been used to inform the report. This section outlines the key findings and implications.

Supporting people in getting the best start in life and ageing well

Whilst Birmingham remains a young city, the number of adults and older people has increased. The average age has increased, and the number of people approaching retirement has grown more than any other age group in the city. Older adults reported better health in 2021 than in 2011, but this is not seen across the city, and there are levels of inequality in people's health based on where they live and the levels of deprivation they experience. Fewer babies are being born, and the number of children in their early years (aged 0-4) has decreased. Despite Birmingham's birth rate declining, the population grew overall.

We know that health is closely correlated with age, emphasising the importance of understanding this demographic trend. With changes in birth rates and the number of young people, there is increased uncertainty about planning for the levels of needs for education and children-related services in the future. This impact will also differ across the city, so targeted approaches may be required. The population's health and care needs will also increase with increased numbers of older adults. The prevalence of long-term conditions and disabilities increase with age, as does demand for care.

From pre-conception to older people, there are critical moments and life stages where action can make a big difference to health and wellbeing. Whilst ageing itself is inevitable, ageing in ill health is not. Prevention and early intervention are essential to ensure people in Birmingham can live long, happy and healthy lives. For older people, a life course approach includes primary interventions such as being in work, living in good housing, and living in a built environment that meets their needs. It also includes delaying or preventing the onset of dementia, preventing falls, loneliness, and isolation. Acting in a more preventative way will also result in less demand for health and care services in the future.

Embracing Birmingham's super-diversity whilst tackling health inequalities

Birmingham's ethnic super-diversity was made official in Census 2021, which has important implications for the health and wellbeing of our city. Greater knowledge of the ethnic identity of Birmingham's population will support our understanding of different needs and collaborative action to address avoidable health inequalities faced by different communities. There is strong evidence that, generally, ethnic minority groups tend to experience higher rates of conditions such as diabetes, obesity, asthma, heart disease, and cancer. The COVID-19 pandemic also had a disproportionate impact. Many factors can lead to inequalities, discussed in this report, such as housing, employment, and genetic factors. Genetic

conditions like sickle cell disease have an increased prevalence in African and Caribbean populations. The risk of developing type 2 diabetes is higher in South Asian groups.

Local and national evidence shows there are differences within broad ethnic groups. By grouping 'ethnic minority communities' and even by the broad classification (e.g. Asian/Asian British), we may not address health inequalities, and in some cases, we may exacerbate them. Therefore, there is a need for nuanced policy approaches and interventions that consider differences beyond the broad-groups, down to more specific groups. This report provides further evidence for the importance of working with communities in Birmingham through approaches such as the Community Health Profiles, Cultural Intelligence Framework, Cultural Humility & Safety Framework and the demographic component of the Birmingham Measurement Toolbox which aims to collect ethnicity data in a way that reflects the views and culture of the city.

Fostering acceptance and supporting inclusion: LGBTQ+ communities and health

For the first time in the 2021 Census, voluntary questions were asked on sexual orientation and gender identity for respondents aged 16 years and over. It was an opportunity to develop a rich understanding of sexual orientation and gender identity. A high proportion of those who identified with an LGB+ orientation were aged between 16-24 years old. Birmingham has a higher proportion of people who identify with a different identity to their sex registered at birth than the national average. Because this was a voluntary question, we can also observe the non-response rate, which differed by age group and ethnicity. This detail on our city's identity and how it intersects with other characteristics, such as age, ethnicity and disability, help us further understand the population's needs.

The LGBTQ+ population is more likely to be affected by inequalities relating to mental health and wellbeing, substance misuse, and smoking rates. They are also more likely to experience direct and indirect discrimination when accessing health-related services and in wider society. Those who identify as 'trans+' and seek to medically transition can face additional barriers as there are no Gender Dysphoria Clinics in the West Midlands and long waiting lists for referrals and treatment.

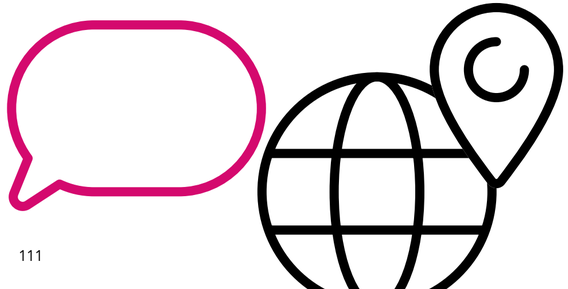
Therefore, local health and care services should be inclusive and address the specific needs of LGBTQ+ communities. We must also build on our understanding to improve data collection locally to measure and monitor our impact. Despite the progress, there is still further work to do to increase understanding and awareness about how different LGBTQ+ identities and experiences can contribute to health inequalities. Opportunities to learn and share good practice, such as the LGBTQ+ Pride History Month Conference, remain important.

Understanding international immigration and its impact on population health

Migration is broadly defined as a change in a person's usual residence, and it is an important contributory factor to population and social change. This report focused on international immigration and people who live in Birmingham but were not born in the UK. Birmingham has a history of immigration, and has been an important destination for migrants seeking to settle and find work. Migrants who now live in Birmingham but were not born in the UK often moved to this country at a young age (the majority were under 30). Migrants are often younger and healthier compared to people in their host country. Evidence has also shown that after a period of time in the UK (15 years), non-UK-born and UK-born populations report similar health outcomes across all age groups.

This has important implications for the needs of this group, which differ significantly depending on their experiences and journeys to Birmingham. Those who migrated for employment, family, and study reasons have better health than UK-born people. This is often referred to as the healthy migrant effect. Those who migrate are more likely to be younger and less reliant on services such as the NHS.
This contrasts with those seeking asylum, who tend to have worse health outcomes. Migrants often experience barriers in accessing health and social services, especially if they are undocumented. Migrants may also experience discrimination and are therefore vulnerable to physical and mental illness.

The diverse needs of migrants mean local services must adapt and consider factors such as age, country of origin, and reason for migration. Migrants can face language barriers, which should be understood and removed. People arriving in the city often desire education and information about provisions and norms in the UK. There are opportunities to implement a health literacy approach to support different communities settling in Birmingham. Similarly to supporting communities of identity, professionals working across the system must be equipped to serve communities of experience, such as migrant populations. Any work to support cultural competency should include the diversity of migrant needs.



Understanding household trends and intersectionality

Housing is a key determinant of health across the life course. The census provides an opportunity to explore different characteristics of households in Birmingham. By combining census data, we have also explored the intersection of communities of identity and household characteristics. The trends in housing composition, occupancy and tenure are important for us to understand the needs of Birmingham's population.

Whilst most people live in a household with others, one third of households in Birmingham consist of one person, and this is more common amongst older adults. This has important implications for understanding the risk of loneliness and social isolation. Living alone can be associated with unfavourable health outcomes such as anxiety, depression, and physical health conditions. Given that this trend is likely to continue, tailored interventions should be considered for older adults to reduce the risk of isolation and support independence.

Some households are also experiencing over-occupation or overcrowding. This is more common among ethnic communities, including those who identify as Asian or Asian British, Black or Black British, and from an Other ethnic group. It is also concentrated in specific areas of Birmingham and experienced by young people. Overcrowding can have negative effects on both physical and mental health and wellbeing. It is associated with the risk of infectious diseases, for example, during the COVID-19 pandemic.

There have been significant changes in housing tenure and a significant increase in private rented accommodation since 2011. Given that this is likely to continue, this has important implications as it has been shown to lead to greater insecurity and poorer levels of mental health. Owning a house can improve health, providing a sense of emotional security.

Facilitating good employment and economic activity

Income and employment are key determinants of health and drivers of health inequalities. The greater one's income, the less likelihood of disease and premature death and being in "good work" improves health and wellbeing across the life course and protects against social exclusion. The census is useful for understanding employment and economic activity in Birmingham and the associated self-reported health of those working and not working.

There has been an increase in economic inactivity, particularly among older working age, and older age groups, although this might reflect the timing of the Census 2021 with respect to COVID-19 pandemic. Forty-two thousand people who are classed as working age are economically inactive due to long-term sickness or disability. This is most prevalent in pre-retirement ages. In the past decade, Birmingham saw England's joint largest percentage point rise in the proportion of people who were economically inactive because they were looking after their family or home. However, 50,000 people are economically active and providing unpaid care. The COVID-19 pandemic changed our work patterns, causing a rise in remote work. Where people were travelling to work, most were still driving in 2021. Active travel for short journeys can have positive health effects, at individual and population level, and should be encouraged. w

Employers in the city should encourage a work-life balance that supports individuals balancing work, their role as unpaid carers and active travel. Some individuals may benefit from resources and support to manage a long-term health condition, for example through flexible working arrangements.

Glossary

Asexual – A person who does not experience sexual attraction. Some asexual people experience romantic attraction, while others do not.

Behavioural Interventions – Coordinated set of activities designed to change specified behaviour patterns.

Bisexual – This term is used when an individual is physically, romantically and/or emotionally attracted to more than one gender. This can mean being attracted to two genders (e.g., men and women) but bisexual attraction is not limited to two genders.

BLACHIR – Birmingham & Lewisham African & Caribbean Health Inequalities Review.

Built Environment – The parts of the places in which we live that have been built by people, for example buildings and streets, rather than the parts that exist in nature.

CVD – Cardiovascular disease.

Cohort effect – A cohort is a group of people who share a common set of demographic characteristics or experiences, including but not limited to age.

Demography – The study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

Deprivation – The damaging lack of material benefits considered to be basic necessities in a society.

Economically Active – A person who is in employment or who is unemployed and were looking for a job and could start in two weeks.

Economically Inactive – A person who does not have a job and had not looked for work for at least a month before the census or could not start work within two weeks.

Ethnic – A group of people who share a similar culture (beliefs, values, and behaviours), language, religion, ancestry, or other characteristic that is often handed down from one generation to the next. They may come from the same country or live together in the same area.

Gay – This term is used to describe people whose physical, romantic and/or emotional attractions are to people of the same gender (e.g. a gay man is attracted to men / a gay woman is attracted to women).

Gender Dysphoria – A sense of unease that a person may have because of a mismatch between their biological sex and gender identity.

Gender Identity – A person's innate sense of their own gender, whether male, female or something else, which may or may not correspond to the sex assigned at birth.

Health Literacy – The degree to which individuals have the ability to find, understand and use the information and services to inform health-related decisions and actions for themselves.

Heterogeneity – the state of being diverse in character or content.

Heterosexual – Refers to a man who has a romantic and/or sexual orientation towards women or to a woman who has a romantic and/or sexual orientation towards men.

Internal Migration – The movement of people within their own country.

International Migration – The movement of people from one country to another.

Intersectionality – The idea that identities are influenced and shaped by race, class, ethnicity, sexuality/sexual orientation, gender/gender identity, physical disability, national origin, etc., as well as by the interconnection of all of those characteristics.

LGBTQ+ – Lesbian, Gay, Bisexual, Transgender, Queer, and all other non-heterosexual sexual orientations and non-cisgender gender identities.

Lesbian – This term is used to describe a woman whose physical, romantic and/or emotional attraction is to other women.
Some lesbians also refer to themselves as gay.

MSM – Men who have sex with men.

Morbidity – Another term for illness or disease.

Mortality – Another term for death.

Multimorbidity – Two or more long-term health conditions

Multiplicative effect – Increasing an effect by multiplying.

NHS – National Health Service.

NICE – National Institute for Health & Care Excellence.

Non-Binary – An umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely.

ONS – Office for National Statistics.

Pansexual – A sexual orientation that describes a person who is emotionally and sexually attracted to people of all gender identities.

Queer – An umbrella term used by some to describe people who think of their sexual orientation or gender identity as outside of societal norms.

RMC – Refugee & Migrant Centre.

Sexual Orientation – How a person characterizes their emotional and sexual attraction to others.

STI – Sexual Transmitted Infection.

Social Cohesion – The extent to which people in society are bound together and integrated and share.

Socio-economic factors – Social and economic experiences that help shape personality, attitudes and lifestyle.

Suicidal ideation – Or suicidal thoughts, is the thought process of having ideas, or ruminations about the possibility of committing suicide.

Superdiversity – A population where no single ethnic group makes up a majority (50% or more).

Trans Man – This term is used to describe someone who is assigned female at birth but identifies and lives as a man. This may be shortened to trans man, or FTM, an abbreviation for female-to-male.

Trans Woman – This term is used to describe someone who is assigned male at birth but identifies and lives as a woman. This may be shortened to trans woman, or MTF, an abbreviation for male-to-female.

TRF – Totally Fertility Rate.

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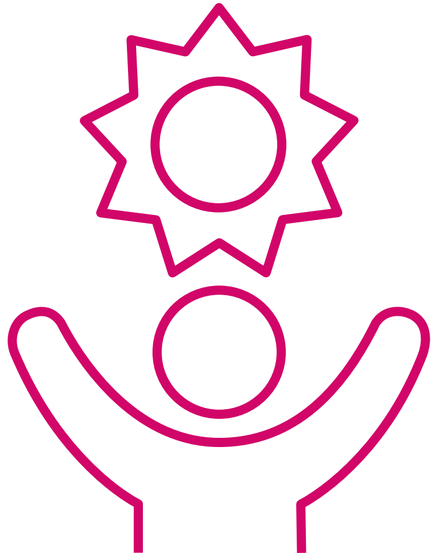

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