Changes in self-reported health over a decade

Midlands Analyst Network

2 April 2026

Today’s presentation

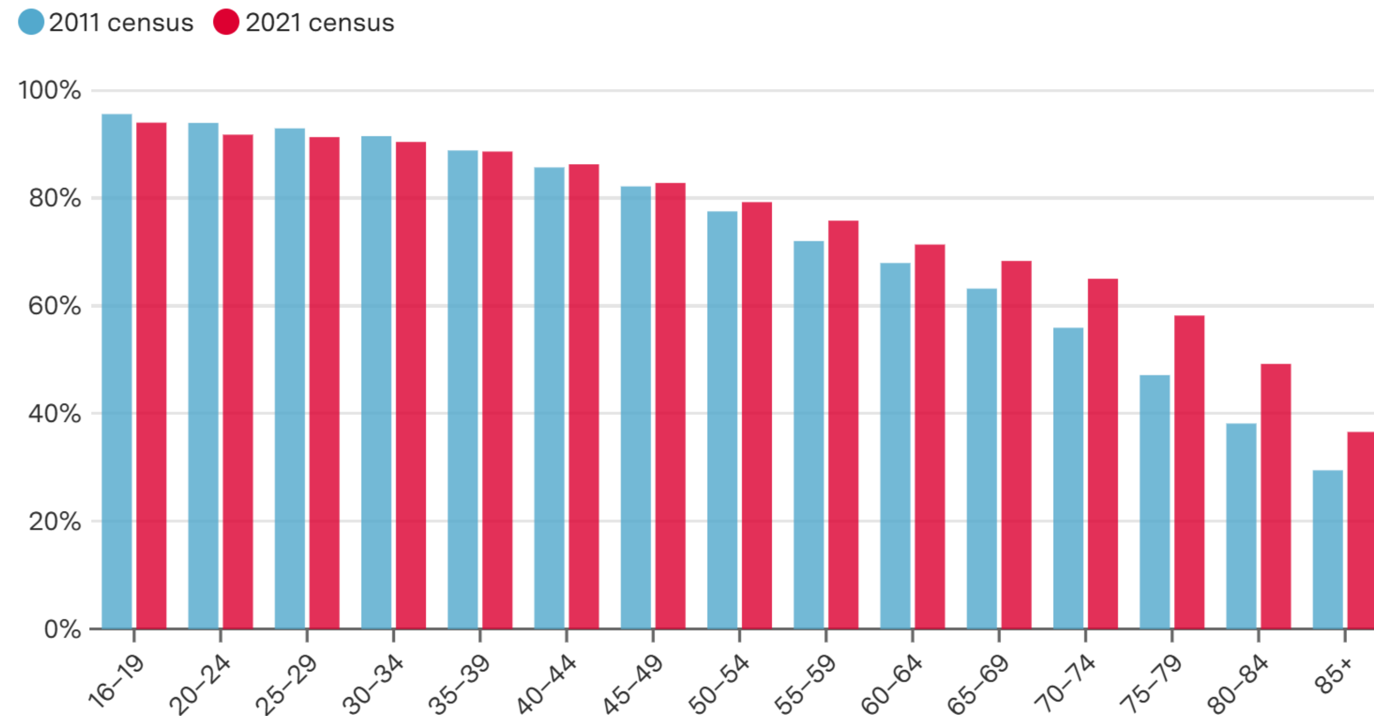
- Freya Tracey (The Health Foundation)
  - Background to changes in self-reported health between 2011 and 2021
  - Findings, focused on working-age population
  - How this relates to the wider public health conversation
- Rhian Davey (Office for National Statistics)
  - Analytical methods used in this research
- Happy to take clarifying questions throughout, with plenty of time for discussion at the end!

1 Background

Self-reported health

- Self-reported health is an important measure of the public's health.
- It is a subjective measure based on individuals evaluating their own health status, rather than based on diagnoses.
- Self-reported health is used to calculate healthy life expectancy, alongside life expectancy.
- The census gives us a unique chance to see how everyone in England views their health.

How did self-reported health change from 2011 to 2021?



Aims for this analysis

- The Health Foundation commissioned analysis from the Office for National Statistics.
- The aim was to look at how changes in self-reported health from 2011 to 2021 were associated with demographic and socioeconomic factors reported in 2011.

2 Methods

Approach

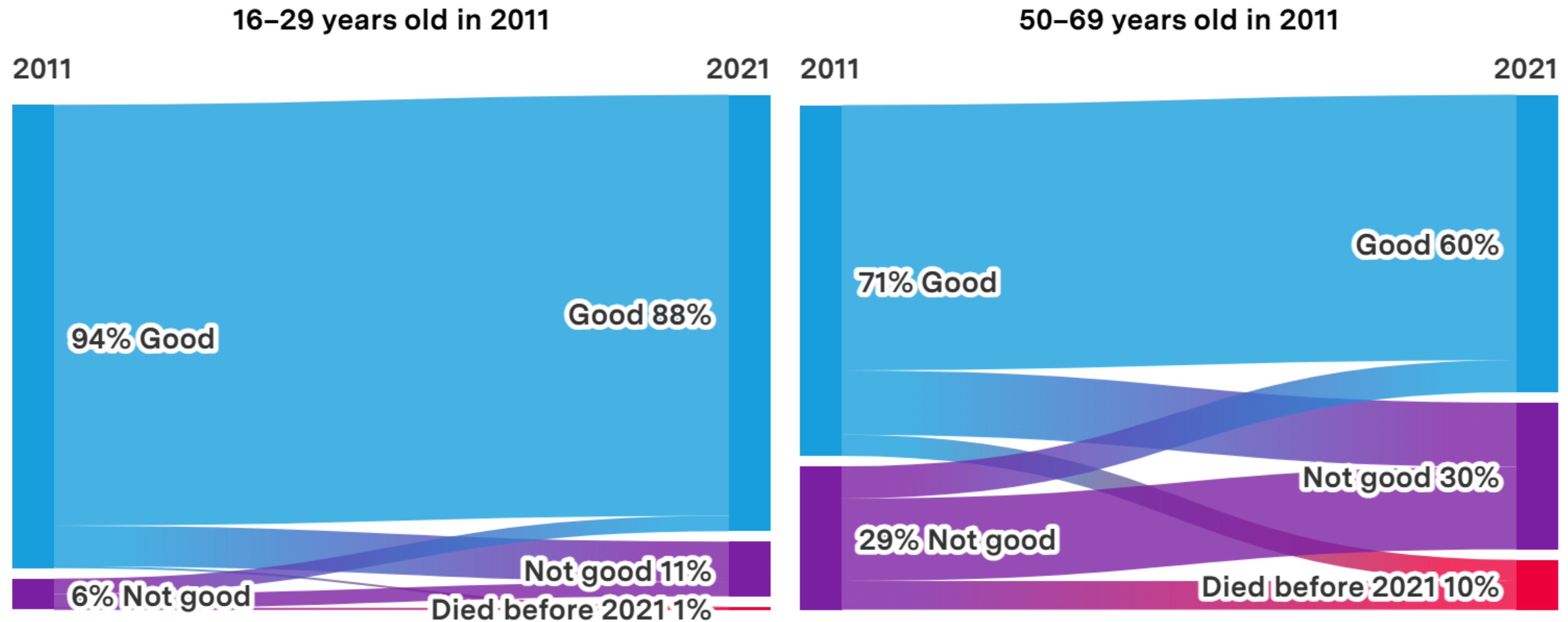
- Census 2011, Census 2021 and death records were linked to create a study population to understand how people's self-reported health changed between 2011 and 2021.
- The analysis includes people living in England who were usual residents, aged 16 to 90 years in 2011 and completed both the 2011 and 2021 censuses, or completed the 2011 census and died before Census 2021.
- Statistical models were built to calculate odds ratios and adjusted for differences in demographic and socio-economic characteristics at baseline (Census 2011).
- The outcome of interest was health in 2021: good, not good or died before Census 2021. Results were calculated separately for those in good or not good health in 2011.
- Reference groups were selected either as the most frequent category or to provide a clear baseline for comparison.

Limitations

- The data and analysis do not support causal inference because we have used cross-sectional observations and cannot infer that 2011 sociodemographic factors **caused** the change in health over 10 years.
- The analysis does not account for health behaviours, healthcare access or underlying disease. These factors affect someone's health and how they perceive it however the data were not available.
- People who migrated out of England between 2011 and 2021 or migrated into England after 2011 – and form part of the England population –were excluded because they did not have data across both time points. Additionally, some groups are more likely to be underrepresented in the censuses, such as those experienced homelessness. These groups may see different changes in self-reported health to the wider population.
- The pandemic may have affected how people perceived their health. However, comparison of self-reported health data with reporting of disability show that completion in 2011 and 2021 were similar.

3 How different factors affect the transition to poorer health

Age



Source: ONS • These results do not account for demographic or socioeconomic differences.

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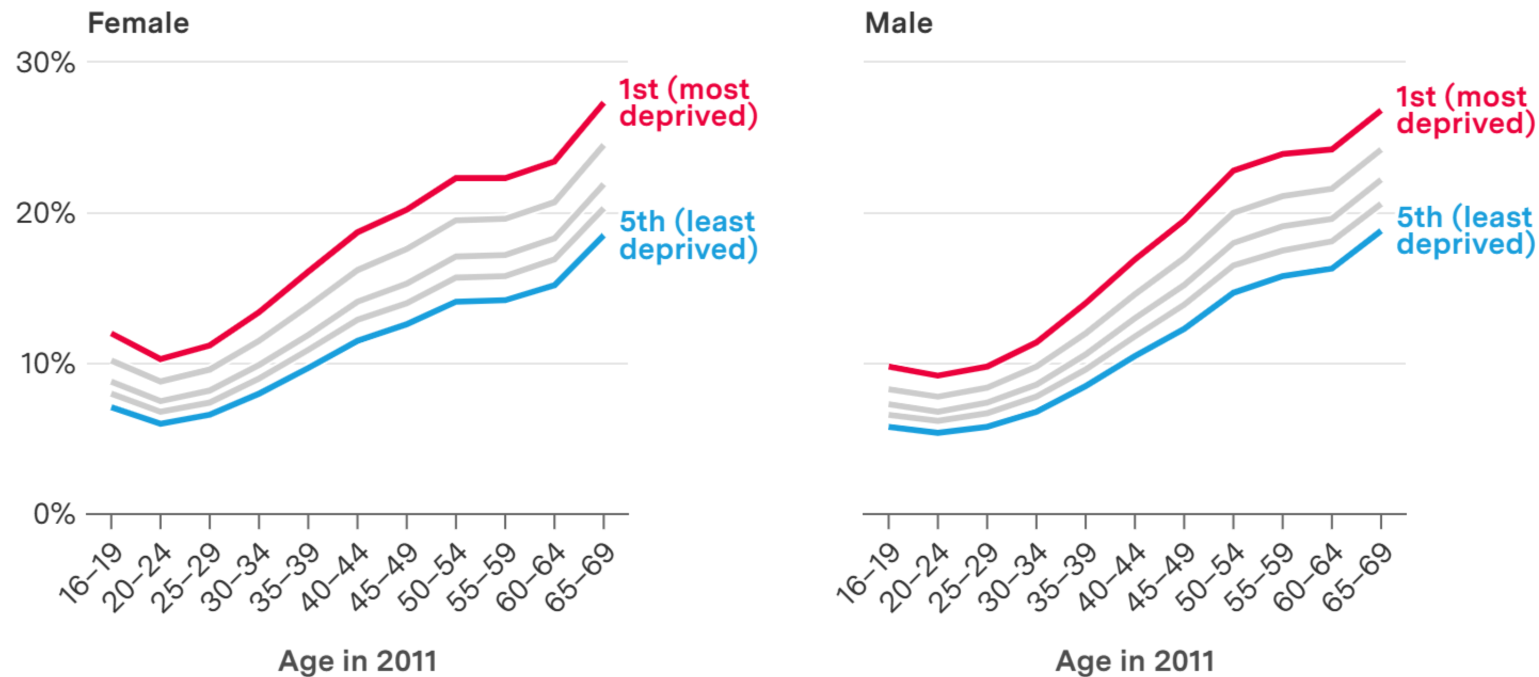
Deprivation



Source: ONS • Accounting for differences in age, sex, ethnicity, household circumstances and employment. 'Not good' health refers to fair or bad health.

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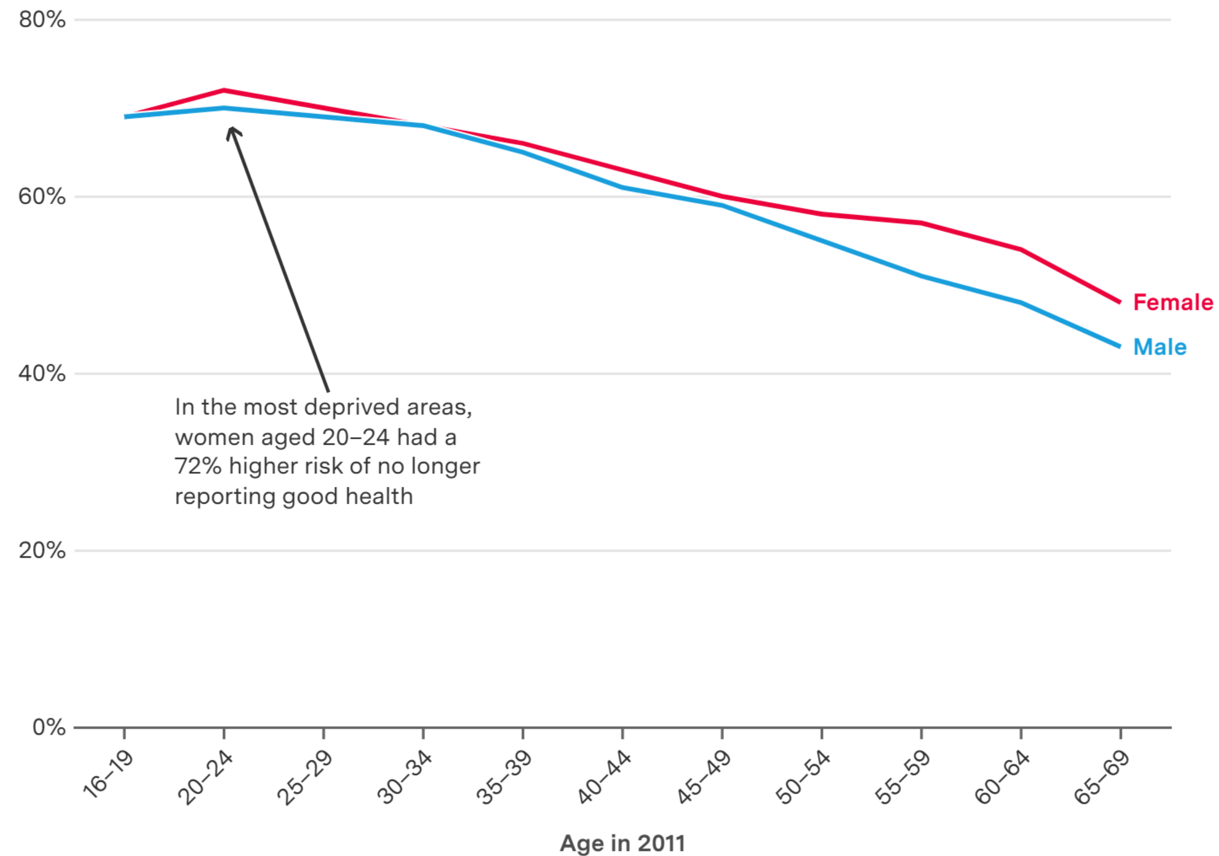
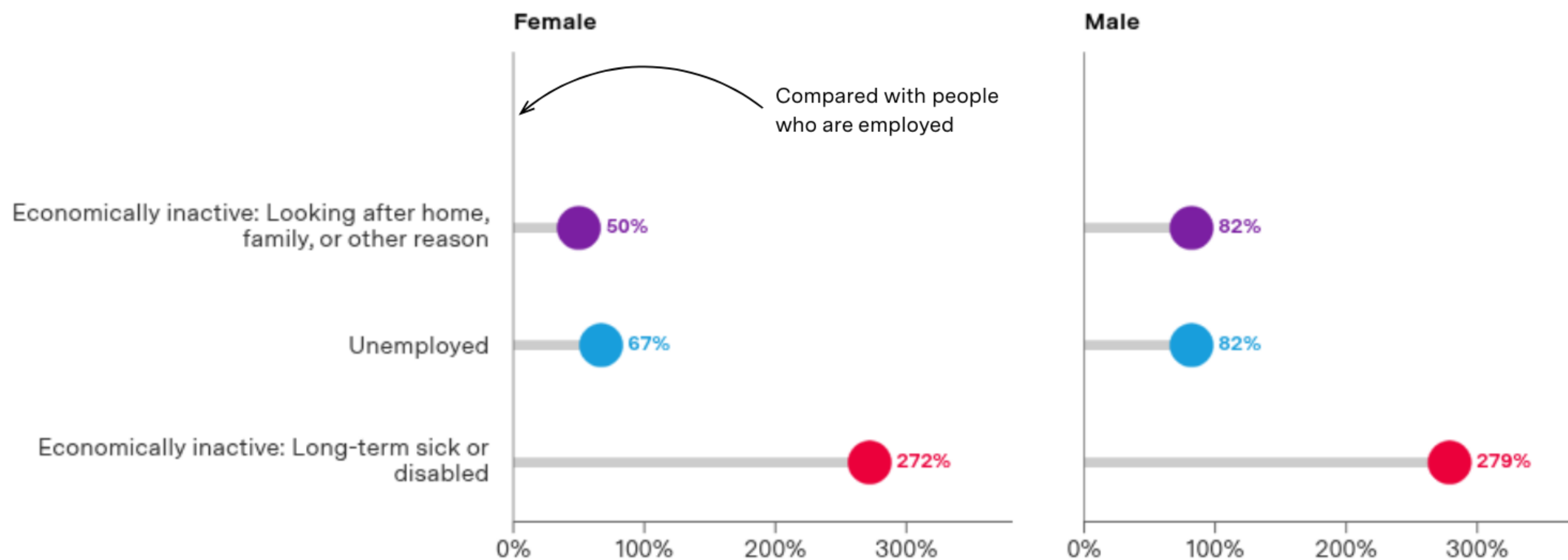
Deprivation



Economic activity



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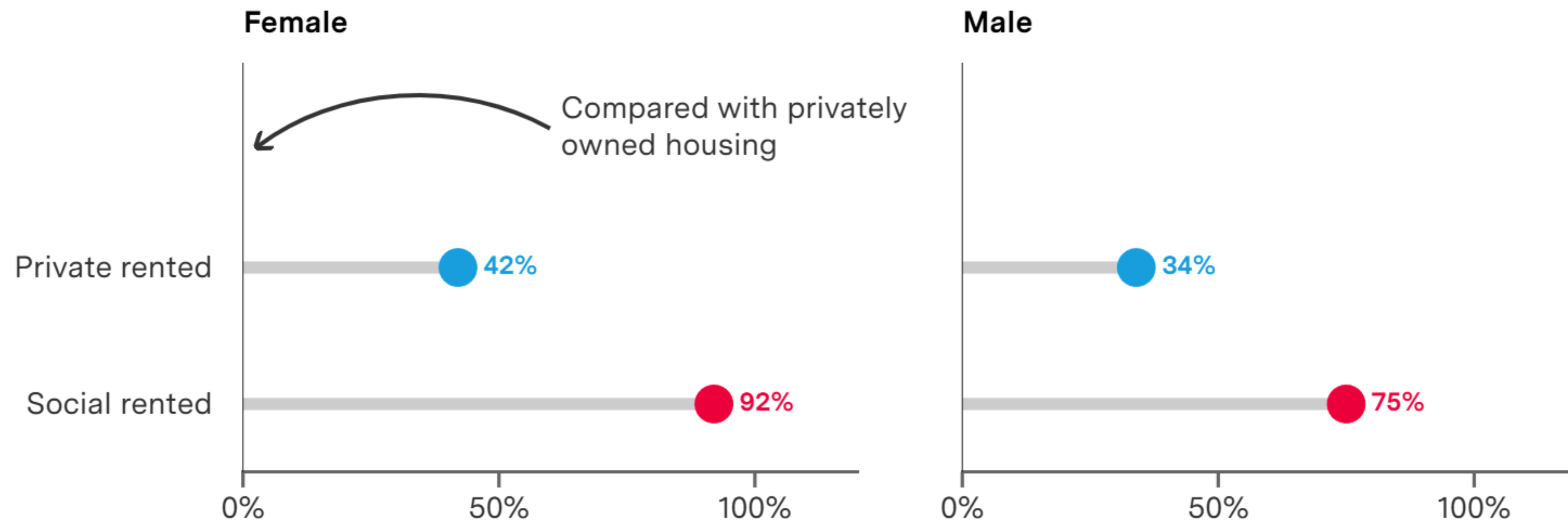
Housing tenure



Source: ONS • Accounting for differences in age, sex, ethnicity, region, area-level deprivation, highest qualification and employment type.

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4 How do these findings link to wider policy landscape?

Preventative approach to unemployment

- Health inequalities among those not in work are often assumed to reflect people's state of health having already worsened.
- Our research shows that people who were out of work and in good health in 2011 had a substantially higher likelihood of no longer reporting good health a decade later, compared with those in employment.
- Future growth in health-related economic inactivity could be three times greater than growth in the working age population due to an ageing population and increasing multimorbidity (Mayfield Review)
- This reinforces the need to keep people in work, where possible, through preventative measures, including more proactive sickness absence management and the introduction of vocational rehabilitation.
- This can have positive impacts on both people's health and the economy.

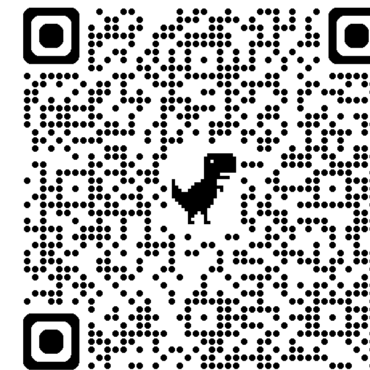
Housing

- Insecurity of tenure in the private-rented sector and higher risks of overcrowding in both social and private-rented housing may contribute to the higher likelihood observed.
- Renters Rights Act 2025 takes important steps to improve the security of private-rented housing
- Improving housing affordability through the ambitious housebuilding programme will take longer to take effect

Healthy life expectancy

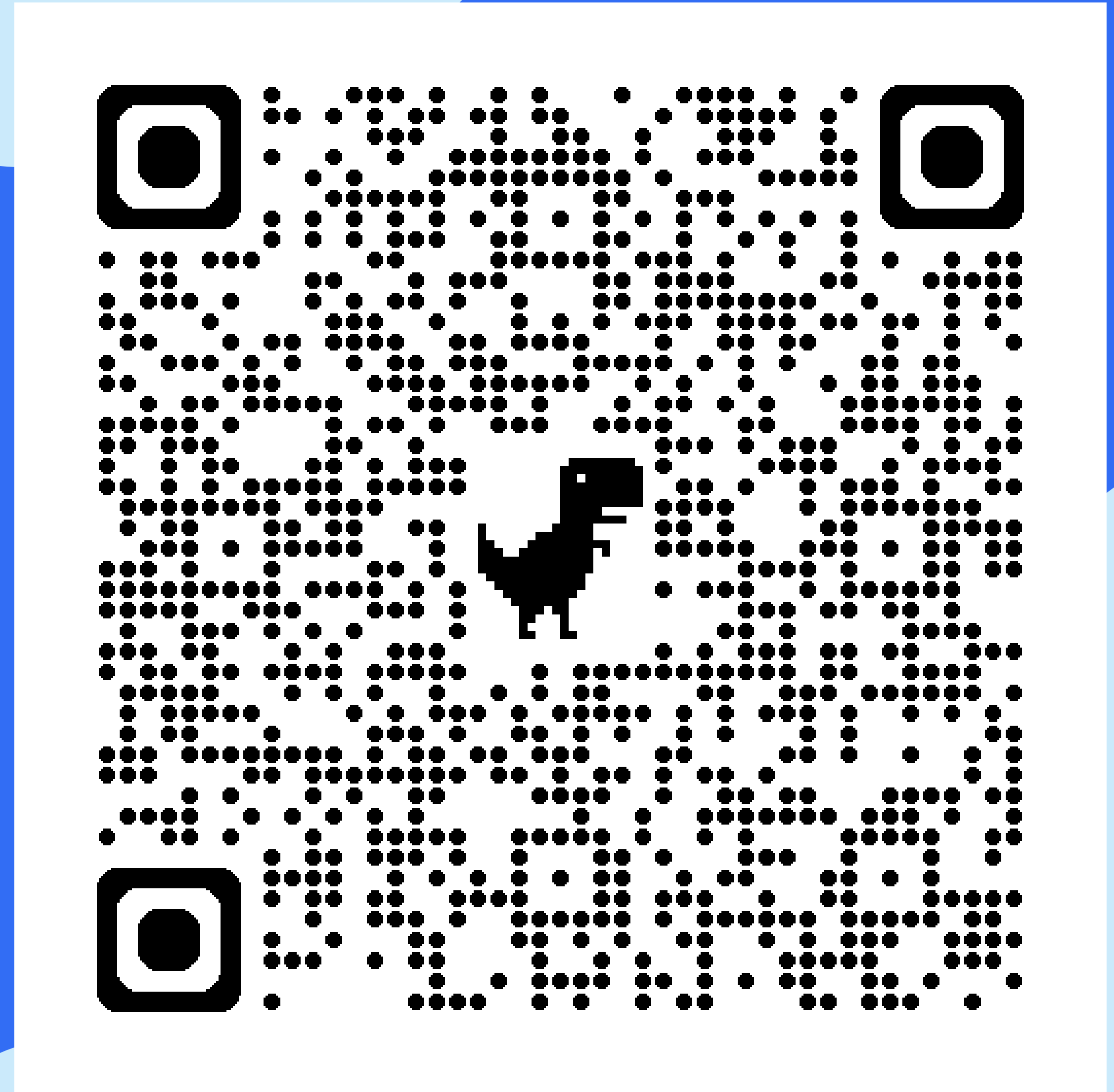
- Andrew Mooney's recent blog 'What would it take to halve the gap in healthy life expectancy?' highlighted the significant contribution self-reported health makes to HLE:
    - For females, 79% of the gap between HLE in North East (lowest region) and South East (highest region) is explained by self-reported health. Slightly lower at 74% for males.
    - Improving self-reported health will have the biggest effect on narrowing regional gaps.
- Our work has shown that no longer reporting good health is associated with unemployment, rented housing and living in the most deprived areas. Action across these building blocks of health will be needed to help people remain in good health, in turn promoting healthy life expectancy.

Read Andrew's blog here:



Thoughts? Questions?

Access the briefing here:



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