Generational continuity and change in British Asian health and health behaviour

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Abstract

Objectives—To trace patterns of health and health behaviour in those with ancestry in the Indian subcontinent (British Asians) compared with the general population of their age (1) in the younger generation age 14–15 mainly born in the UK and (2) in the older mainly migrant generation.

Design—Cross sectional random sample surveys of two age groups in Glasgow.

Samples—334 British Asians (86% born in the UK) and 490 non-Asians, all aged 14–15; 173 British Asians aged 30–40 (mean age 35, 93% born abroad), and 344 general population aged 35.

Measures—Health: self assessed health/fitness, longstanding/limiting illness, chronic phlegm, accidents, symptoms, tooth loss. Health behaviour: smoking, alcohol, drugs, exercise.

Results—At age 14–15, compared with non-Asian counterparts: fewer British Asian girls reported limiting illness ($p<0.05$) or chronic phlegm ($p<0.01$), fewer boys reported accidents ($p<0.01$), and fewer of both sexes had lost second teeth ($p<0.05$); more of both sexes reported not smoking, drinking alcohol, or using drugs ($p<0.01$ or below), fewer reported frequent exercise ($p<0.05$ or below). Smoking patterns were consistently related to ethnic differences in chronic phlegm, and patterns of alcohol consumption to those in accidents. In health, British Asian girls aged 14–15 generally compared more favourably with non-Asian counterparts than did those aged 30–40. The reverse was true for British Asian male subjects. In health behaviour, British Asians of both sexes aged 14–15 showed strong continuities with those aged 30–40.

Conclusions—Favourable health behaviour has brought a health advantage to young British born Asians, even though this was not the case in the migrant generation. Female health disadvantage is also much less marked than in migrants aged 30–40, but may re-emerge between ages 15–30. Migrant Asian male subjects may have had misleadingly high respiratory health levels because of positive selection.

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health. Even allowing for variations within heterogeneous British Asian communities, the general picture is favourable whether in regard to smoking, drinking or diet,^{1,2} and only exercise levels seem to be unfavourable.^{1,3} However, the health of these communities does not seem to have benefited as much as it should from their generally exemplary behaviour. Low levels of lung cancer are not matched by low levels of heart disease, and respiratory health too does not seem to show the advantages that might be expected from such low smoking levels, particularly among women. It is true that while migrant women of South Asian descent show a number of health disadvantages, migrant men show a number of advantages in relation to the majority of population, and this is evident both in studies of mortality,^{4,5} and morbidity.⁶ The male advantage, however, tends to be put down to positive selection for health at the time of migration, though this has been assumed rather than tested.

It would be tempting, in this situation, for the younger generation of British Asians to conclude that good behaviour does not pay; and certainly the health record does not provide much counterweight to the powerful pressures drawing them towards conformity with the norms of their peers in the majority population. Although earlier studies have shown health behaviour in young British Asians that continues to differ from the patterns of the majority population in broadly similar ways to that of their parents,⁷ it has not been possible without more accurate comparisons to assess how far these differences are eroding. Meanwhile little is known of the general health of young British Asians, or, consequently, of whether their health is as unrelated to their health behaviour as it is in the migrant generation.

An opportunity to explore these issues is provided by a school-based study of 14–15 year olds from the British Asian and general populations, nearly all born in the UK, which asked similar questions on health and health behaviour to a community survey of migrant South Asians and the general population aged 30–40, both studies taking place in the same city. This report considers the following questions:

(1) What pattern of health advantages and disadvantages do young British Asians show compared with the majority population?

(2) What patterns of health behaviour do they show compared with the majority population, at the age when addictive behaviours tend to be tried out?

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The health behaviour of British Asians (those with ancestry in the Indian subcontinent) is generally thought to be advantageous for

(3) How far is their health related to their health behaviour, and how far does this account for any ethnic differences in health?

(4) How far do these patterns of health and health behaviour among largely British born Asians aged 14–15 differ from those of the largely migrant generation aged 30–40?

This last question yields only provisional information at this stage. It is important to know whether the pattern at age 14–15 is the same as at age 30–40 or not, but if there are differences, we cannot yet determine whether these are age or cohort differences until the British born generation reaches age 30–40 in sufficient numbers.

Methods

In the Glasgow District of Strathclyde Region's Education Department in the West of Scotland, 11 secondary schools included 94.3% of all Muslim, Sikh, and Hindu pupils recorded by the Education Department in 1991. A total of 824 respondents were drawn from nine of these schools, the two remaining schools having been used for piloting.⁸ A total sample was sought of pupils with South Asian names in Scottish Secondary 3 and 4 (S3 and S4, catering for pupils 14–15 years old on 1 March), yielding an achieved sample of 334. Non-Asian pupils in the same school year groups, 98% of British descent, were randomly sampled proportionally to their numbers in each school, or, where the school preferred not to take pupils out of classes, by taking random classes, yielding an achieved sample of 490. The overall response rate was 71%.

Taking random classes yielded numbers in excess of the target sampling proportion for non-Asians, and statistical reweighting was used to correct this after data collection. When reweighting, variations in response by school and ethnicity were also corrected. School totals by ethnic group were weighted by the ratio of target to achieved totals, and the greater sampling error implied was calculated and allowed for by a further reduction in the effective sampling total,⁹ resulting in a reweighted sample total of 677. In addition, the reweighted sample used here excludes a small number of pupils who were over age for their age set, resulting in a current reweighted total of 651. The non-Asian sample compared closely in social class distribution with a large random sample of 15 year olds in Clydeside in 1987.¹⁰ Of the British Asian sample, 86% were born in the UK.

As this was a survey concerned with a wide range of health and health behaviours, power calculations to determine the sample size were based on earlier health and health behaviour comparisons between British Asians and the general population in Glasgow.^{6,7} Effect sizes were stipulated to be the same as those reported in the earlier studies, and we aimed to detect these at the 5% level of significance with 80–90% confidence for continuous variables, and with 75% confidence for categorical variables. Fuller details of the sample are available elsewhere.⁸

For comparison, a largely first generation British Asian random sample aged 30–40 years ($n=173$, mean age 35), and a general population counterpart aged 35 ($n=344$) deriving from the West of Scotland Twenty-07 Study, are also available from Glasgow. These samples have been fully described elsewhere.⁶ Of the British Asian sample of this age, only 7% were born in the UK, and 86% spoke Punjabi, thus indicating the main originating source of both samples in the East and West Punjab.

For the 14–15 year olds, a self completion questionnaire was filled in under the supervision of the second author. Pupils were assured of complete confidentiality, and collection of scripts was carried out solely by the research team. General questions were asked on self assessed health and fitness, on longstanding and limiting longstanding illness (as in the British General Household Survey),¹¹ on accidents and injuries requiring medical attention in the last three years, and on loss of second teeth. Questions from the MRC Chronic Bronchitis Questionnaire¹² on production of phlegm, which have been considered crucial indicators of respiratory health,¹³ were also included. A list of symptoms experienced in the last month was added, derived from the Health and Lifestyle Study,¹⁴ and adapted for use in the West of Scotland Twenty-07 Study, with the inclusion of symptoms indicative of a psychosomatic dimension of distress.⁶ Questions on smoking, drinking alcohol, and taking exercise followed standard formats, which are apparent from the tables. On drugs, pupils were asked whether they had tried soft drugs like cannabis or hard drugs like heroin.

The 30–40 year olds were asked a wide range of questions in pretranslated interviews that have been described elsewhere.⁶ Questions used here were identical to those for 14–15 year olds, except those on accidents (which covered the period since age 15), exercise (which specified getting out of breath or sweating), and health in the last 12 months and trial of drugs (omitted).

Analysis was by SPSS. In tables 1 and 2, Kendall's τ was used to measure the association of ordinal and dichotomous health variables with ethnicity, taking each sex separately. For brevity, a single dichotomised percentage is presented for each variable in table 1. In tables 3 and 4 logit modelling (equivalent to logistic regression when there is no continuous covariate) is used in multivariate analyses to examine how far ethnic differences in health can be redescribed in terms of an association between health behaviour and health. When health is predicted by health behaviour in cross sectional analyses the direction of causation is open to question; interpretations are explored in the discussion. In table 5, crude odds ratios (British Asians compared with non-Asians) are presented for each sex separately in each age-based sample.

Results

Table 1 shows ethnic differences in self reported health among 14–15 year olds, by sex. No differences occur in self assessed health,

Table 1 Glasgow 14–15 year olds 1992: ethnic differences in self reported health

Self reported health	Men		Women	
	British Asian	Other origin	British Asian	Other origin
Health fairly/not good in last 12 months	45	40	49	57
Health fair/poor v others own age	22	22	36	29
Fitness moderate/not very good	23	23	46	42
Longstanding illness or disability	19	26	16	23
Limiting longstanding illness	12	16	7	15*
Indications of chronic phlegm	9	10	2	11**
Accidents/injuries in last three years	27	41**	17	23
Lost 1+ second teeth	20	30*	18	29*
Report 6+ symptoms in last month	40	29*	44	45

British Asian v other origin within sexes. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Data shown as column percentages.

Table 2 Glasgow 14–15 year olds 1992: ethnic differences in reported health behaviour

Reported health behaviour	Men		Women	
	British Asian	Other origin	British Asian	Other origin
<i>Age 14</i>				
Drinking alcohol				
never	88	27	87	18
tried once or twice	6	21	4	18
used to but gave up	0	2	0	4
on special occasions	6	37	4	39
regularly	0	13***	5	21***
Smoking				
never	72	53	65	41
tried once or twice	16	20	27	25
used to but gave up	10	4	3	12
occasionally	2	5	4	8
regularly	0	18**	1	14***
Drugs				
tried (soft or hard)	4	27***	1	21***
<i>Age 15</i>				
Drinking alcohol				
never	80	25	89	11
tried once or twice	10	20	4	21
used to but gave up	2	6	1	4
on special occasions	4	33	4	40
regularly	4	16***	2	24***
Smoking				
never	70	51	84	36
tried once or twice	16	22	9	27
used to but gave up	3	10	1	8
occasionally	7	8	5	9
regularly	4	9**	1	20***
Drugs				
tried (soft or hard)	10	26**	3	25***
<i>Age 14–15</i>				
Physical exercise for 20 minutes				
daily	26	40	16	20
4–6 times per week	27	30	15	26
2–3 times per week	29	22	53	39
once a week or less	18	8**	16	15*

British Asian v other origin, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Data shown as column percentages.

either in the last 12 months or compared with others of the same age, nor in self assessed fitness or longstanding illness. In limiting longstanding illness, and indications of chronic phlegm on the MRC Bronchitis questionnaire, no differences occur for male subjects, but among female subjects fewer British Asians report problems on each measure. In accidents and loss of second teeth fewer British Asians of both sexes report problems (accidents NS for female subject). In experience of symptoms last month, no differences occur for female subjects, but among male subjects more British Asians report a high number of symptoms, mainly on the psychosomatic dimension of distress. This is examined in a companion paper, and is not further referred to here.

Table 2 shows ethnic differences in reported health behaviour. Use of stimulants, which shows rapid change in teenage years,^{15 16} is

reported for age 14 and 15 separately. Markedly higher proportions of British Asians of both sexes report never having tried drinking alcohol, smoking or taking soft or hard drugs. On the other hand more British Asians of both sexes report taking exercise infrequently.

Smoking, drinking, and trying drugs are strongly related: 39% of those who have ever smoked and 78% of those who smoke 30+ cigarettes a week drink once a month or more; 34% and 85% have tried drugs.

Tables 3 and 4 show health variables for which there were significant ethnic differences in table 1, and considers how far these differences are reduced when ethnic differences in health behaviour are introduced into the equation. Exercise levels are omitted: the health differences to be accounted for favour British Asians, and cannot be accounted for by their exercise levels, which are unfavourable to health.

Two multivariate logit models are reported for each health variable. Test 1 gives how much greater the odds of having the health condition concerned are for non-Asians than Asians, and for male than female subjects, before risk behaviour is taken into account. For example in the first row and column in table 4, in test 1, the odds of an accident are 3.4 times greater among non-Asians than Asians before drinking is taken into account. Test 2 then shows that the odds of an accident are only 1.2 times greater among non-Asians than Asians after drinking is taken into account, as the odds of an accident are 2.6 times greater for those who drink once a month or more compared with non-drinkers (and we saw earlier that regular drinkers are commoner among non-Asians).

In table 3, the odds of longstanding illness, limiting longstanding illness, and chronic phlegm are significantly greater among non-Asians than Asians before smoking is taken into account, the odds ratio for each condition in test 1 rising as one moves from the most general category (longstanding illness) to the most specific (chronic phlegm). However, the non-Asian odds ratio for chronic phlegm is reduced almost to one (that is, is almost identical with the odds for Asians) after smoking is taken into account, as the odds of phlegm increase sharply for the heaviest smokers compared with non-smokers. The non-Asian odds ratios for longstanding and limiting longstanding illness also become non-significant when smoking is included in the analysis. These odds ratios are only marginally reduced, however, and smoking is only significantly related to limiting longstanding illness, and is as strongly related for those who smoke less than 30 cigarettes per week as for those who smoke more. This weak relation reflects the fact that respiratory conditions comprised only 43% of longstanding illnesses reported (nearly all cases of asthma), and other conditions included were those of skin (10%), musculoskeletal and connective tissue (9%), eye and ear (9%), and digestive/genitourinary tracts (8%).

In table 4, the analysis of accidents shows that the non-Asian odds ratio is greatly reduced, becoming non-significant, when

Table 3 Glasgow 14–15 year olds 1992: explanation of ethnic differences in health by differences in smoking. Odds ratios (95% confidence intervals)

	Longstanding illness		Limiting illness		Chronic phlegm	
	Test 1	Test 2	Test 1	Test 2	Test 1	Test 2
Non-Asian	1.6*	1.4	1.8*	1.6	2.0*	1.2
	(1.0,2.4)	(0.9,2.2)	(1.1,2.9)	(0.96,2.8)	(1.1,3.6)	(0.6,2.3)
Male	1.2	1.3	1.3	1.4	1.5	1.6
	(0.8,1.8)	(0.8,1.9)	(0.8,2.2)	(0.8,2.3)	(0.8,2.7)	(0.9,3.0)
Ever smoked cigarettes	—	1.5	—	1.7*	—	1.2
		(0.98,2.3)		(1.0,3.0)		(0.6,2.6)
Smokes 30+ cigarettes per week	—	1.6	—	1.8	—	8.7***
		(0.7,3.5)		(0.7,4.4)		(3.8,20.2)
Interaction	—	—	—	—	—	—

*p<0.05, **p<0.01, ***p<0.001.

Table 4 Glasgow 14–15 year olds 1992: explanation of ethnic differences in health by differences in drinking alcohol. Odds ratios (95% confidence intervals)

	Accident last three years		Lost 2nd teeth	
	Test 1	Test 2	Test 1	Test 2
Non-Asian	3.4**	1.2 (0.7,2.0)	1.8**	1.0 (0.6,1.7)
	(1.2,2.5)		(1.3,2.7)	
Male	2.1***	2.3*** (1.5,3.3)	1.1 (0.8,1.6)	1.2 (0.8,1.7)
	(1.5,3.1)			
Ever drunk alcohol	—	1.5 (0.9,2.5)	—	2.2**
				(1.3,3.7)
Drinks once/month+	—	2.6** (1.4,4.7)	—	2.7**
				(1.4,5.0)
Interaction	—	—	—	—

*p<0.05, **p<0.01, ***p<0.001.

drinking alcohol is taken into account. The odds of an accident are increased for those who drink once a month or more, and less increased for those who drink less, compared with non-drinkers.

Tooth loss is not related to brushing teeth (analysis not shown). It was found to be related to drinking alcohol, however, and table 4 shows that when this is considered the odds of losing teeth are no longer higher for non-Asians. The odds of tooth loss are also high for those who drink once a month or more and less high for those who drink less compared with non-drinkers, but the increase is only marginal.

Table 5 shows how much greater or less the odds are for British Asians than non-Asians of reporting each health condition and health behaviour (in dichotomised form), computed separately for each age-based sample and sex (crude odds ratios), thus making it possible to compare odds ratios for each sex at age 14–15

Table 5 Ethnic differences between British Asians and comparison group at age 30–40 and at age 14–15

	Men		Women	
	30–40	14–15 or 14	30–40	14–15 or 14
Odds ratios (British Asians/comparison group)				
Health				
Self rated health v others own age (fair/poor)	1.67	0.97	6.43***	1.37
Longstanding illness	0.34**	0.66	1.03	0.62
Limiting illness	0.59	0.71	0.76	0.44*
Chronic phlegm	0.29	0.85	0.69	0.25*
1+accidents	0.16***	0.52**	0.25***	0.69
1+teeth lost	0.09***	0.56*	0.39**	0.54*
Health behaviour				
Exercise <4 times/week	2.59*	2.05**	0.81	1.92**
Have drunk alcohol	0.06***	0.05***	0.01***	0.03***
		0.08***		0.02***
Have smoked	0.40**	0.45*	0.02***	0.37**
		0.44*		0.11***

*p<0.05, **p<0.01, ***p<0.001.

and at age 30–40. For example, in the first column, male British Asians aged 30–40 had 1.67 times greater odds of fair/poor self rated health than non-Asians of their age and sex, but only 34% of the non-Asian odds of longstanding illness. The measures are the same as those in tables 1 and 2, except, as noted earlier, that health in the last 12 months and the question on drugs were not asked in 1987, the question on accidents covered the period since age 15, and the question on exercise specified getting out of breath or sweating.

Among male subjects, significant British Asian advantages at age 30–40 in longstanding illness and chronic phlegm (just NS as an odds ratio in men age 30–40 but p<0.05 in the full table) are no longer present in the largely British-born group at age 14–15.

Among female subjects, there are significant British Asian advantages at age 14–15 in limiting illness and chronic phlegm, which were not present in the mainly migrant group at age 30–40, and the migrant group's substantial disadvantage in self rated health (probably influenced by high levels of psychological distress)¹⁷ has disappeared. On the other hand a significant advantage in the migrant group's experience of accidents is also no longer present.

Turning to health behaviour, table 5 shows strong continuities in ethnic differences between those aged 30–40 and those aged 14–15. This is true of exercise (male subjects only), drinking alcohol, and smoking. However 14–15 year old British Asian girls report low levels of vigorous exercise where this was not evident at age 30–40.

Discussion

These results show in summary that young British born Asians have a health advantage over the general population, and this is associated with their favourable health behaviour. So far male health advantage and female disadvantage are also much less marked in this group than in migrants aged 30–40.

Firstly, however, some qualifications about our measures need to be stated. Indices of health in adolescence are problematic.¹⁸ Height and weight can provide objective clues of earlier nutrition and social environment, carefully used, and we have reported on these physical measures elsewhere.¹⁹ A number of self reported indices of general morbidity are available, and have been used here, and some of these are linked with variations in psychological distress, which are important at this age, and which again are discussed elsewhere.²⁰ Many specific physical conditions that occur later but have their origin in adolescence or earlier, such as insulin dependent diabetes, are rare, and of little use at this age for an overall picture. At the same time specific physical health problems that are common include respiratory problems, accidents or injuries, and dental problems, all assessed here. Many of these health measures, and the measures of health behaviour too, have in common that they are self reports, and require to be assessed with due caution, especially where adult

sanctions are strong, as with use of various stimulants in South Asian cultures. However, while strong adult disapproval may lead to covert use being disavowed in our questionnaire, it is also likely to lead to lower levels of use at the same time, and the connections established in this paper between reports of smoking and chronic phlegm, and between reports of drinking alcohol and accidents, give confidence that the differences reported here have a measure of validity.

The first two questions posed in our introduction concerned the comparative health and health behaviour of 14–15 year old British Asians. In the differences found here, except for those in symptom experience, which are related to psychological distress, and are to be examined separately under that head, British Asians of this age show a consistent health advantage, particularly among female subjects. In health behaviour, 14–15 year old British Asians report much lower levels of smoking, drinking alcohol, and drug use than others, though they also report lower levels of exercise. There is little comparative literature at this age, but the findings on smoking and drinking are consistent with previous results,⁷ and those on drugs are consistent with evidence from the British Crime Survey.²¹

These ethnic differences in health behaviour are associated with, and in two of the four cases explain, the ethnic differences in health. Ethnic differences in chronic phlegm production have a consistent dose/response relation with the smoking patterns. Other studies have also noted health effects of smoking in adolescents.^{22–23} However, the connection between smoking and longstanding and limiting illness in our study does not have a consistent dose/response relation, possibly because this category of illness includes other less common conditions besides the respiratory. Alternatively, it might be that smoking is a sign of other unknown factors that affect longstanding and limiting illness, or is itself a response to such illness.

The connection between accidents and injuries and drinking alcohol is also not new,²⁴ and has a consistent dose/response relation here. A small dose/response relation might also be inferred for drinking and tooth loss, but the result is marginal. It might be thought that the association of tooth loss with drink is because of accidents or violence; but there is no increase in the the proportion reporting tooth loss through accidents among those drinking alcohol and taking drugs. Rather, smoking, drinking alcohol, and drug taking are often part of a wider complex of correlated behaviour both at this age and in young adulthood,^{25–27} and aspects of lifestyle or dental provision that may be involved in the relation with dental health are unclear. As we noted in the previous paragraph, it may even be that poor physical and dental health and low self esteem can itself lead to a mild tendency to poor health behaviour.

Health behaviour, therefore, is here associated with ethnic variations in adolescent health. The evidence presented here is the first to suggest unambiguously, within the limits of a cross sectional study, that British Asians are

showing a broadly based health advantage in conditions common to a particular age, which is associated with beneficial patterns of health behaviour.

This brings us to the last question of our introduction, whether the patterns of health and health behaviour in young largely British-born Asians are different from those of the migrant generation aged 30–40. Here the key issue is that at age 30–40 British Asians, overwhelmingly of the migrant generation, show a number of health advantages among men, and a number of disadvantages among women, when compared with the general population. At age 14–15, the British born generation show a number of aspects in which the comparative position of girls is better—in overall self assessed health, in limiting longstanding illness, and in chronic phlegm; and they seem only to have lost an advantage in women's previously low rate of accident and injury. The comparative position of the men, on the other hand, is worse, with the loss of previous advantages in longstanding illness and chronic phlegm. Accordingly at age 14–15, sex differences in health are possibly smaller, and certainly no greater, among British Asians than among non-Asians—a situation quite opposite to the striking sex differences among British Asians at age 30–40.⁶

Are these changes in the British Asian or the general population? Calculation of the odds ratios for 14–15 year olds compared with 30–40 year olds within each ethnic and sex group shows that in the general population both male and female adolescents at age 14–15 are about half as likely to report limiting longstanding illness and about three quarters as likely to report chronic phlegm. However at 14–15 British Asian male adolescents are as likely to report both these conditions as 30–40 year olds or more so, and female adolescents are about a third as likely. A less advantaged position in young British Asian male adolescents, and a more advantaged one in female adolescents, are both involved.

In health behaviour, meanwhile, ethnic differences across generations have remained remarkably constant. The only exception is that among British Asian women, 14–15 year olds are likely to take comparatively little exercise, and 30–40 year olds are not; here though our data for 30–40 year olds may be atypical, for other data show British Asian women around this age also taking little exercise.²⁸ The constancy of the ethnic differential in health behaviour over the two generations despite pressures to conform to teenage norms, may relate to factors in teenage socialisation within British Asian families, such as high levels of parental protection,²⁹ religious belief,^{30–31} and value placed on school work. At all events, it is an indication of the strength and vitality of British Asian cultures.

This combination of constant health behaviour with changes in health advantage underlines the fact that the consistency of health and health behaviour observed at age 14–15 in the second generation is absent in the migrant generation. Among the older migrant group,

the South Asian predisposition to diabetes and coronary heart disease, and a record of male advantage and female disadvantage in respiratory health, which is out of line with low female smoking, so far seem to have partially nullified the benefits of approved patterns of health behaviour.

What is the explanation for the disjunction between health and health behaviour among 30–40 year olds? The disappearance in 14–15 year olds of the British Asian advantage in male longstanding illness and chronic phlegm suggests that the apparent effect of somewhat lower smoking levels among 30–40 year old British Asian men may have been given an artificial boost by positive health selection of men at the time of migration, which could be expected to wear off with time and in the second generation. A review of such evidence from the Punjab as there is does not support the view that male migrants are selected for good lung function, and lung function is not worse among men who are long established. However, men recently arrived report low levels of chronic phlegm, and long established male subjects report it more frequently, while this is not the case with women.³² It is possible that men selected for migration have lower levels of chronic phlegm than their compatriots, though this has yet to be reported, and that this advantage disappears not only with time but in the second generation.

Meanwhile the appearance of a British Asian advantage in female limiting illness and chronic phlegm is consistent with their very low smoking levels, and either suggests the disappearance of other adverse factors among the new generation of British Asians born in the UK, or it locates the emergence of marked female disadvantage to the ages between 15 and 30. Although such an emerging trend would be against the pattern of health behaviour, a similar trend has been discerned in the general population.³³ This trend would have to be even stronger among British Asians to give rise to a sharper sex divide at age 30. The questions raised by the possibility of increasing female health disadvantage after the youth/adult transition makes a follow up of samples such as the present one of particular interest.

In brief, favourable health behaviour has reaped a health advantage among young British Asians, but it is too soon to conclude that it will continue to do so, as the migrant generation's health was less responsive to the same behaviour in middle age. Part of the reason may have been trivial, that men who migrated were already selected for good health; but part of the reason may relate to factors other than health behaviour that disadvantage women, and in particular British Asian women, between ages 15 and 30.

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