

Clarifying what we mean by health inequalities for young people

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December 2021



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In brief

Health inequalities have been brought into sharp focus during the Covid-19 pandemic, as we have witnessed differences in health between individuals and groups. There has been renewed impetus to tackle health inequalities and it has become a buzzword in policy discussions. But is it clear what we mean by the term? What does it mean for young people’s health? How are inequalities formed for young people? And where can we intervene to take effective action?

This paper seeks to help by offering a definition for health inequalities that is specific to young people and a conceptual framework to help us identify key causes and levers that influence health outcomes. We know that adolescence is a defining period for young people’s health, when inequalities between individuals and groups can become established and embedded, yet there is not enough focus within research, policy and practice on young people’s experiences of health inequalities. In highlighting the levers through which the “social determinants” of health are translated into divergent health outcomes, we hope to highlight opportunities for guidance and resources to improve young people’s health.

What is the issue?

Young people from different backgrounds with different lived experiences can have different physical and mental health outcomes – these are “health inequalities”. Research has shown a clear link between poorer health outcomes, socio-economic status, housing, education, employment and the other factors of people’s wider lives – these are “social determinants of health” (Marmot *et al.*, 2020). Differences caused by these social factors are unfair and preventable. We need to know more about health inequalities experienced by young people, how they occur and how we can intervene.

Framing of the issue typically focuses on differences in expected years lived (“life expectancy”) and expected years lived in good health (“healthy life expectancy”). Policy and research focuses on healthcare improvements for older adults and the early years. Yet we know that young people, at their particular life stage and development, experience unequal

outcomes across a range of health and health-related issues, from obesity to accidents. The causes of inequality are somewhat unique for young people as they are transitioning through different life events, such as education and first employment experiences.

We need to be clearer about what we are talking about when we refer specifically to young people’s health inequalities so that we can galvanise action. To do so we need more clarity around constructs and terms so that we can be clear how to effectively intervene. In this paper, we provide a definition and a conceptual framework exploring the causes and outcomes of young people’s health inequalities. We also consider the ways in which these are translated into different health outcomes through a range of “levers”, the opportunities available to young people experiencing success or disadvantage. We hope that this will state the case for focusing policy and research attention on the 10-25 age group.

Impact of Covid-19 on young people

Young people have been uniquely impacted by Covid-19. They have faced huge upheavals to education, examinations and university experiences; high rates of furlough and redundancy; disrupted social lives and reduced access to healthcare (Hagell, 2021). There has also been a major impact on young people’s relationships with others (Leavey *et al.*, 2020). There are clear implications for their physical and mental health. These experiences have not been felt evenly by all young people, with some doing worse and some doing better than others.

There has been renewed policy focus on the importance of the adolescent period, with calls to prevent scarring and failing this generation (Hill, 2020). The realisation that young people in pre-existing situations of disadvantage have taken a disproportionate ‘hit’ from the pandemic has fuelled an increased interest in their health inequalities.

A new definition and conceptual model for understanding health inequalities in relation to young people

Understanding health inequalities is complicated, they represent a “wicked problem” – a complex and evolving subject matter that cannot be easily solved (Rittel & Webber, 1973). As use of the term health inequalities has become more widespread, its definition has become less clear as it has been confused and conflated with other terms, such as inequity¹ and poverty. When there is confusion around terms, they can lose their power and meaning, and the way through to solutions becomes more muddled.

At its simplest level, inequality means disparity or difference. There is no absolute inequality, only inequality in relation to something or someone else. When thinking about the difference between individuals or groups, discussions on inequality should refer to ‘poorer’ or ‘worse’ outcomes in comparison to others, as opposed to ‘bad’ or ‘worst’ to represent the scale of difference between individuals or groups.

In 1992, Margaret Whitehead – one of the UK’s leading experts on health inequalities – described health inequalities as “*health differences that are avoidable, unnecessary and unjust*” (Whitehead, 1992).

NHS England (2020) and others have provided more recent definitions that take into account the influence of the “social determinants”. In many ways these general definitions of health inequalities are directly applicable to issues young people face. They are subject to poverty, disadvantage, stigma and disrupted access to services in similar ways to the rest of the population. However, there are some unique and particular issues facing young people. Young people experience a period of physical, social and brain development, making them particularly vulnerable to the impact of the wider environment (Viner *et al.*, 2015). Relationships and interactions with others are vitally important for wellbeing, social development, and identity formation – which we have labelled young people’s opportunities to “socialise”.

Young people are transitioning through different phases and life experiences during a general period of flux. The transition into adulthood is marked by multiple changes within a young person’s life, including changes to their education, employment, housing, managing finances, moving locations and forming new relationships. Without adequate support, this can bring with it challenges and stress that impact on a young person’s wellbeing and mental health. Exposure and experience of different factors can accumulate and proliferate during this time. Adolescence marks a critical juncture when both positive and negative actions and interventions can shape future outcomes across the young person’s life, we see these as a range of the potential trajectories or possible journeys that form during this period.

Having specific definitions for young people’s health inequalities upholds the UN Conventions on the Rights of the Child (1990).

Our suggested definition for health inequalities in young people is:

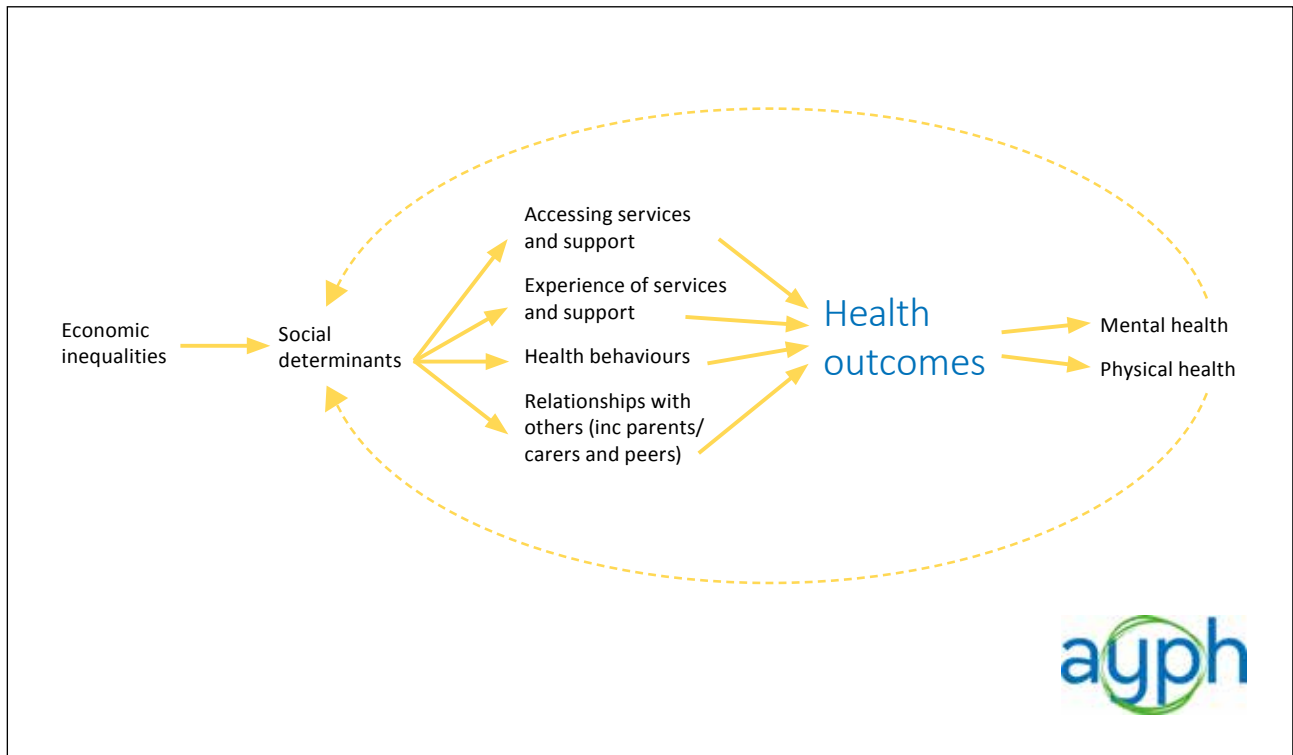
*“The **avoidable and unfair differences** in physical and mental **health outcomes** between individuals or groups aged 10-25.”*

Additional explanation:

*“Health inequalities are caused by economic and social differences that influence the **conditions in which young people live, learn, work and socialise**. These factors influence current and future health outcomes. Young people’s developmental and life stages makes them **particularly sensitive to changes in their environment**, providing an opportunity to improve or worsen inequalities in health.”*

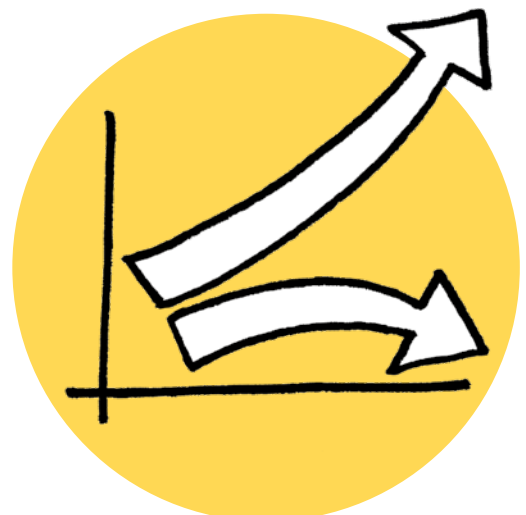
1 In the US context, “inequities” are described as unfair and avoidable differences, while “inequalities” are differences that may arise from a number of reasons that are not always unjust (e.g. genetic). In the UK context, the term “health inequalities” is used when describing these unfair and avoidable differences, as we do throughout this paper.

A conceptual model of how health inequalities arise for young people might look something like this:



The definition and conceptual model represent our current thinking, which we expect will evolve and develop over time. This is an initial classification attempt on our part, but there has been a lack of research or engagement with young people themselves to seek their views on what health inequalities mean to them. This is a very important part of developing our constructs so there is much more to be done.

We will now look at each aspect of the model, exploring the different health outcomes young people have and the experiences they encounter which shapes their trajectories.



Health outcomes

Health relates to an individual's mental and physical status. Being 'healthy' is to be free from physical and mental illness, but also to feel positively well ("positive wellbeing"). People can move between positions of 'good' and 'bad' health and may have both 'good' and 'bad' health simultaneously. This can make analysis of self-reported health status complex.

Overall there are 11.7 million young people in the UK aged 10-24, forming 20% of the population (Hagell & Shah, 2019). Although this is generally considered a healthy lifestage, different young people have different outcomes across a range of measures. There are a number of different kinds of health outcomes for young people that are important when we are thinking about health inequality. One way of conceptualising them is to split them into the health they experience 'now' and the 'foundations for the future' in terms of ensuring that they go on to live healthy lives. Some examples include:

'Now'

- **Mortality.** Death rates are low in our age group, with only approximately 2,000 of those 11.7 million young people dying each year (Hagell & Shah, 2019). However, most deaths in young people are preventable.
- **Disability.** Young people living with constraints on their everyday life, which can impact on their ability to engage with school and work opportunities.
- **Long-term health conditions.** Adolescence and early adulthood represent the most common period for the onset of long-term healthcare conditions such as asthma, mental health, and epilepsy.

'Foundations for the future'

- **Health behaviours.** Adopting certain behaviours during this period can predict health behaviours later in life.
- **Future health conditions.** Poor health and coping strategies (diet, physical fitness and substance use) can lead to the development of health conditions later in life (e.g. Type 2 diabetes).

- **Self-management of health care.** As part of the transition to adulthood, young people are expected to learn to navigate different health systems and develop self-management practices to manage their own health conditions.

Causes of health inequalities

There have been a number of different attempts to group or identify the key causes of health inequality, none of which completely cover the territory. A range of economic and social factors combine to influence young people's health outcomes.

Economic inequalities in society underpin health inequalities. Differences in access to economic opportunities or living in more deprived areas, can lead to inequalities across a range of social, economic and health outcomes. Financial resources provide access to services and goods that can improve health and allow participation in social activities that improves mental wellbeing (PHE, 2021).

In recent years, UK Governments have pursued austerity policies, resulting in cuts across government budgets, including to local authority, public health, legal aid and welfare, which have had a direct impact upon young people:

- Income inequality has increased since 2017 as disposable income for the poorest 20% of people in 2018 and 2019 has fallen (ONS, 2019). Rising income inequality has had a particular impact on children and young people, limiting their life chances and making them more vulnerable to poorer outcomes (Odgers, 2015; OECD, 2019).
- Many young people rely on welfare benefits for financial support – during 2020, the number of young people aged 18-24 claiming Universal Credit doubled in three months (Department for Work and Pensions, 2021a). Within the current system, young people under the age of 25 receive 20% less in Universal Credit payments in comparison to adults.
- The 'two-child' limit on tax credits and Universal Credit, resulting in a £53.50 reduction in support for each young person in families that do not qualify (Stewart *et al.*, 2020).

- Child poverty rates are at the high rate of 31% of the population (Department for Work and Pensions, 2021b). Even pre-Covid child poverty rates were projected to rise to 5.2 million children by 2022 (Francis-Devine, 2020).
- Young people facing financial pressures are less able to save money and are more likely to be in debt than adults. It has been estimated that 37% of young people have taken out loans through credit cards, overdrafts and other sources (Money Advice Trust, 2016).
- Between age groups, “generational inequalities” have emerged, such as claims that living standards have not been improving for successive generations, particularly in relation to home ownership and access to disposable income (Bangham *et al.*, 2019; Gardiner *et al.*, 2020).

Young people may or may not be shielded from economic insecurity depending on the “safety net” that is provided by their family and friends during periods of instability. This makes it difficult for some young people to “break the cycle” without external support. During Covid-19, young people have reported that it was more difficult to rely on familial financial support as incomes generally had been negatively impacted (Health Foundation, 2021).

It is important to note that inequality is the measure of difference, so income inequality is distinct from a measure of absolute poverty or disadvantage. Conflating poverty with income inequality implies that there is a direct causal relationship between being in poverty and experiencing inequalities, which may not always be true.

Social factors affecting young people are also important drivers of health inequalities. Broadly these have been referred to as the “wider / social determinants of health”, the conditions in which young people live, learn, work and socialise, or the “causes of the causes” of health (Marmot *et al.*, 2010; Shah *et al.*, 2018; Viner *et al.*, 2012; Kings Fund, 2020). The Health Foundation’s Young people’s future health inquiry labels these the “building blocks” that enable young people to go on to lead healthy lives, which include having a positive home and good work opportunities (Jordan *et al.*, 2019).

We have not come across a complete list of the “social determinants” of health that affect young people, as they are complex, multiple and overlapping factors within an individual’s life. Change in one aspect of a young person’s life may have knock-on implications on other social aspects, meaning that there can be a build-up or a clustering effect of the “social determinants” on health. For example, lack of engagement in education could lead to poor employment opportunities, low pay and housing instability.

The following list represents key factors that are particularly relevant for young people:

- **Education.** Education is known to improve health outcomes, social development and wellbeing (DHSC & PHE, 2021). Most young people are in full time education or are transitioning between the worlds of education and employment. Educational outcomes and academic attainment between young people are unequal and have been exacerbated during the Covid-19 pandemic (Sharp *et al.*, 2020).
- **Employment** is linked to financial stability, positive wellbeing and healthy behaviours – with unemployment or low quality work linked to opposite outcomes such as poverty and stress (PHE, 2019). Young people are typically employed in more insecure sectors that are precarious in nature and provide lower wages (e.g. zero-hour contracts); meaning young people were particularly impacted during the pandemic (Gustafsson, 2020). Pre-Covid, the UK’s youth unemployment rate was low and falling, suggesting that employment is not a protective factor against poverty.
- **Geography and the physical environment.** Different regions, areas and neighbourhoods contain different levels of amenities and services that support positive health and wellbeing for the young people living there. Public outdoor spaces provide places for young people to be active and socialise with their peers. Some urban environments and housing stock have high levels of air pollution that can cause health harms for young people (McBride *et al.*, 2019). Whereas, rural environments may face accessibility and isolation issues (National Youth Agency, 2021).

- **Housing** can impact young people's health outcomes due to the related issues of affordability, quality and adequate space. A young person's environment can provide protection from ill health (NCB, 2016). Space allows young people to concentrate on school or work, socialise with their friends and engage in physical activity. Young people who are able to live independently often live within the private rented sector, which is known for being precarious and high cost. Some young people without access to secure housing may find themselves either homeless, living in temporary accommodation or "sofa surfing". Centrepoint, a charity for young people facing homelessness, has seen a record demand for their services as a result of Covid-19 (Centrepoint, 2021).
- **Transport** provides young people with access to opportunities that can impact upon their health (Chatterjee *et al.*, 2019). Depending on where young people live, public transport options may be limited, expensive and unreliable, which impacts on young people's ability to access opportunities.

The levers that translate socio-economic factors into health inequalities

Depending on where young people live, their education or employment status and the situation they grow up in, they are either provided opportunities or presented with barriers for participating fully in society. Some groups of young people may be more likely to experience racism, discrimination or stigma that prevent them from accessing and engaging with services and aspects of society. The opportunities available to young people are not fixed and may flux over time and between groups.

This is a significant way in which "social determinants" are translated into health inequalities, which we are terming the "levers" which can bring about better or poorer health outcomes for different groups of young people. This relationship is by no means deterministic. It is also not a comprehensive list of potential levers, these are just the ones that we consider to be particularly important for young people's health. These levers offer us a good place to start in terms of interventions to reduce inequality.

Accessing and experiencing services and support. In order for services to effectively provide support, they must be accessible and young people must consider them to be positive experiences. The main services young people interact with include: health, education, social care, youth clubs and services, charities and community groups, and social welfare advice services.

Young people may encounter multiple barriers in accessing services (e.g. affordability, digital exclusion, lack of appropriate opening times, transport, language and understanding). Thinking about healthcare services, if an individual is unable to overcome these barriers, they may not engage with healthcare settings until their illness is at crisis level. This may mean that their burden of disease is higher than if they had engaged earlier when it could have been prevented.

The extent to which services are accessible to young people relates to the availability of services within different places – if services do not exist then young people are unable to attend. Cuts to young people's services have had huge implications on accessibility. Youth organisations provide safe spaces for disadvantaged young people to build self-confidence and positive wellbeing and are linked to violence reduction in communities (Robertson, 2000). Youth clubs have faced closures across the country due to lack of funding (YMCA, 2020; UK Youth 2021). Youth advice services provide support with benefits, education, employment, housing (many of the "social determinants") and the services have been proven to improve young people's health and wellbeing (Kenrick, 2011). Unfortunately, the number of dedicated youth advice services has also reduced, leading to calls for creation of more youth hubs to fill the gaps (Youth Access, 2021). Additionally, the number of school nurses in schools has fallen by 11% in recent years (NHS Digital, 2020a).

Experiences of services are equally important as they affect the likelihood of individuals reengaging with services in the future. It is particularly important that young people foster positive relationships and self-management techniques in this period that they can carry through life. Young people have identified poor experiences in settings or with professionals that are not youth friendly or supportive to their needs.

Similarly, many of the solutions already exist for how services can be improved to better cater for young people aged 16-25 (Rigby *et al.*, 2021).

The importance of adolescence for learning and adopting healthy behaviours and avoiding behaviours that can have positive or negative health consequences. This includes participating in physical activity, eating a balanced diet, maintaining positive sleep habits and adhering to prescribed medical treatments – these are known as health promotion behaviours. It also includes avoiding behaviours that are likely to harm your health such as smoking, alcohol, substance misuse and unprotected sex – these are known as health risk behaviours. Engaging, or not engaging, in healthy behaviours represents an interim stage in the model, influencing young people’s health both now and into the future.

The likelihood of young people engaging in such behaviours is influenced by the wider context of their life. Although often presented as an individual choice, adopting healthy behaviours is a reaction to circumstances and the wider determinants. Young people themselves often view it as their personal responsibility to adopt healthy behaviours, though they recognise the influence of their family and peers in their decision-making (Tinner *et al.*, 2021).

Young people’s relationships with others are important in informing how young people navigate and interact in society. Adolescence marks a period of forming new and independent relationships, which can have a lifelong impact.

Relationships are important for wellbeing and as opportunities to socialise and can reduce stress and improve mental health. The Health Foundation’s Young people’s future health inquiry found that peer relationships are an important “building block” for young people’s future health (Jordan *et al.*, 2019). Peer influence and the embedding of peer norms is much stronger in this lifestage than earlier in childhood, as young people have greater freedom and less surveillance from adults.

Positive relationships are formed in childhood and are somewhat modelled on the relationships young people have with their families, carers, peers and

professionals (e.g. teachers). Some young people have trusted adults in their lives, who can act as advocates on their behalf. Conversely, negative relationships in childhood can have harmful impacts, such as Adverse Childhood Experiences or peer-on-peer bullying (Asmussen, 2020). Parental health and relationships are particularly important for young people’s later health outcomes, including their mental health (Morgan *et al.*, 2012) and young people’s likelihood of adopting health risk behaviours (Riesch *et al.*, 2006).

Professionals often do not have enough time to form trusting relationships with young people. However, for youth workers a central tenant of their work is to develop positive relationships which can be transformative for young people who are lonely or who have negative relationships with others in their lives (Mental Health Foundation, 2021).

Most children and young people will naturally acquire the skills needed to form relationships as they develop, but some young people might need additional support (Lavis, 2016). The more positive experiences a young person has had interacting with adults, the more confident they are likely to feel when communicating with professionals. Poor communication between young people and professionals often results from a power imbalance and can exacerbate inequalities.

Coming full circle in the model

The health status of a young person influences their ability to fully participate in society, which can have implications on things like participation in education and employment. Thus, poorer outcomes can perpetuate the “social determinants”, creating a cyclical relationship between cause and outcome. This is a bidirectional relationship, not a linear one, in which social inequalities cause health inequalities, whilst health inequalities can also maintain social inequalities.

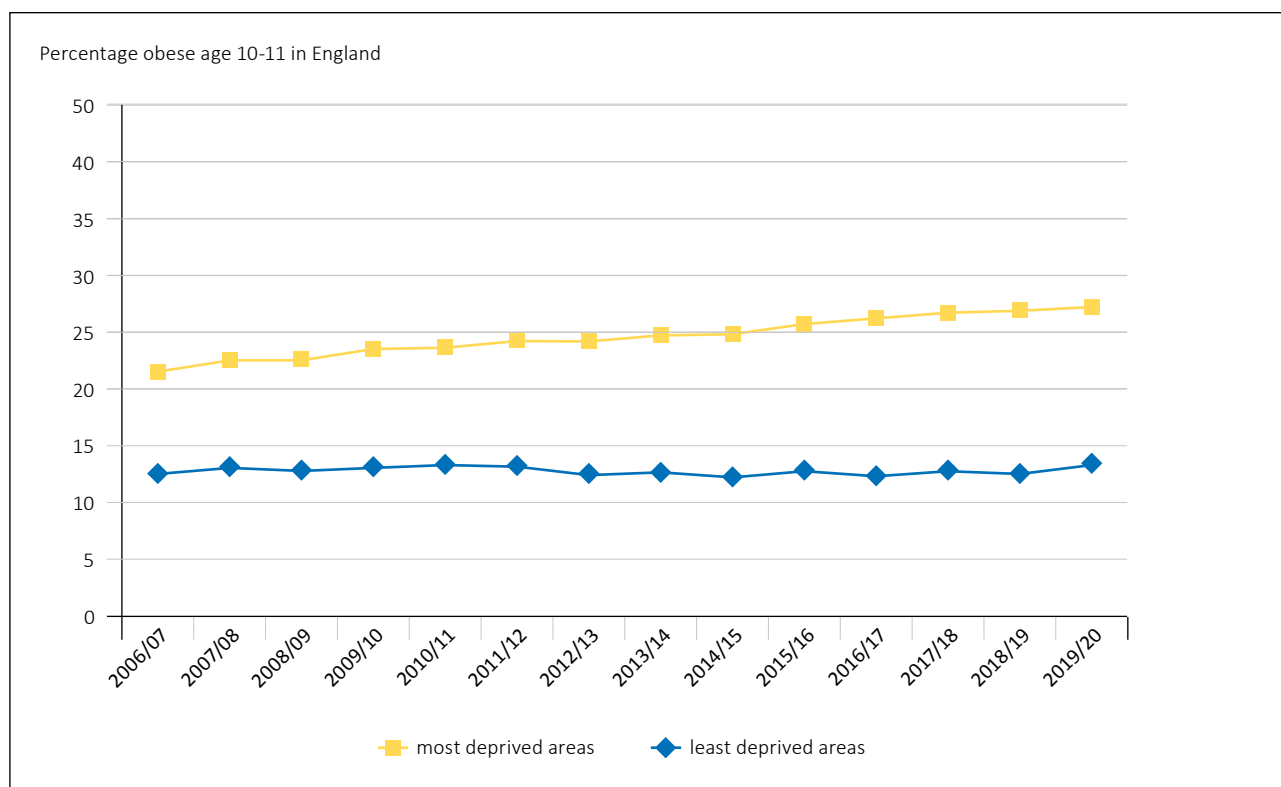
Mapping young people’s health inequalities

There are challenges in measuring health inequalities and monitoring what ‘successful’ change looks like (Marmot *et al.*, 2010). In our experience this is exacerbated in relation to data on young people’s health inequalities. Some data are available by socioeconomic status and groups. However, not all publicly available healthcare data are subdivided in this way. Many of the things we’re interested in are not broken down by demographic factors such as gender or ethnicity. Even getting data broken into five year age bands (“quinary” bands) can be difficult (Diaz *et al.*, 2021).

AYPH and colleagues have published a number of pieces that start to dig deeper into health inequalities

and “social determinants” of health in young people, and begin the process of learning more about the determinants and outcomes that specifically matter for this age group (Davis, 2020; Hagell & Shah, 2019; RCPC, 2020; Shah *et al.*, 2018). For example, available data indicates that young people living in more deprived areas are more likely to be overweight or obese, smoke regularly and be killed or seriously injured in road traffic accidents (Hagell & Shah, 2019). Trends over time have shown diverging outcomes for the most and least deprived obese young people (see Figure 1).

Figure 1: Inequalities in obesity are increasing for age 10-11 year olds in England



Source: NHS Digital – National Child Measurement Programme 2019/20

It is critical that current and future attention on young people’s health does not just examine the average experience. Health inequalities and differences of experience must be explored in more detail for subgroups of young people. Means and averages within current data do not provide an accurate picture

of the varied experience of different groups of young people. A number of different groups of young people are more likely to be disproportionately adversely affected by the “social determinants” and so more likely to experience poorer health outcomes than their peers. Though not a complete list, this may include:

- Care experienced young people
- Young people living in deprived areas and / or families
- Young carers
- Young people not in education, employment or training (NEET)
- Young people from ethnic minority backgrounds
- LGBTQ+ young people
- Young migrants and refugees
- Homeless young people
- Young people in the criminal justice system
- Gypsy, Roma and Traveller young people

Information on health outcomes of different groups of young people is often captured through self-reported surveys, posing challenges for comparison against other young people and determining the level of health inequality that exists. Also, young people have told us that they do not like to be defined by their belonging to a specific group as it represents just one part of their identity. There should be a holistic approach to young people’s intersecting identities, their health outcomes and their experiences of health inequalities.

Care experienced young people – an example of health inequalities

For young people in care, the state is their legal guardian. For these young people, the transition into adulthood is much more difficult and complex than most teens, as they also navigate leaving care and becoming fully independent. There are huge variations in the level and adequacy of support provided to care leavers after their 18th birthday. Without sufficient guidance and support, these young people are more likely to encounter barriers in accessing services. Negative experiences in aspects of the “social determinants”, such as finding a quality and affordable home and securing employment, can have implications on their health and wellbeing.

Inequalities faced by care experienced young people:

- Children **living in deprived areas are more likely to end up in care** than those living in affluent areas (Bennett *et al.*, 2020).
- 60% of children who are looked after in England are reported to have **emotional and mental health problems** (NICE, 2013).
- For looked after children in 2020, **90% had completed their annual health assessment and 88% were up to date with their immunisations**, although older males were less likely to be up to date with their immunisations (Department for Education, 2021).
- Looked after children at Key Stage 4 (aged 14-16) scored an **average Attainment 8 score of 19.1, compared to 44.6 for all children** (Department for Education, 2020).
- In 2020, there were 31,260 care leavers aged 19-21 – **39% of these were not in education, employment or training (NEET)** (Department for Education, 2021). For all young people aged 16-24, it is estimated that 11.6% are NEET (ONS, 2021).
- Female care leavers are **three times as likely to become teenage mothers** than young women who haven’t been in care (PHE, 2018).
- **14% of care leavers have slept rough** and 26% have “sofa surfed” (Centrepoint, 2017).
- Into adulthood, there are **higher rates of premature mortality** for care leavers than the general population (Sacker, 2021).

Conclusion

This paper demonstrates the depth and complexity of defining the concept of health inequality, how it is caused and why it is relevant for young people. We believe that health inequality is a particularly pertinent issue for young people that demands policy and research attention.

Young people are experiencing a unique lifestage and period of transition, which makes their experiences of the “social determinants” and health inequalities different to other age groups.

Changes to their social and economic status can have impacts on their health now and into the future. Thus, adolescence marks a defined period when interventions can be made that either positively or negatively influence the trajectories of young people’s health.

This paper provides a new definition and conceptual model for understanding young people’s health inequalities, highlighting where to intervene. It identifies the causes of health outcomes and, importantly, the ways in which “social determinants” are translated into health inequalities through different levers. This stage of the model provides a tangible place to target resource and interventions to make a difference in tackling young people’s health inequalities. Policy-makers, professionals and researchers can hopefully identify aspects of their own work which fall under these different levers to make improvements. We plan to supplement this conceptual framing with evidence-based resources and guidance to improve policy and practice on this topic, as part of our [Health Inequalities Programme](#).



To cite please use: McKeown, R. & Hagell, A. (2021) *Clarifying what we mean by health inequalities for young people*. London: AYPH.

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More information

About the Health Inequalities Policy Programme

This Health Inequalities Policy Programme aims to shine a light on young people's specific experiences of health inequalities and how this is a unique experience for the 12-24 age group, which hasn't previously been given due attention. Covid-19 has exposed both inequalities within society and has revealed a disproportionate impact on the lived experiences of young people specifically. The project will seek to understand what the data and evidence says on the topic and will speak to specific groups of young people about their lived experiences. We plan to work with key, influential stakeholders who have the power to help make a difference, to learn from their experiences and work together on developing solutions. The project will develop useful guidance, tools and resources to deliver changes within both policy and practice.

The project is part of the action phase of the Young people's future health inquiry, which is funding work across a range of organisations to build the policy agenda and amplify the voices of young people. Other projects include the RSA on economic insecurity, UWE and Sustrans on transport, and projects at the Resolution Foundation and the IES exploring different aspects of youth employment.

Association for Young People's Health

AYPH is the leading independent voice for young people's health in the UK. To find out more about our work visit www.youngpeopleshealth.org.uk

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