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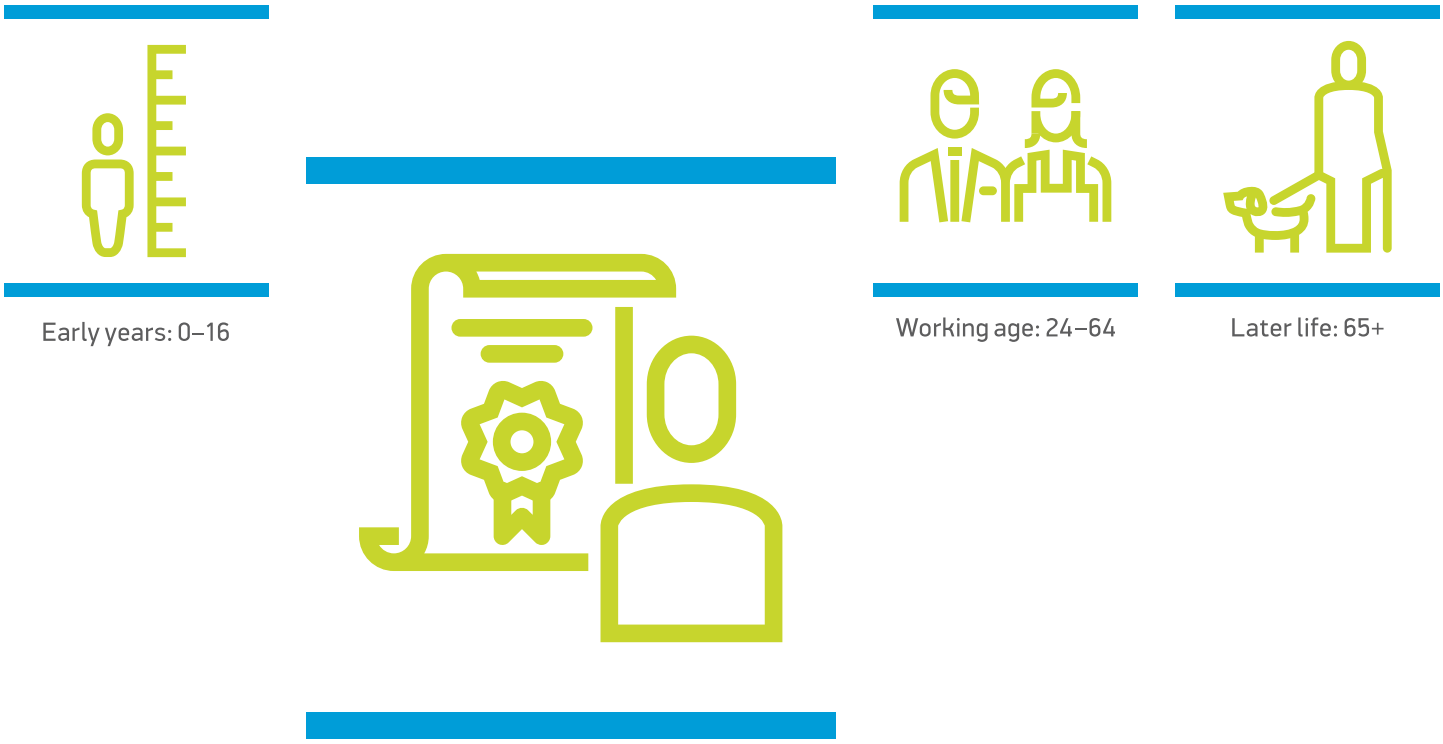


# Reducing inequities in health across the life-course

## Transition to independent living – young adults

A publication of the European Health Equity Status Report initiative

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By: Clare Bambra & Katie Thomson

**ABSTRACT**

Taking a life-course approach, this paper outlines the key health equity issues for young adults, their social determinants and how policy-makers can act to reduce them. Chapter 1 discusses young adulthood as a significant – yet overlooked – life-course stage for health equity. Chapter 2 describes the key health issues for this group and how the social determinants of health impact on health inequalities during young adulthood. Chapter 3 outlines policies that could reduce health inequalities among young adults, including outlining specific indicators to measure change within different policy areas and highlighting country examples. Chapter 4 outlines Member State commitments that give policy-makers the mandate to take action on young adults' health, alongside European priorities and policy drivers. Chapter 5 outlines the key stakeholders and partners needed to reduce health inequalities, arguing that intersectoral action to improve health is crucial for young adults.

**Keywords**

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# Contents

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This publication is one of the products developed under the WHO European Health Equity Status Report initiative (HESRi). The work is led by the WHO European Office for Investment for Health and Development of the WHO Regional Office for Europe based in Venice, Italy and aims to bring forward innovations in the methods, solutions and partnerships to accelerate progress for healthy prosperous lives for all in the WHO European Region. Chris Brown, Head of the WHO Venice Office, is responsible for the strategic development and coordination of the HESRi. Development of the initial framework was guided by the external Scientific Expert Advisory Group to the WHO European HESRi.

# Introduction

This short paper sets out the key health equity issues for young adults and how policy-makers can act to reduce them. Health inequalities are defined in it as *(1)*:

> *systematic differences in health between different socioeconomic groups within a society. Because they are socially produced they are potentially avoidable and widely considered unacceptable in a civilised society.*

The paper also notes gender differences in health from social norms *(2)* and the intersection of different elements of social inequality (such as socioeconomic status, gender, ethnicity, sexuality and disability) *(3)*.

A life-course approach to understanding health inequalities is adopted. The life-course perspective highlights the role of the accumulation of disadvantage over the life-course, combining the amount of time someone has spent in more/less disadvantaged circumstances *(4)*. Health inequality is therefore a result of inequalities in the accumulation of social, economic and psychological advantages and disadvantages over time *(4)*, meaning young adults' experiences and opportunities affect their future health outcomes.

Lower socioeconomic status (SES) (determined by, for instance, low income, low occupational status and low educational achievement), gender and other axes of social inequality in young adulthood shape life-course health trajectories through exposure to the social determinants of health (such as access to health services, living conditions, personal and community capabilities, working conditions, unemployment and social protection) *(5)*. These inequalities might not be apparent in health outcomes during young adulthood, but will manifest in future years. Policies therefore need to address specifically those being left behind during the formative years of young adulthood.

This introductory chapter defines young adulthood as a life-course stage (with a specific focus on those not in education, employment or training, or so-called NEETs) and provides a description of the main health inequalities apparent at this stage.

## Young adulthood as a life stage

Young adults aged between 16 and 25 years[1] are at a key life-course stage, during which time they may leave compulsory schooling and transition into the labour market or higher education.[2] They may also leave home and the family. This period is characterized by change, waiting, and periods of uncertainty and insecurity *(6)*. This unsettling time can be plagued by long periods of temporary employment, low pay, poor-quality work, unemployment or other inactivity. Social transitioning makes the examination of socioeconomic inequalities among young adults difficult: people aged 18–25 years are just developing their own social status, but most data sets use parental indicators (such as parental occupation).

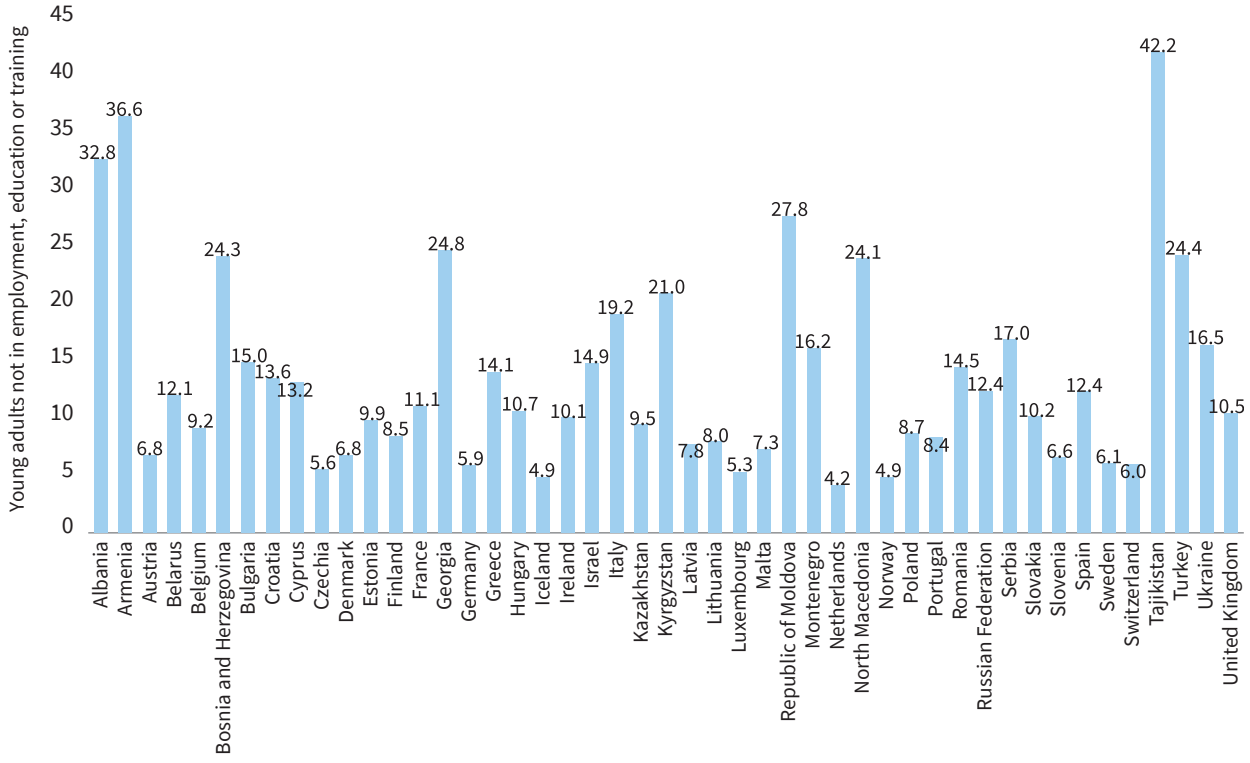
[1] Some data sets define young adulthood as age 15–24, others as 16–25. Data presented in this report therefore vary a little in terms of age boundaries.

[2] The age at which young people leave compulsory schooling varies greatly across the WHO European Region – approximately a third of countries *(2,4)* allow young people to leave before they are 16 and a fifth require education to continue until aged 18/19.

The acronym NEET is used widely to refer to young adults between the ages of 15 and 29 *(7–10)*. Societal costs of NEETs relate to lost productivity, taxes, and welfare and public service costs *(11)*. More significant, though, are the effects on young adults, which may last throughout the life-course and centre on social exclusion, marginalization, lower income, and poorer health and well-being *(12–16)*. Both young men and young women are at risk of NEET status *(13)*. Many NEETS are in the informal labour market, and therefore are not captured in official statistics *(17)*.

Fig. 1 shows the percentage of young adults who are NEETs across the WHO European Region in 2018. The rate ranges from 42.2% in Tajikistan to 4.2% in the Netherlands. Twenty-seven countries have a rate of over 10%, including the United Kingdom (10.5%), France (11.1%), the Russian Federation (12.4%), Spain (12.4%), Greece (14.1%) and Italy (19.2%).

**Fig. 1. Percentage of young adults (aged 15–24) not in employment, education or training, 2018[ab] (latest available data)**



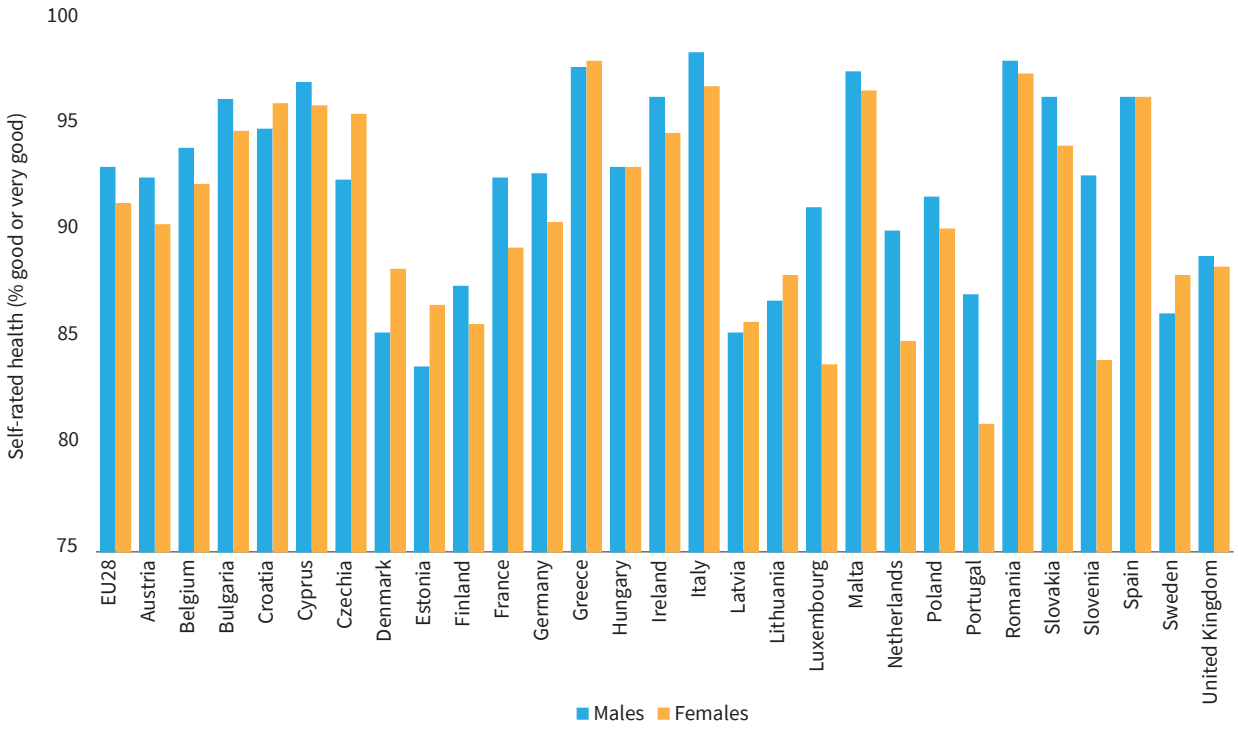

[a] No data available for Andorra, Azerbaijan, Georgia, Monaco, San Marino, Turkmenistan and Uzbekistan.
[b] The International Labour Organization defines NEETs as: the percentage of the population of a given age group and sex who is not employed and not involved in further education or training.
*Source:* International Labour Organization *(18)*.

## Key health equity issues for young adults

Health inequalities by SES (education, occupation or income) and gender differences in health from social norms begin to become evident in young adulthood both between and within the countries of the WHO European Region. By way of example, data from 2017 for all European Union (EU) Member States (EU28) *(19)* suggest that the proportion of young adults (between 16 and 24) experiencing "good" or "very good" self-rated health was 92.3% (ranging across EU28 countries from 83.7% to 98.1 %) (Fig. 2). Self-rated health across the EU28 consistently is slightly higher in young men than young women (93.1% and 91.4%

respectively), and also slightly higher for young adults living in households with the highest incomes (95.6% living in high-income households compared to 90.0% living in low-income households).

**Fig. 2. Self-rated health for young adults (aged 16–24) across the EU28, 2017**[a]




[a] Self-rated health as reported by young adults with health rated as "good" or "very good".
*Source:* Eurostat *(19)*.

Health and health behaviours in young adulthood are also affected by gender norms and the intersection of social characteristics (including SES, gender, sexuality, ethnicity and migrant status) *(3)*. EU data highlight inequalities in rates of obesity for young men and women by income quintile, with the lowest rates among those from the highest income backgrounds *(20)*.

## *Mortality in young adults*

Table 1 provides a summary of the leading causes of death for young men and young women (aged 15–29) in the WHO European Region. Self-harm and road injuries are the top-two causes of death for men and women. Interpersonal violence is also common, while drug disorders and HIV/AIDS are important for men and women respectively.

## *Inequalities in self-harm and mental health*

Poor mental health is a significant problem for many young adults, particularly young women. Twenty per cent may experience a mental health problem in any given year *(24)* and approximately half of mental health problems are established by the age of 14 (75% by the age of 24) *(25)*.

Socioeconomic inequalities in mental health and gender differences among young adults are high in all European countries. Recent analysis of European data (20 EU countries) found a social gradient in health for depression across the life-course *(26)*, with people with lower education reporting a higher

prevalence of depression compared to those with higher secondary and tertiary education. Research has also found clear gender differences in depression, anxiety and self-harm across the life-course in the EU *(27)*. These inequalities in mental health are also evident in young adulthood *(28)*.

**Table 1. Top-five causes of death for men and women aged 15–29[a] in WHO European Region, 2016 (latest available data), with crude death rates given per 100 000 per year[b]**

| | Men | Women |
|---|---|---|
| 1 | Self-harm (19) | Self-harm (5) |
| 2 | Road injury (17) | Road injury (4) |
| 3 | Drug-use disorders (6) | HIV/AIDS (2) |
| 4 | Interpersonal violence (5) | Interpersonal violence (1) |
| 5 | Drowning (4) | Lower respiratory infections (1) |

[a] No specific data available for 16–25-year-olds.
[b] A total of 849 individuals were reported to have died due to AIDS-related causes during 2016 in 29 countries of the EU/European Economic Area. Nevertheless, AIDS-related death reports have consistently been decreasing since 2007 due to improvements in care and treatment *(21)*. Death rates may relate to the fact that only 96% of people diagnosed with HIV receive antiretroviral treatment *(22)* and around 12% of the total number of people living with HIV are undiagnosed. Twenty-one per cent of new HIV diagnoses in 2016 in the WHO European Region were among people originating from outside the reporting country *(21)*.
*Source:* WHO *(23)*.

There are new and emerging challenges for the mental health of young adults, such as the rise in incidence of online bullying and grooming, which are often targeted at young people in deprived communities, particularly young women *(29)*. Evidence links gambling (online and in betting shops and other outlets) with deprivation and adverse mental health outcomes *(30)*.

## *Road injury*

About 1.3 million people die each year on the world's roads and a further 20–50 million sustain non-fatal injuries *(31)*. Most road fatalities involve men between the ages of 10 and 19 *(31)*, with the highest casualties found in the central Asian states. In Kazakhstan, for example, there are 24.2 deaths per 100 000 population per year, and in Kyrgyzstan, 22.0 deaths per 100 000. The lowest rates are found in western Europe (2.8 and 2.9 deaths per 100 000 per year in Sweden and the United Kingdom respectively).

WHO research suggests that driving under the influence of drugs is one of the five main causes of accident-related injuries *(32,33)*. There is evidence that road injuries are higher among people from lower SES backgrounds *(34–37)*. People from lower socioeconomic areas are almost twice as likely to be involved in a motor vehicle collision compared to people from high socioeconomic areas *(37,38)*. Alcohol consumption is often a contributory factor in road accidents *(39)*. Evidence from southern Europe demonstrates that women have a higher risk of road-traffic injury than men, but severity is worse among men *(40)*; this in turn is linked to differences in risk exposure related to gender norms *(41,42)*.

## *Violence and gender-based violence*

Interpersonal violence (family and intimate-partner violence, and community violence) particularly impacts on young adults *(43)*. More than 15 000 young Europeans are murdered each year, over 40% with a knife *(44)*, and many more are hospitalized from their injuries. Young men account for over 80% of these deaths *(45)*.

Men are much more likely to be perpetrators of violence and women are much more likely to be victims, a finding that is related to traditional masculine gender norms *(2)*. Sexual violence and gender-based violence and bullying are significant issues for young women. Up to 24% of women surveyed in the *WHO multi-country study on women's health and domestic violence against women (46)*, for example, reported that their first sexual experience was forced.

Human trafficking for the sex trade is an increasing issue across the WHO European Region, with young women being sent from poorer parts of the Region to richer parts for the purpose of sexual exploitation. It is a form of gender-based violence that disproportionately affects women – 95% of registered victims of trafficking for sexual exploitation in the EU are women or girls *(47)*.

International reviews consistently have shown an association between deprivation and risks of being both a perpetrator and a victim of violence *(43,48)*. A study in the United Kingdom (England) found that in males aged between 17 and 19, violence accounted for 20% of the difference between the most and least deprived quintiles in all-cause emergency hospital admissions *(49)*. Violent crime increases psychological distress, reduces quality of life, has financial costs to the judicial system and leads to lost productivity *(50–52)*.

## Sexual health

HIV incidence in the WHO European Region nearly doubled between 2000 and 2013, from 3.5 per 100 000 to 6.7 *(53)*. Rates are much higher in the east of the Region *(21)*, but deaths from HIV/AIDS have decreased significantly since 2007 due to improved access to antiretroviral treatment *(21)*. Increased prevalence of HIV has been accompanied by a larger number of *Chlamydia trachomatis* infections reported in countries of the EU and European Economic Area *(54)*. Three quarters of all chlamydia infections in Europe are detected in the young adult age group (15–24 years) *(54)* and there is strong evidence of socioeconomic inequalities in sexually transmitted disease. An international systematic review, for example, found that disadvantaged young people across multiple axes of disadvantage, including lower educational attainment, lower occupational class and residence in deprived areas, have an increased risk of having chlamydia infection *(55)*. Girls and young women aged 15–20 have twice the chlamydia prevalence of boys *(56)*, which is attributed to girls having older sexual partners.

HIV is strongly associated with social disadvantage, including injecting drug use, homelessness and migration status *(21,57,58)*. In 2016, over 160 000 people in the WHO European Region were newly diagnosed with HIV, 9% of whom were young people aged 15–24. Most of these cases (69%) were young men *(21)*.

Inequalities exist across the Region in unmet need for family-planning services, with women from more affluent countries and backgrounds having better access *(59)*.

## Drug use

Young adults may experiment with illicit drugs such as cannabis, cocaine, amphetamine and ecstasy, during the transition to adulthood. This can disrupt future education, employment and other life circumstances *(60)*.

Data from the European Monitoring Centre for Drugs and Drug Addiction highlight drug prevalence rates across Europe *(61)*:

- cannabis use ranges from 0.4% in Turkey to 22.1% in France
- cocaine use ranges from 0.2% in Greece and Romania to 4.2% in the United Kingdom

- ecstasy use ranges from 0.1% or less in Italy and Turkey to 3% in Czechia and the United Kingdom
- amphetamine use ranges from 0.1% or less in Romania, Italy and Portugal to 2.5% in Estonia.

Young adults from lower SES backgrounds are more likely to use drugs and experience related health (including drug-related death) and social harms *(62)*. Addiction rates are lowest among young adults from higher socioeconomic backgrounds *(60,63,64)*, while low income and unemployment have a strong association with addiction at all ages *(64–66)*. Drug use also varies by gender: data from the EU and neighbouring countries for young adults (between the ages of 15 and 34 years) show consistently higher rates of cannabis use by young men (range 0.4% to 21.5%) than young women (range 0.1% to 15.5%) *(67)*.

# Evidence

This chapter outlines the key social determinants of health that negatively impact on health inequalities during the young-adult life-course stage. It includes discussion of the economic cost of inequalities and the economic benefits of health equity.

## Social determinants of health among young adults

The WHO Commission on Social Determinants of Health *(5)* defined the social determinants of health as:

> *the conditions in which people grow, live, work and age and the systems put in place to deal with illness … The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.*

The following key social determinants are examined: access to health services; living conditions; personal and community capabilities; working conditions; and unemployment and social protection.

### *Access to health services*

Access to health care is important for young adults, particularly those who have pre-existing conditions. Universal and free access to health care is vital to reducing health inequalities across the life-course, but provision of health care is less in countries and regions that have higher health need – the so-called inverse care law *(68)*.

Across the life-course, people from lower SES backgrounds are less likely to access and use health-care services than those in higher SES groups with the same health need *(69,70)*. Inequalities in access to health care for young adults arise from issues of accessibility (due to geographic, legal and information barriers, and privacy) and affordability (service costs and the lower purchasing power of young adults) *(71)*. The transition from paediatric to adult care can be particularly difficult for young adults with chronic conditions. Unplanned transfers may affect education, work and health and result in patients being lost to follow-up, poor treatment adherence and more frequent hospitalization *(72)*. How this transfer is managed, and whether adolescent-only facilities are available, could directly affect young adults' care and health outcomes *(73)*.

### *Living conditions*

Housing is an important determinant of health inequalities *(74)*. People living in lower-quality, or insecure, accommodation have poorer health than others *(75)*. Expensive rents and high housing costs can have a negative effect on health, as expenditure in other areas (such as diet) is reduced *(76)*. Housing costs may also impact negatively on health through the burden of debt involved in home ownership or high rents leading to anxiety and worry *(77)*. Low housing quality (such as damp homes, poor safety or sanitation, or overcrowding) also have negative impacts on health (manifested in, for instance, increased rates of respiratory disease).

Insecure housing tenure (such as short-term rental contracts) have negative psychosocial impacts on health, particularly mental health *(78)*. Young adults are particularly likely to be exposed to poor

housing as they are more likely to be renting, have lower incomes and less security of tenure *(79)*. Young adults are also more likely to experience homelessness *(80)*. Migrants (most of whom are younger adults) are at risk of poor living conditions due to discrimination, unemployment and poverty (with young women migrants being particularly vulnerable). Migrant householders are three times less likely to be homeowners; the overcrowding rate among those born outside the EU and aged 20–64 stands at 25% (compared with 17% for nationals), and the housing-cost overburden rate for non-EU citizens of working age is 30% (compared to 11% among nationals) *(81)*.

## *Personal and community capabilities*

Personal and community capabilities have a strong association with health inequalities across the life-course. Disadvantage in young adulthood can lead to worse outcomes in the future *(82)*. Lower rates of individual and community social capital *(83)*,[3] and levels of control, resilience and trust are associated with poorer health outcomes *(83,84)*.

Social networks and supportive personal relationships are also important for health inequalities. Social isolation and loneliness are associated with poorer health outcomes, including lower life expectancy *(85)*. Access to good-quality education and lifelong learning are associated with better health outcomes *(86,87)*, as is volunteering and participation in communal social activities (such as faith groups or youth associations *(88)*).

Literacy and health literacy are important for health (in relation to, for example, accessing services and the labour market), particularly among women living in lower-income communities and countries *(89–91)*. Teenage pregnancies affect education and training opportunities as well as future earnings, leading to worse health outcomes over the life-course both for parents and their children *(92)*. Young men and women from deprived backgrounds are more likely to become single parents *(92)*. Young adults from low socioeconomic backgrounds are also more likely to be carers for family members with health problems or disabilities *(93,94)*. This adversely affects their educational outcomes and employment opportunities, and their mental health *(93)*.

Health behaviours influenced by the commercial determinants of health (alcohol, smoking, physical activity rates, nutrition, gambling and drug use) are very strongly socially patterned among young adults and are associated with adverse health outcomes *(53,95–99)*. Personal and community capabilities are also socially patterned, with lower levels among more socioeconomically disadvantaged people and communities having an impact on health inequalities across the life-course *(100–102)*.

## *Employment and working conditions*

The work environment is an important determinant of health and health inequalities across the life-course. As a result of their labour-market position, young adults from low SES backgrounds are more likely to be in health-damaging jobs (including temporary or insecure work, working longer hours, being in more physically demanding work and/or on lower wages), which over the life-course is associated with poorer health outcomes. EU data from 2017 suggest the percentage of temporary employees among young adults (15–24) is 44.0%, compared to only 14.4% for the whole working-age population (15–64) *(103)*. These occupational exposures accumulate over their working life, leading to inequalities in health in later life *(104)*. They can also contribute in the short term to inequalities in mental health among young people.

[3] Social capital refers to reciprocity, trust, civic identity, civic engagement, feelings of belonging and community networks.

The health problems associated with the physical work environment (such as noise, heavy loads and exposure to chemicals) are more prevalent among manual than non-manual workers *(104)*. European working conditions survey data show that the lowest occupational groups (manual workers or those in low-paid insecure work) have 50% higher exposure to most physical hazards than the highest occupational groups (managers or professionals) *(104)*.

People in lower-status jobs also experience higher exposure to adverse psychosocial working conditions (including time pressure, monotonous work, social reciprocity, job control and autonomy, fairness, work demands, job security and social support *(104)*) that results in an increased risk of stress-related morbidity, including coronary heart disease *(105)*, adverse health behaviours (such as unhealthy food habits, physical inactivity, heavy drinking and smoking) *(106)*, obesity *(107)*, musculoskeletal conditions *(108)* and mental health problems *(109)*.

Flexible or precarious employment (informal work, temporary or fixed-term work, uncontracted hours (zero hours), part-time work and other less regulated forms of labour), which are more common among women, are also associated with adverse mental and physical health outcomes *(59)*. Adverse working conditions make it harder to access health-care services due to the constraints of irregular working hours or because health insurance is tied to employment contracts. This is important in the EU, but also for other countries in the WHO European Region, where informal jobs account for a growing proportion of the workforce. In the Russian Federation, for example, informal jobs account for 16% of the national workforce, but with substantial regional inequalities ranging from less than 5% in the affluent cities of Moscow and St Petersburg to over 20% in the poorer Southern and North-Caucasus regions *(110–112)*.

Disability leads to exclusion from employment *(113)*. Gender segregation in jobs based on traditional gender norms is also an issue. The extent of this varies across the Region. Young women from low socioeconomic backgrounds are increasingly more likely to be in low-skill, low-paid jobs, contributing considerably to the gender pay gap between men and women *(114)*. They are also more likely to work part-time, reducing their overall earnings and lowering their pension contributions, which may contribute to poverty in later life *(114)*.

## *Income and social protection*

Social protection[4] can mitigate the consequences of unemployment and/or precarious employment *(104)*. In general, there is evidence that providing income protection for people who are unemployed or experiencing sickness, old age or other situations of need (such as lone parenthood, inactivity or underemployment) is associated with better population health outcomes (as measured by, for example, lower infant mortality rates, better child health and well-being, and lower mortality rates for all age groups and across all socioeconomic groups) *(115)*. A further issue exacerbating inequalities is the decline in wages and reduction in the share of wealth that goes to workers that has been seen since the 1970s *(116)*.

Health inequalities among young adults are affected by unemployment, low income and social protection policies in a variety of ways. For example, young adults may receive less financial benefits than older people due to eligibility criteria *(117)*. In 2015, for instance, the United Kingdom severely restricted access to housing benefits for 18–21-year-olds *(118)* and to income-related benefits for single parents *(92)*. Similarly, benefits in social insurance systems are often linked to prior work history and

[4] Social protection refers to a bundle of state-provided income-support entitlements in different adverse circumstances, such as sickness benefits, unemployment compensation, pension plans and lone parenthood.

previous wage levels, both of which are usually lower for young adults. Unemployment protection for young adults in the Nordic countries has been reduced, now covering only 10% of unemployed young Swedes and Finns and 45% of unemployed Norwegians aged 24 or younger *(119)*. Outside the EU, social protection tends to be less generous across all age groups: in the Russian Federation, for example, unemployment benefits are fixed for 12 months *(120–122)*.

Low, or reduced access to, benefits may lead to an increased risk of homelessness among young adults. The impact of low social protection is acutely felt by one-parent families. There have been significant reductions in the support available to lone parents across Europe since the early 2000s, which particularly affects young women *(123)*.

Unemployment is another important determinant of health inequalities among young adults. Unemployment increases the chances of poor health *(25)*, including an increased likelihood of mortality *(26)*, poor mental health and suicide *(27)*, self-reported poor health and life-limiting long-term illness *(28)*, and risky health behaviours *(29)*. Social protection policies can mitigate the effects of unemployment on health *(16)*. People from lower SES groups are disproportionately at risk of unemployment *(31)*, and unemployment rates are higher among young adults than other groups (as noted in terms of NEETs). Research has demonstrated that NEET status in early adulthood has an independent effect on the development of later labour-market opportunities for both young men and young women *(124)*, and that NEET status is a mechanism for social exclusion *(124)*.

## Economic costs of health inequalities

This section discusses the economic cost of inequalities and the economic benefits of health equity. Health inequalities result in unnecessary premature deaths, entailing large economic costs in terms of lower productivity and higher health-care and welfare costs *(125)*. Better health and lower health inequalities improve productivity, reflected in higher labour-market participation rates, better working hours, and higher rates of consumption and efficiency *(126–128)*.

It has been estimated that the costs of SES inequalities in health across the EU amount to 9.4% of gross domestic product (GDP) *(125)*. Annually, 700 000 deaths per year in the EU are attributable to inequality, accounting for 20% of total costs of health care and 15% of total costs of social security benefits *(126)*. Increasing the health of the lowest 50% of the European population to the average health of the top 50% would improve labour productivity by 1.4% of GDP each year, meaning that EU GDP would be more than 7% higher within five years of these health improvements being introduced. Data from the United Kingdom (England) in 2012 suggest that over 250 000 excess hospitalizations are associated with inequalities in health *(129)*, with an estimated cost to the health-care system of £4.8 billion per year *(130)*.

Inequalities in unhealthy behaviours also incur economic costs. For example, the total cost of smoking – health spending on treating smoking-attributable diseases and smoking-related productivity losses – are estimated to have cost the EU €7.3 billion in 2009 *(131)*. Similarly, the global costs attributable to alcohol represent from 1.3–3.3% of GDP *(132,133)*. This amounted to between €200 and €500 billion in the EU in 2017 *(134)*.

The economic burden associated with unhealthy diets and low physical activity rates is also large. It was estimated that the cost of obesity to the EU in 2012 was more than €80 billion per year *(135)*, of which diabetes amounted to €883 million for France, Germany, Italy, Spain and the United Kingdom alone

*(136)*. While much of these costs appear later in life as health inequalities become starker, prevention interventions are needed across the life-course, including at the crucial stage of young adulthood.

There is clear evidence of return on investment in terms of interventions that target early-years and school-aged children *(137)*, but there is little evidence on return on investment for interventions targeted at young adults or NEETs *(13)*. This is something that should be addressed in future research.

# Policies

This chapter outlines policies that could reduce health inequalities among young adults by acting on the social determinants, including outlining specific indicators to measure change within different policy areas and highlighting country examples.

## Policies to reduce health inequalities among young adults

Tables 2–6 describe the policies that could reduce health inequalities among young adults across each of the key determinants, alongside a summary of supporting evidence.

**Table 2. Health-care access policies**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES[a] |
|---|---|---|---|---|
| Access and health-care quality | • Private health insurance may discourage young adults (particularly from low-SES backgrounds) from seeing health professionals due to cost, leading to late diagnoses, morbidity and mortality<br>• General practitioners and hospitals should be sufficient to cover a population, ensuring young adults can seek the primary, secondary or tertiary health and social care they require in a timely manner<br>• Young adults from deprived or ethnic minority backgrounds may be reluctant to engage with health services or may experience discrimination within them, leading to poorer health outcomes<br>• Health care should provide universal access to high-quality prevention services (especially in terms of mental health and sexual health services)<br>• People with disabilities may struggle to access high-quality and affordable health care | • Universal provision of primary, secondary and tertiary health and social care across the life-course<br>• Adequate level of health system facilities across the population, with additional services where need is highest<br>• Training for health-system staff and outreach work with vulnerable groups<br>• Universal provision of high-quality prevention services, with additional services where need is highest<br>• People with disabilities have financial and practical help to access services<br>• Existing health services are youth-friendly and primary care services are responsive to adolescents' and young people's needs | • Self-reported health in young adults (age 16–25) | ✓ |
| | | | • Life expectancy | ✓ |
| | | | • Private medical expenditure | × |
| | | | • Public expenditure on health as percentage of GDP | × |
| | | | • Public expenditure on public health as percentage of GDP | × |
| | | | • Physicians or doctors per 100 000 inhabitants | × |
| | | | • Self-perceived quality in health care | ✓ |
| | | | • Self-reported unmet needs for health care (by age) | ✓ |
| | | | • Development of subnational health-care resource allocation formulae | × |
| | | | • Policies protecting rights of non-national migrants to health care services in a country | × |
| | | | • Screening (cervical) | ✓ |
| | | | • Avoidable admissions per 100 000 population | × |
| | | | • Out-of-pocket expenses (OOPs) | × |
| | | | • Impoverishing OOPs | × |
| | | | • Catastrophic OOPs | × |
| | | | • People providing informal care or assistance at least once a week | × |
| | | | • Tuberculosis | × |
| | | | • Prevalence of self-reported diabetes | ✓ |
| | | | • Health-care audit to assess accessibility for people living with disabilities | × |

**Table 2 contd**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES[a] |
|---|---|---|---|---|
| | | | • Money spent on improving access for people with disabilities | × |
| | | | • Number of suicides and attempted suicides | × |
| | | | • Youth self-harm fatalities | × |
| | | | • Youth stress | × |
| | | | • Youth perceptions of health | × |
| | | | • Self-perceived long-standing limitations in usual activities due to health problems (by age) | × |
| | | | • People having a long-standing illness or health problem (by age) | ✓ |
| | | | • People reporting an accident resulting in injury | ✓ |
| Adequate provision of mental health and sexual health services | • Young adults, particularly low-SES young men, are at high risk of mental health problems and health-care services may struggle to identify and treat those at risk<br>• Young adults, particularly low-SES, are at high risk of sexually transmitted diseases (STDs) | • Universal provision of mental and sexual health services – proportionate to need<br>• Adequate level of mental and sexual health system facilities across population, with additional services where need is highest<br>• Training for health-system staff and outreach work with vulnerable groups<br>• Universal provision of high-quality mental and sexual health prevention services, with additional services where need is highest<br>• Integrated mental health provision in schools and health services<br>• More spending on mental health services<br>• Anonymous sexual health diagnosis and free treatment regardless of immigration status | • Suicide rate among young people | × |
| | | | • Money spent on mental health as a proportion of total budget | × |
| | | | • WHO five-point Mental Well-being Scale | ✓ |
| | | | • Life satisfaction | ✓ |
| | | | • HIV and other STD rates | × |
| | | | • Money spent on preventive services as a proportion of total budget | × |
| | | | • Adolescent fertility rate (births per 1 000 women ages 15–19) | × |
| | | | • Unmet need for family planning services for women aged 15–49 by wealth | × |
| | | | • Unintended pregnancies | × |
| | | | • Unmet need for family planning services for women aged 15–49 by wealth | × |
| | | | • Psychological distress of young people | × |

[a] Policy indicators that disaggregate data by SES determined using Health Atlas and Eurostat data.

**Table 3. Living-conditions policies**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| Housing | • Young adults, especially those of low SES, are more likely to be in privately rented property, leaving them at increased risk of high costs, poorer quality and homelessness<br>• Low-quality housing standards can increase the risk of poor mental, physical and social health and well-being linked to inadequate heating, ventilation, water supply and accidents in the home | • Adequate social housing<br>• Incentives offered to developers to build property<br>• Privately rented homes are a good standard (ensured via regulation and inspections, for instance)<br>• Rent controls and tenure regulation<br>• Sufficient hostels and accommodation for homeless people and support to transition to more permanent housing<br>• Quality of housing in relation to, for instance, sanitation and ventilation ensured | • Housing-cost overburden rate | ✓ |
| | | | • Housing-cost overburden rate for young people | × |
| | | | • Prevalence of safety managed water services and location of source, disaggregated by urban/rural or wealth quintile | ✓ |
| | | | • Percentage of population with basic or safely managed sanitation services, disaggregated by urban/rural or wealth quintile | ✓ |
| | | | • Severe housing deprivation rate | ✓ |
| | | | • Severe material deprivation rate of young people | × |
| | | | • Inability to adequately heat home | ✓ |
| | | | • Overcrowding | × |
| | | | • Public spending on housing and community amenities as percentage of GDP | × |
| | | | • Inability to adequately heat home | × |
| | | | • Statutory rights protecting security of tenure/property rights | × |
| | | | • Satisfaction with living environment | ✓ |
| | | | • Housing overcrowding | ✓ |
| | | | • Overcrowding rate for young people | × |
| | | | • Disability-adjusted life-years (DALYs) due to unsafe sanitation | × |
| | | | • Share of households receiving housing allowance | ✓ |

**Table 3 contd**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| Environment | • Young adults living in deprived communities may be exposed to poor-quality built environments (leaving them exposed to, for instance, air pollution and crime)<br>• Young adults are disproportionately exposed to violence<br>• Young people may not afford private transport and therefore need good-quality public transport at affordable prices<br>• Young adults should be protected from harms from unhealthy foods, alcohol and smoking | • Access to high-quality built environments for young adults that encourage healthy behaviours and limit exposure to pollutants<br>• Legislative approaches to tax unhealthy substances (such as tobacco and alcohol)<br>• Regulation to discourage unhealthy behaviours (such as banning tobacco advertising or banning alcohol in public places)<br>• Interventions to reduce the harmful use of drugs<br>• Restrictive firearm licensing and purchasing policies<br>• Community and problem-oriented policing<br>• Interventions to reduce concentrated poverty and upgrade urban environments | • DALYs due to air pollution | ✗ |
| | | | • Percentage reporting pollution/grime/other environmental problem | ✓ |
| | | | • Passenger cars, by type of motor energy and size of engine | ✗ |
| | | | • Road deaths | ✗ |
| | | | • Annual average nitrogen dioxide ($NO_2$) concentrations in the air | ✗ |
| | | | • Percentage reporting difficulty accessing green space | ✓ |
| | | | • Access to public transport | ✓ |
| | | | • Feeling unsafe walking around after dark | ✓ |
| | | | • Feeling unsafe from crime in your own home | ✓ |
| | | | • Value-added tax (VAT) on alcohol | ✗ |
| | | | • Tobacco excise tax as a percentage of retail price | ✗ |
| | | | • Regular alcohol consumption (at least weekly) | ✓ |
| | | | • Violent claim rate (fatal and non-fatal) | ✗ |
| | | | • Hospital admissions for violent attacks | ✗ |
| | | | • Youth tobacco use | ✓ |
| | | | • Youth road fatalities | ✗ |
| | | | • Youth interpersonal violence | ✗ |
| | | | • Human trafficking | ✗ |
| | | | • Youth perceptions of government | ✗ |
| | | | • Young people living with their parents | ✗ |
| | | | • Food insecurity | ✓ |

**Table 4. Personal and community capabilities**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| Low levels of social and community capital | • Youth engagement measured in terms of membership of political parties, and turnout in elections has decreased<br>• Youth engagement in volunteering and civic engagement (such as faith groups and youth associations)<br>• Young adults from deprived backgrounds are more likely to be carers | • Culture of empowerment created, whereby young people are engaged in politics and feel there are opportunities for their views to be heard<br>• Community control and participation over decisions increased<br>• Outreach activities to build resilience, capabilities and inclusion, including e-health and m-health<br>• Volunteering encouraged<br>• Support for young carers through education, health-care and social-care interventions | • Participation in voluntary activities | ✓ |
| | | | • Youth participation in civic groups | × |
| | | | • Public spending on housing and community amenities as percentage of GDP | × |
| | | | • Perceived ability to influence politics | ✓ |
| | | | • Trust in others | ✓ |
| | | | • Frequency of meeting socially with friends, relatives or colleagues | × |
| | | | • Self-reported social support in young people | × |
| | | | • People who have someone to ask for help | × |
| | | | • Freedom of choice and control over one's life | × |
| | | | • Perceptions of government corruption | × |
| | | | • Equal treatment under the law and absence of discrimination | × |
| | | | • Youth policy | × |
| | | | • Age for holding elected office | × |
| | | | • Youth perceptions of government | × |
| Poor education and learning chances | • Young adults who come from low-SES backgrounds have poorer educational attainment, leading to unemployment/ low-paid jobs<br>• NEET status leads to stigma and exclusion | • Education policies, including life-long learning and child development<br>• Increased funding for children/young adults from low-SES backgrounds<br>• Apprenticeship opportunities in a range of technical and service organizations | • Youth literacy | × |
| | | | • Public spending on education | × |
| | | | • Upper-secondary completion | × |
| | | | • Proportion of 20–29-year-olds with low educational attainment level (ISCED[a] 0–2), percentage | × |
| | | | • Early leavers (18–24), percentage | × |

**Table 4 contd**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| | | • Outstanding teaching for all, especially for those children and young adults in deprived areas<br>• School liaison officers to help families and students achieve their potential<br>• Support NEETs with educational and vocational services | • Number of apprenticeships undertaken/ those completing tertiary education | ✗ |
| | | | • Youth satisfaction with education | ✗ |
| | | | • Number of young adults achieving good secondary qualifications | ✗ |
| | | | • School ratings | ✗ |
| | | | • School dropout rates | ✗ |
| | | | • Percentage of children/young people minimally proficient in reading and mathematics | ✗ |
| | | | • Participation rate in formal and non-formal education and training | ✗ |
| | | | • Literacy rate | ✗ |
| | | | • Participants per 100 looking for work | ✗ |
| | | | • Public spend on active labour-market policies as percentage of GDP | ✗ |
| Health behaviours and commercial determinants | • Unhealthy behaviours (such as smoking, alcohol) are higher among low-SES young adults in most countries<br>• Low-SES young adults are less likely to be physically active and eat well | • Use regulatory and fiscal approaches to discourage unhealthy behaviours and promote healthy choices<br>• High-quality universal health education and health promotion<br>• Universal access to prevention services (such as smoking cessation)<br>• Income for adequate diet<br>• Tobacco advertising banned | • Youth tobacco consumption | ✓ |
| | | | • Alcohol consumption (regular and binge) | ✓ |
| | | | • Obesity/overweight | ✓ |
| | | | • Physical activity in children | ✓ |
| | | | • Food insecurity | ✗ |
| | | | • Money spent on preventative services as a proportion of total budget | ✗ |
| | | | • Sports club participation | ✗ |
| | | | • Body mass index (by age) | ✓ |

[a] ISCED: International Standard Classification of Education.

**Table 5. Working conditions**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| Type/ quality of employment | • Low-SES young adults are more likely to be in poorer-quality jobs (insecure, temporary, informal)<br>• Low-SES young adults are more likely to have unstable and insecure jobs<br>• Low-SES young adults are at greater risk of low pay and poverty<br>• Low-SES young adults are at greater risk of work/life imbalance<br>• The gender pay gap particularly impacts on young women from low-SES backgrounds | • Employment legislation and rights for temporary workers are enforced<br>• Access to unions for those not traditionally seen as employees<br>• Legislative ban for zero-hour contracts<br>• Regulation to give temporary workers access to holiday entitlement, sick leave and pension<br>• A living wage for all workers<br>• Occupational health and safety legislation is in place and enforced<br>• Work/life balance protected through enforcing national working-week legislation with sanctions for those who are in breach<br>• Reduced gender pay gap through legislation, monitoring and sanctions | • Workers by type (permanent, temporary) | ✗ |
| | | | • In-work at-risk-of-poverty rate for young people by sex and age | ✗ |
| | | | • Young people living in households with very low work intensity | ✗ |
| | | | • Youth employment | ✓ |
| | | | • Average wages/earnings | ✗ |
| | | | • Numbers of workers paying into pension | ✗ |
| | | | • Employment by sector | ✗ |
| | | | • Job strain | ✓ |
| | | | • Accidents at work | ✓ |
| | | | • Disability employment gap | ✗ |
| | | | • Statutory nominal gross monthly minimum wage | ✗ |
| | | | • Average wages/earnings | ✗ |
| | | | • Collective bargaining coverage rate (%) | ✗ |
| | | | • Average number of labour inspectors per 10 000 employed people | ✗ |
| | | | • Collective bargaining coverage rate (%) | ✗ |
| | | | • Trade union density rate | ✗ |
| | | | • Self-reported work-related health condition | ✓ |
| | | | • DALYs due to occupational exposure | ✗ |
| | | | • Proportion of workers working in excess of 40 hours per week | ✗ |
| | | | • Underemployed part-time workers | ✗ |

**Table 5 contd**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| | | | • People seeking work but not immediately available | ✗ |
| | | | • People available to work but not seeking | ✗ |
| | | | • Minimum entitlement to paid annual leave | ✗ |
| | | | • Skills and discretion index | ✓ |
| | | | • Involuntary part-time employment as a percentage of the total part-time employment for young people | ✗ |
| | | | • Main reasons for part-time employment of young people | ✗ |
| | | | • Part-time employment as a percentage of the total employment for young people | ✗ |
| | | | • Young temporary employees as percentage of the total number of employees | ✗ |
| | | | • Youth self-employment | ✓ |

**Table 6. Unemployment and social protection**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| Social protection | • Social protection is an important determinant of health<br>• Young adults are often excluded from social protection<br>• Social protection levels have been eroded so that they seldom provide an adequate standard of living | • Increased spending on social protection<br>• Relaxed criteria for receipt of benefits<br>• Young adults are eligible for benefits<br>• Any child benefit payments continue until the end of full-time education | • Poverty | ✗ |
| | | | • Young people at risk of poverty | ✗ |
| | | | • In-work poverty | ✓ |
| | | | • Disability poverty gap | ✓ |
| | | | • Indicator of income inequality (Gini) | ✓ |

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| | | • Benefit levels raised so they are adequate for a healthy life<br>• Eligibility for 16–25-year-olds | • Loss of earnings from moving to unemployment benefits as share of previous earnings | ✗ |
| | | | • Proportion of poor people covered by social protection systems | ✗ |
| | | | • Public social protection expenditure on benefits for people of working age (including general social assistance) as a percentage of GDP | ✗ |
| | | | • Catastrophic and impoverishing OOPs for health | ✗ |
| | | | • Redundancy pay at two years of tenure, in months | ✗ |
| | | | • OOP health expenditure as a percentage of total health expenditure | ✗ |
| | | | • Inactivity rate | ✗ |
| | | | • Share of long-term unemployed | |
| | | | • Share of temporary employees | ✓ |
| | | | • Labour-force participation rate | ✗ |
| | | | • Social protection expenditure | ✗ |
| | | | • Coverage, benefit incidence and adequacy of social assistance programmes | ✗ |
| | | | • Ratification of International Labour Organization social protection conventions by programme | ✗ |
| | | | • Public spend on active labour-market policies as percentage of GDP | ✗ |
| | | | • Length of paid maternity, parental and home-care leave available to mothers in weeks | ✗ |

**Table 6 contd**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| | | | • Length of paid paternity and parental leave reserved for fathers in weeks | ✗ |
| | | | • Percentage of mothers with newborns receiving maternity benefits | ✗ |
| | | | • Coverage of social assistance programmes (Aspire data) | ✗ |
| | | | • Incidence of social assistance programmes (Aspire data) | ✗ |
| | | | • Adequacy of social assistance programmes (Aspire data) | ✓ |
| | | | • Labour share of GDP (wages and social protection transfers) | ✗ |
| Unemployment | • Unemployment places young adults more at risk of poverty and homelessness<br>• NEETs rates are high among young adults | • Social protection as a social safety net extended to all young adults<br>• Universal basic income<br>• Active labour-market programmes<br>• Increased public and private investment into areas with low employment rates<br>• Volunteering encouraged to improve future work prospects | • Youth unemployment rate (%), 15–24 | |
| | | | • Youth unemployment ratio (%), 15–24 | ✓ |
| | | | • Youth unemployment ratio (15–24) to adult unemployment ratio (25–74) (by sex and age) | ✗ |
| | | | • Percentage youth unemployed for long periods | ✗ |
| | | | • NEET rate (percentage of population 15–24 and 25–29) | ✓ |
| | | | • NEET rate (15–24) by labour-market status (percentage of population) | ✓ |
| | | | • Composition of the NEET population | ✗ |
| | | | • Employment-to-population ratio of young people aged 15–24 and 25–29 (percentage of population) | ✗ |
| | | | • Young people (20–24) educational attainment level (ISCED[a] 3 and over) (%) | ✓ |

**Table 6 contd**

| Risk factors | Evidence | Policy intervention areas | Policy indicators to measure change | Data available by SES |
|---|---|---|---|---|
| | | | • Youth (20–24) educational attainment level (ISCED 3 and over) (%) | ✓ |
| | | | • Employment rates of individuals (20–34) recently graduated (ISCED 3–8) (%) | ✓ |
| | | | • Labour share of GDP (wages and social protection transfers) | × |
| | | | • Proportion of unemployed receiving unemployment benefits | × |
| | | | • Share of temporary employees | × |
| | | | • Earnings loss from moving to unemployment benefits as share of previous earnings | × |
| | | | • Public spend on active labour-market policies as percentage of GDP | × |
| | | | • Youth long-term unemployment rate | × |
| | | | • Youth long-term employment rate | ✓ |
| | | | • Economic inactivity rate | × |

[a] ISCED: International Standard Classification of Education.

# Examples of successful interventions, including country examples

The most important interventions from Table 2 are highlighted in the policy basket (Fig. 3), colour-coordinated by policy area. This section also provides an overview of the evidence base underpinning the policy basket, with country examples. While presented as single areas for intervention, it should be noted that holistic policy approaches drawing across the full policy basket are needed.

**Fig. 3. Basket of policy interventions**


## *Universal health care*

Private health insurance, out-of-pocket payments and the marketization or privatization of health- and social-care services increase health inequalities' effects *(138)*. Increased private insurance contributions in France, for example, led to increases in inequalities in access to services *(138)*. Evidence from Sweden and the United Kingdom suggests that the marketization and privatization of health-care services also have negative health equity effects, with those from the lowest income groups less likely to access health-care services relative to need *(138)*. This is important for young adults: a universal health-care system, free at the point delivery and with supplementary targeted outreach policies, would enable young adults to access health care in a timely manner and reduce inequalities across the life-course.

## *Access to good–quality housing*

Improving neighbourhoods for communities and providing safe, secure, affordable, suitable, temperate and energy-efficient housing for the most disadvantaged groups can improve health and reduce health inequalities *(75)*. In the United Kingdom, for example, internal housing improvements (such as warmth- and energy-efficiency measures, rehousing and refurbishment) have had positive impacts on health, particularly when targeted at vulnerable groups *(75)*. Access to good-quality housing would benefit the health and well-being of young adults given their higher exposure rate, thereby reducing inequalities across the life-course.

## *Personal capabilities*

Young adults, among others, can also benefit from supportive and health-enhancing public health polices to improve health behaviours and thereby reduce health inequalities *(139)*. Effective interventions include taxes on unhealthy food and drinks, food-subsidy programmes for low-income women,[5] banning tobacco advertising, water fluoridation, a nutrition programme targeted at low-income families to improve fruit and vegetable consumption, reproductive cancer screening information campaigns and population-wide screening programmes. Evidence is emerging from a community empowerment initiative in the United Kingdom (England) that increasing levels of individual and collective control in low-SES groups and communities can improve health *(140)*.

## *Working conditions*

Increasing control at work is another way in which health can be improved *(141)*. For example, there is international evidence to suggest that workplace interventions that increase worker control and choice (such as participation in management, control of tasks or self-scheduling of working hours) are likely to have a positive effect on health outcomes *(142,143)*, as suggested by the demand–control–support model of workplace health. The hypothesis is that employee health may negatively be associated with job demands and positively associated with control and social support in the workplace (see, for example, Marmot et al. *(106)*). Given the higher prevalence of low-control jobs among low-SES young adults, these interventions might reduce health inequalities across the life-course.

## *Unemployment and social protection*

International evidence shows that increased unemployment-benefit generosity may improve population mental health by reducing financial strain, poverty and insecurity *(13)*. This would be particularly relevant to NEETs, who are more susceptible to mental health problems. Evidence also suggests that interventions to increase employment among NEETs can potentially improve health by increasing income. A recent international evidence review, for example, found that multicomponent interventions that used social skills, vocational or educational classroom-based training, counselling or one-to-one support, internships, placements, on-the-job or occupational training, financial incentives, case management and individual support led to a 4% increase in employment outcomes *(13)*.

[5] Food subsidy programmes provide healthy foods, referrals to health and social services and nutrition education to pregnant women and families with young children *(139)*.

# Member State commitments

This chapter outlines Member State commitments that give policy-makers the mandate to take action on young adults' health, alongside European priorities and policy drivers such as:

- European Pillar of Social Rights *(144)*
- United Nations Convention on the Rights of Persons with Disabilities *(145)*
- Copenhagen Consensus of Mayors: healthier and happier cities for all *(146)*
- WHO Framework Convention on Tobacco Control *(147)*.

## WHO mental health action plan: core objectives

The core objectives of the *European mental health action plan 2013–2020 (148)* are that:

1. everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk;
2. people with mental health problems are citizens whose human rights are fully valued, protected and promoted;
3. mental health services are accessible and affordable, available in the community according to need; and
4. people are entitled to respectful, safe and effective treatment.

## WHO response to youth violence

WHO is committed to *(149)*:

- developing a package for schools-based violence-prevention programmes;
- drawing attention to the magnitude of youth violence and the need for prevention;
- building evidence on the scope and types of violence in different settings;
- developing guidance for Member States and all relevant sectors to prevent youth violence and strengthen responses to it;
- supporting national efforts to prevent youth violence; and
- collaborating with international agencies and organizations to prevent youth violence globally.

## WHO global accelerated action for the health of adolescents

WHO published a major report, *Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation (150)*, in May 2017. The AA-HA! guidance has drawn on inputs received during extensive consultations with Member States, United Nations agencies, adolescents and young adults, civil society and other partners. It aims to assist governments in deciding what they plan to do and how they plan to do it as they respond to the health needs of adolescents in their countries. This

reference document targets national-level policy-makers and programme managers to assist them in planning, implementing, monitoring and evaluating adolescent health programmes.

## United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child *(151)* is the most widely ratified human rights treaty in the world. The Convention comprises all aspects of a child's life and sets out the civil, political, economic, social and cultural rights to which all children are entitled. Children up to 18 years of age are included, so the Convention applies to young adults between the ages of 16 and 18.

# Stakeholders and partners to reduce health inequalities among young adults

Fig. 4 outlines the key stakeholders and partners needed to reduce health inequalities. Intersectoral action to improve health is crucial for young adults. Different agencies are responsible, and policies across governments and elsewhere can be used to improve mental and physical health and reduce exposure to risk factors.

**Figure 4. Stakeholders**

**Health care**

- Universal provision
- Unified assessment
- Adequate mental health provision for young adults
- Schools/college identify and train a designated senior leader who oversees the approach to mental health and well-being
- Local mental health support teams to address the needs of young people with mild-to-moderate mental health
- Specialized residential care administered regionally aimed at young adults

**STAKEHOLDERS**: government departments (health, social care and education), local public health, third sector (families), religious bodies

**Living conditions**

- Walfare policies (including parenting and family programmes, sickness benefit, and job-seeking allowance)
- Ensure eligibility of young adults for welfare benefits
- Green and play spaces
- Housing tenure and financial security (particularly for cared-for young adults as they transition to independent living)

**STAKEHOLDERS**: government departments (local governement, social care, housing, recreation), third sector (families)

**Personal and community capabilities**

- Education policies including: life-long learning, child development, opportunities for high-quality apprenticeships
- Community projects providing opportunities for young adults to engage whithin their local area
- Opportunities for young people to engage with local and national politics
- The use of regulation, education and fiscal strategies to promote healthy behavioural choices (and discourage negative ones)

**STAKEHOLDERS**: government departments (health, social care, education, treasury), community and local government, local primary and public health, third sector (children and families, national youth organizations, religious bodies)

**Working conditions**

- Labour/workforce policies to ensure rights for young adults
- Occupational safety and health legislation
- Disability legislation
- Maternity and paternity working leave
- Minimum/living income and working-time policies (which includes young adults)
- Small/medium enterprises promote mental health and access for support for their young adult employees

**STAKEHOLDERS**: employers, government departments (labour, business, trade, health, social care), local public and primary health, third sector (children and families), trade unions, EU Cohesion Fund, human resources (private and public)

**Unemployment and social protection**

- Adeguate welfare benefits
- Inflationary increase in welfare payments
- Relaxation of welfare eligibility requirements for young adults
- NEET training programmes

**STAKEHOLDERS**: government departments (labour, finance, education)

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The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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