Health Risks in Adolescents in Europe

Sakari Karvonen, PhD, is a Senior Researcher at STAKES (National Research and Development Centre for Welfare and Health), Finland

As a phase of life, adolescence has been associated with positive health status and lack of social inequalities in health, or relative equality (West & Sweeting 2004). In most European countries, mortality among young people is low and only a minority suffer from major diseases or disabilities that would limit everyday life (European Commission 2000). Paradoxically, it is precisely because so few teenagers are physically impaired that their health and health-related behaviours carry so much importance when assessing population health in general or when setting priorities for prevention.

First, poor health or disability may stigmatise or create a sense of otherness by casting out socially or functionally from many of the activities that young people normally engage in. Furthermore, these activities serve important functions in psychosocial development. They also provide critical means for operating in the modern day societies, such as networks, trust and social capital.

Second, youth age clearly represents a phase of life in which resources for health potential in adult life are formed. This refers particularly to the aspects of lifestyles that have health consequences but it also includes a wider range of influences from knowledge and skills to self-esteem and self-efficacy (Koivusilta et al. 2003).

Finally, adolescents make up the segment of society that emblems the general wellbeing of a nation. Broadly speaking, this notion suggests that the more young people face risks compromising their health the worse-off the whole society is likely to be. In other words, early investment in prevention of risks will obviously be beneficial in terms of less health burden later in life.

Against this broad frame of reference, this issue of SPM presents papers that highlight the value of timely and reliable data for the preparation of prevention and evaluation of legislation (Baska et al. 2006, Ergüder et al. 2005, Matthys et al. 2006, Ruiz et al. 2006). The focus is limited on the more traditional risks, namely risk factors of cardiovascular diseases and cancer. It has to be kept in mind that despite the rise of new challenges, traditional public health risks endure. The smoking epidemic has yet to reach its height in many European countries. According to the WHO-study (Health Behaviour in School-Age Children (HBSC)) highest increase in smoking has taken place in countries like Estonia, the Czech Republic and Lithuania (Currie et al. 2004). Equally, dietary behaviours remain an important focus. Educational patterning of dietary behaviours among Belgian adolescents is reported by Matthys et al. (2006) in this issue. Their study highlights one of the most crucial challenges facing European populations in the future. Overweight and the associated dietary problems probably already create more worry and suffering in young people and in their families than the other well-known risk factors. Furthermore, as the paper shows, dietary behaviour may also contribute to social inequalities in health. The WHO-study finds highest prevalences of obese children in Greenland, followed by the British Isles and some of the Mediterranean countries (Currie et al. 2004). Even though the Mediterranean diet has been considered less hazardous than the palate from other parts of Europe, dietary preferences among young people are changing rapidly which challenges the traditional beneficial health effects.

Young people of modern industrialised Europe are currently facing rapid societal change resulting in complexities that question traditional ways of life, earlier division of labour and, even, the nation state. Globalisation and other transnational powers (such as the European Union) modify also the context of adolescents' everyday life (Urry 2003). When confronting this development, young people face ambivalence of options for conducting their lives. At the same time youth transitions – from family of origin to own family, from school to work, from family house to own accommodation – have

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become more problematic, prolonged and more individualised (Furlong & Cartmel 1997). This is accompanied by novel health risks that are grounded on living in the time of late modernity, as the sociological phrase puts it (Giddens 1991). In the face of these challenges, particularly the most vulnerable youth may risk depression, alcohol or drug use. Further challenges arise from complexities around sexuality, represented among others in the tension between the celebration of sexuality and sexual pleasure and the ambivalences of anxiety around teenage sexual behaviour and sexual diseases (Scott & Jackson 2005). Completely new health risks relate to sedentary behaviour, particularly compulsive use of the internet (Kaltiala-Heino et al. 2004) and range from the physical risks of neck and shoulder pain to psychosocial problems and addiction.

However, these risks – whether of traditional cardiovascular nature or of the more "modern" type – are not distributed equally. Even though social inequalities in youth may in fact be less severe than among the working age population, young people also are deeply divided by social position, such as ethnicity, gender and social class. These divisions impair some groups more than others in terms of health as also the Matthys et al. (2006) paper in this issue suggests. A final but by no means less demanding challenge arises from the great diversity of life chances and future options with which young people in different parts of Europe are faced. Both the organisation and the development of health services vary greatly between areas, not to mention the educational systems and the coverage of social policy. Tackling the inequalities, diversity of living conditions and variation of both emerging and traditional health risks is a major challenge that cannot be addressed solely by the efforts of the health services. Health promotion should particularly target the most vulnerable youth but also campaigns with a wider focus on families and poverty are needed.

Sakari Karvonen

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Address for correspondence

Sakari Karvonen, PhD
National Research and Development Centre
for Welfare and Health (STAKES)
Promotion of Well-being and Health
P.O. Box 220
FIN-00531 Helsinki
e-mail: sakari.karvonen@stakes.fi