The health and wellbeing of young people in low income areas in England and Wales:

Key health trends and policy developments

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Executive summary

Data are accumulating on the patterning of health inequalities for young people living in low income communities. It is clear that, on most measures, low income is related to poorer outcomes for this age group. This can be both in relation to the prevalence of disease and also to access to services and lack of support for management of pre-existing conditions. Data reveal inequalities in a range of physical and mental health outcomes and also in health behaviours. These include higher rates of mortality, more disability and long-term illness, higher rates of obesity, more mental health problems and poorer diet and nutrition.

The policy landscape reflects a number of high level commitments to young people and to those living with low income, but in practice the age group is often neglected. There is a need for more inequality-reducing policies that are specific to children and young people.

Restrictions to public funding have a particular impact on the age group, and there is a need for more support for the workforce supporting this age group, and for the voluntary sector who bear much of the burden.

Awareness of the health inequalities that young people experience is critical for voluntary sector organisations seeking to deliver services to the age group, and to mitigate some of the disadvantages these young people face. We may not be able to do much about the underlying cause of inequality, but removing the barriers to services is critical to improving outcomes. This will be more effective if the barriers are clearly understood.

Background

What's the issue?

Discussions about health inequalities often refer to health outcomes in later life. However, we know that distinct inequalities exist from childhood. These affect children's health at the time, predict to poorer health outcomes later as they age, and predict to poorer outcomes for their children. This opens the way for a 'triple dividend' – investing in the health of adolescents can improve all three outcomes (Patton et al, 2016). In order to develop appropriate and successful services, charities working directly with young people in low-income communities need to be informed about the health challenges these groups face, and to understand the barriers that may affect their ability to engage.

The Association for Young People's Health (AYPH) was invited by StreetGames, the doorstep sport charity, to conduct a review into the current state of health and wellbeing of children and young people in England and Wales, with a specific focus on those affected by low income, living in what might be termed underserved communities.

The project had five central aims:

- Highlight key trends in data relating to the health and wellbeing of children and young people in low-income areas;
- Identify any recent or planned policy changes that have or are likely to impact on the health and wellbeing of children and young people in low-income areas;
- Reflect on the particular issues at play in communities affected by low-income;
- Undertake a horizon scan – in terms of seeking to identify early signs of potentially important developments;
- Consider what challenges and opportunities exist that are most likely to impact on third-sector organisations that support children and young people affected by low-income.

Because of AYPH's particular focus on 10-25 year olds, the majority of the information in the report will focus on this age group, but there are implications for younger children as well.

What do we mean by health in relation to this age group? The longstanding WHO definition of health (originating from 1948) defines it as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (World Health Organisation, 2020). Our working definition of health for this report covers both physical and mental health, although we note that while this distinction is widely reflected in how health services are organised, data collated and research is undertaken, most young people do not make the same clear distinction between the two domains. Many physical illnesses of adolescence – such as problems with skin, the diagnosis of long-term health conditions like diabetes, or musculoskeletal problems all affect young people's sense of self, autonomy and mood. And mental health problems clearly interact with physical health issues such as sleep, healthy eating and exercise. In addition, because they are subject to so much discussion and research, we have included information on significant health behaviours of adolescence including physical activity, smoking and drug use.

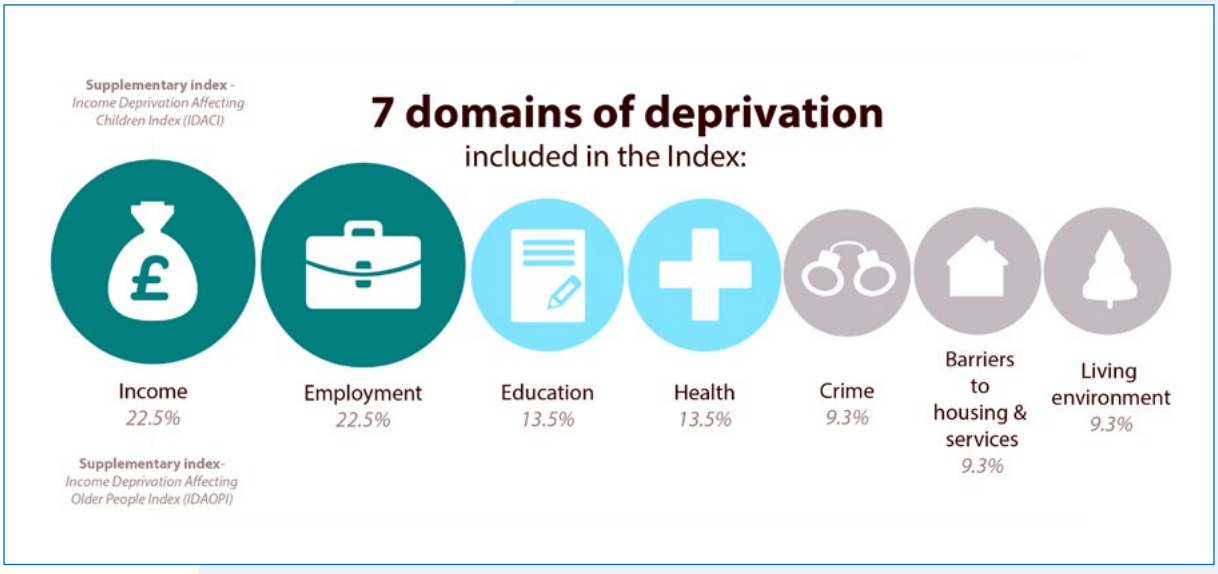
The influences on health are many and varied. What we have focused on here is a snapshot of what we know about the health outcomes and behaviours for young people affected by low income at the time of writing. However it is important to acknowledge that around this there

is a huge selection of non-medical risk and protective factors that will play a part in the aetiology of disease. For young people in the 10-25 age group, in addition to poverty, these social determinants will include family relationships, educational and employment experiences, availability of appropriate services, peer group dynamics, housing and environmental issues, social and economic policies and systems, and discrimination and social exclusion. Estimates usually suggest these social determinants account for between 30-55% of health outcomes (World Health Organisation, 2023). Reviewing all of these was beyond the remit of this paper, but AYPH does present a considerable range of data on the social determinants of health inequalities on our youth health data hub. The important thing to note here at the outset is that our model of health outcomes stresses the importance of social determinants beyond individual behaviour. Particularly in relation to young people, who are not in control of many of the influences they experience, promoting good health is not just an issue of telling people what to do.

A note on 'low income'

As the focus for this report was specifically on young people living in low-income communities, the data are mostly framed through the lens of the Index of Multiple Deprivation (IMD), which is a rating of area deprivation rather than household income, and which represents the official measure of relative deprivation. In England this was last calculated in 2019, and area deprivation may have gone up or down since then.

The IMD draws on seven indicators, as shown in the excerpt from the Department of Communities and Local Government's (as was) infographic below. Generally the areas of the country are divided into ten categories (deciles), ranging from the least deprived 10% to the most deprived 10%. Sometimes the blocks relate to fifths (20%). The area of analysis is called a "Lower Super Output Area" (LSOA), which is quite small, comprising of between 400 and 1,200 households with a usually resident population between 1,000 and 3,000 persons.



Source: DCLG's Infographic: The Indices of Multiple Deprivation 2015

In addition to the main IMD, the Government also publishes the income deprivation affecting children index (IDACI), which gives the proportion of children aged 0-15 living in income deprived families. It is a supplementary index to the overall income domain (Ministry of Housing, Communities and Local Government, 2019). However, this is used to inform local authorities about the situation of the children in their area; very few (if any) health data are cross tabulated against this.

In some cases data may be presented by scores on the Family Affluence Scale, which is a more household based approach used in a number of surveys. Welsh data often use the Family Affluence Scale. It is a self-reported, 3 level score (1=low family affluence, 2=medium family affluence, 3=high family affluence) based on answers to six questions about material circumstances in which children and young people live. It is also used in the World Health Organisation's Health Behaviour in School Age Children.

Another measure sometimes used is receipt of free school meals. Children are entitled to free school meals if their families receive various state benefits, and family income falls below thresholds (which vary according to the benefit). For example, families in receipt of Universal Credit must have an equivalent annual net earned income of no more than £7,400. In some surveys and studies we have health outcome data plotted against receipt of free school meals.

How good are the data?

It is important to understand the shortfalls in the data we are drawing on for this report. While there is a huge interest in young people, and a growing understanding of health inequalities for this age group, often the data are cut one way or the other, but not both; it can be hard to find health inequalities data presented by age in the way we need.

Also, some of the key health issues that we know are important to this age group are not properly reflected in the publicly available data, which may be driven by agendas other than our own population health perspective. Thus, for example, we have lots of data on the nationally audited topics of diabetes, asthma and epilepsy, but very little on pain and musculoskeletal issues, which we know are key to this age group.

As a result, in our work at AYPH, we often try to supplement the headlines with more detailed information from less representative samples involved in specific research studies or other kinds of projects, piecing together the most likely story from a variety of sources.

The evidence presented in this report derives from desk based research, drawing on AYPH's existing data hub on health inequalities, with additional deep dives and extra searches to complement and update available data. We also drew on our contacts in the fields to check for recent updates and intelligence.

Results

How many children and young people are living with low income?

According to official statistics, more than 3 million children (under 18) live in houses with relative low income before housing costs (the Department for Work & Pension's measure of income inequality); about a quarter of the age group. Approximately 80% of people on low incomes live in the 30% most deprived areas, so there is a clear correlation between individual or family poverty, and area poverty.

Poverty statistics are not available specifically for the 10-24 age group excluding younger children. However we do know that approximately one in five young people of secondary school age are entitled to free school meals. In addition, as noted, the Income Deprivation Affecting Children Index (IDACI) – a sub-set of the IMD – measures the proportion of all children aged 0 to 15 living in income deprived families. This ranges around the country from 25% to 32% depending on the local authority. Those with the highest proportions are typically found in the Midlands or the north of England. So, by any measure available to us, between a fifth and a third of children and young people are living in low-income areas.

Physical health – headline health inequalities

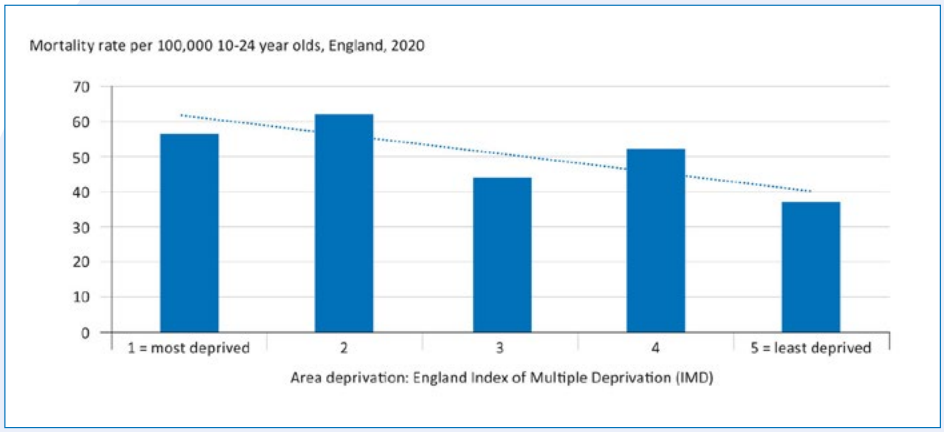
Most measures of physical health problems in childhood and adolescence show patterning by low income:

- **Mortality** – there is a clear relationship between low income and mortality for most causes. Death rates in young people are low, but the causes of deaths in this age group are often preventable (accidents etc). A recent British Medical Journal article showed that for those under 18 the risk of death in the two bottom IMDs was around 29 to 33 per 100,000 children, falling to 12 to 15 in the two wealthiest deciles (Odd et al, 2022).

  Figure 1 below shows a clear relationship between area deprivation and mortality rates for 10-24 year olds in England. The National Child Mortality Database (2023) has estimated the inequality gap between the most and least deprived areas has increased in recent years. Typically only 2-3000 10-25 year olds (1% of all deaths) die every year across the whole of the UK, so by the time the numbers are divided up into area locations, any patterns in the data – by gender, or for each year group – can be much harder to detect.

Figure 1:
10-24 year olds from the most deprived local authority areas in England are more likely to die than those in the least deprived areas.

Source:
AYPH analysis of ONS – Mortality statistics: underlying cause, sex and age.

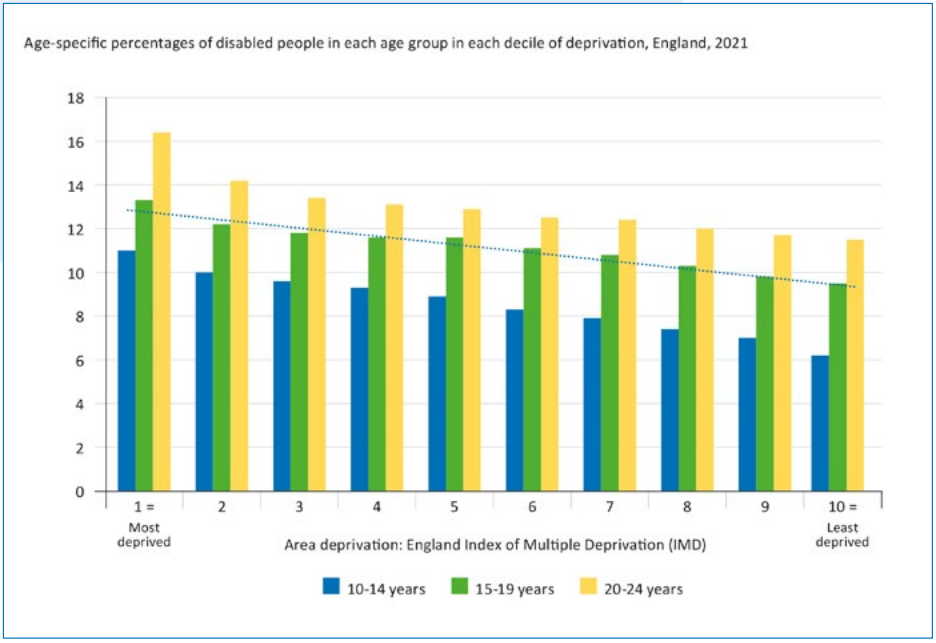


For example, the numbers are too small to be clear about the trends for different cause of death, although there is evidence that the trend is very clear for death from traumatic incidents such as abuse (National Child Mortality Database, 2023). It is important to note that 41% of these deaths were in 15-17 year olds, and 70% were male. Those from Black or Black British background had twice the risk of dying as those from white or Asian backgrounds. Overall, those from deprived regions had a 26 per million chance of dying due to traumatic injury compared to a rate of 9 per million for those in the least deprived quintile. However, it is important to note that suicide was an exception and does not seem to have a clear relationship with deprivation (possibly drowning does though – the numbers are really too small to tell) (National Child Mortality Database, 2023; ONS/ Samaritans, 2020).

- **Disability** – the conceptualisation and measurement of disability is an issue, but Figure 2 shows that just in response to the simple 2021 census question ("Do you have a disability?"), there is a clear relationship with deprivation for 10-24 year olds in England and Wales

Figure 2: Young people living in areas of most deprivation are more likely to report disability

Source: ONS Census 2021, England and Wales



- **Pain** – we have very poor data on pain but it is a critically important issue for the age group. Common sources for the 10-25 age group relate to headaches and abdominal pain. The 2017 Health Survey for England (now long out of date) showed that a number of young people were living in pain at that time and that this had a gradient depending on deprivation (Public Health England, 2018).

- **Type 1 Diabetes and epilepsy** – Diabetes and epilepsy are highly tracked conditions, as a result of the fact that they are subject to national data audits. There is evidence from the audits that diagnosis of both conditions in children is higher in low income areas (RCPCH 2023a,b). The extent to which this is actually directly caused by deprivation rather than other aspects of place is possibly less clear.

Figure 3:
More 0-19 year olds are registered with diabetes in England and Wales in areas of most deprivation

Source:
RCPCH National Paediatric Diabetes Audit (2023)

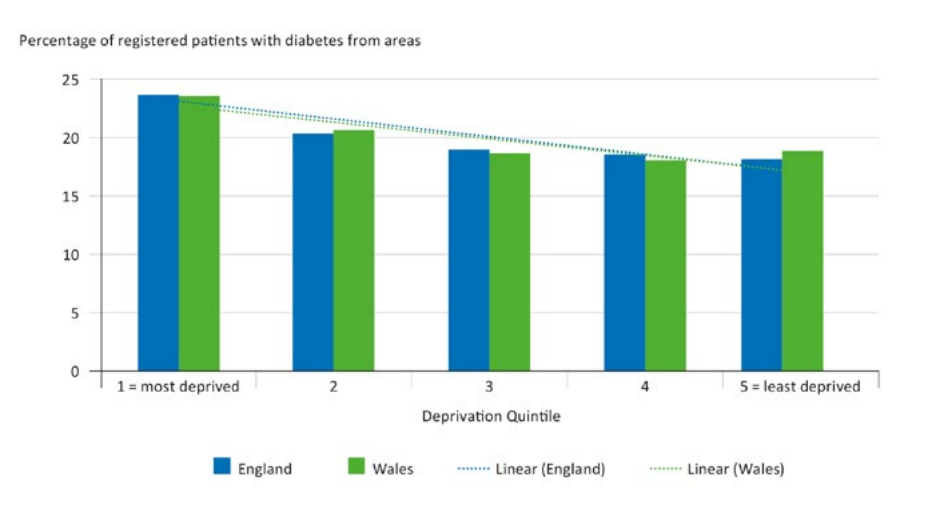
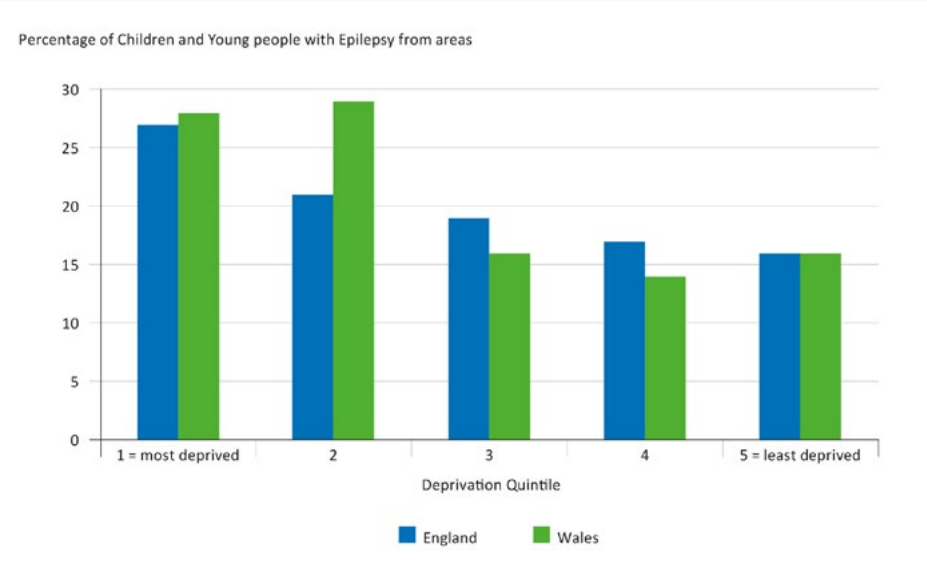


Figure 4:
Epilepsy diagnoses in 0-19 year olds in England and Wales have a clear relationship with deprivation

Source:
RCPCH National Paediatric Diabetes Audit (2023)

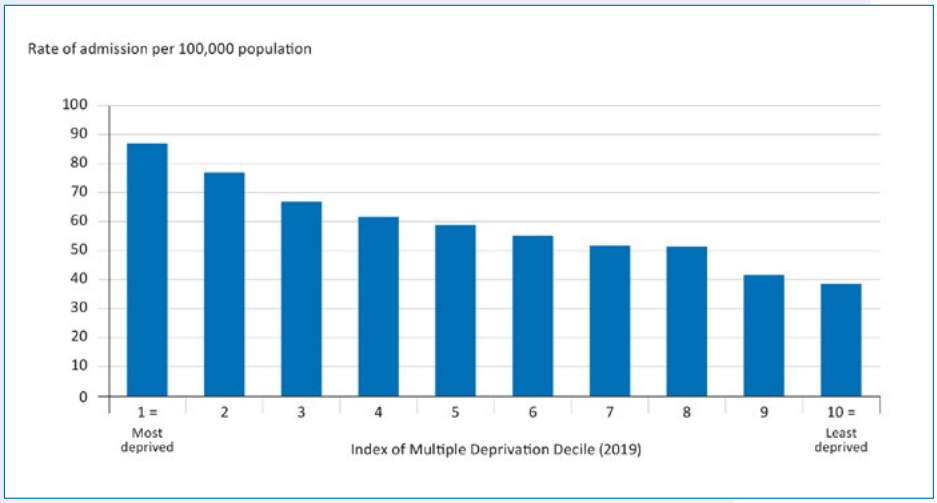


- **Asthma.** Asthma is the most common long term condition among children and young people, with 1.1 million children currently receiving asthma treatment (RCPCH, 2021). Despite being a condition of considerable interest, we do not have prevalence data for asthma in the community of children and young people. This partly reflects difficulties of establishing diagnoses of asthma.

  Receipt of services and management of long-term conditions is also related to deprivation. Data from 2020 on emergency hospital admissions for asthma, epilepsy and diabetes (which should all be well controlled in the community for optimal outcomes) showed a clear link between level of deprivation and likelihood of emergency treatment required (Figure 5). But it is clear (as with the other conditions) that outcomes are worse for children and young people living in the most deprived areas.

Figure 5:
In the first three months of 2020, emergency admissions for under-19s for asthma, epilepsy and diabetes were more than twice as likely in those from the most deprived areas compared to those from the least deprived

Source:
NHS Digital (2022) Hospital Episode Statistics



- **Obesity** – Figure 6, drawing on data from the school measurement programme of Year 6 children, shows that not only is childhood obesity higher in areas of deprivation, but also that the gap is getting larger. Increases in obesity in recent years have all occurred in areas of deprivation. There have been no increases for children living in more affluent areas. There was a sudden rise and fall for the whole age group at the time of the pandemic, but the important thing is that rates of obesity in low income areas continued to be higher at the last point of measurement than they were at any time in the previous 8 years apart from during the pandemic.

  Obesity is a term related to height and weight profile and is regarded as a medical condition, but is not in itself necessarily a disease. However it is associated with several other health conditions that can be very problematic, such as type 2 diabetes, joint pains, back pain and headaches. Obesity rates are linked to low-income communities for a number of reasons including paucity of transport options to cheaper options such as larger supermarkets, increased number of low nutritional food options in the local area, increased income pressure meaning less time to seek out and prepare fresh food, poorer facilities for fresh food preparation and more reliance on convenience foods (eg, Ohri-Vachaspati et al, 2021).

- **Sexual health** – As Figure 7 demonstrates, there are differences between the rates of newly diagnosed sexually transmitted diseases for young people under 25 who live in the highest income communities and those who live in lower income communities.

  Note that this does not include chlamydia, where rates are less clearly related to deprivation, which might be an impact of the push for national screening.

  There are also deprivation effects on under 18 conception rates, as demonstrated in Figure 8, although the divergence between rates in the most and least deprived areas is narrowing.

Figure 6:
Obesity rates for Year 6 pupils in England are higher in areas of deprivation and the gap is increasing.

Source:
NHS Digital (2023) National Child Measurement Programme, England

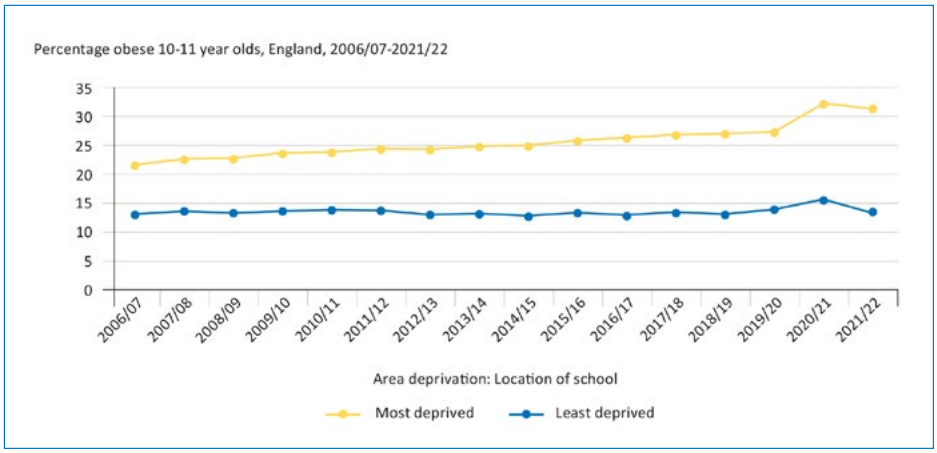


Figure 7:
Sexually transmitted disease rates for young people under 25 living in the lowest income areas are higher than for those living in higher income areas

Source:
OHID (2023) Fingertips

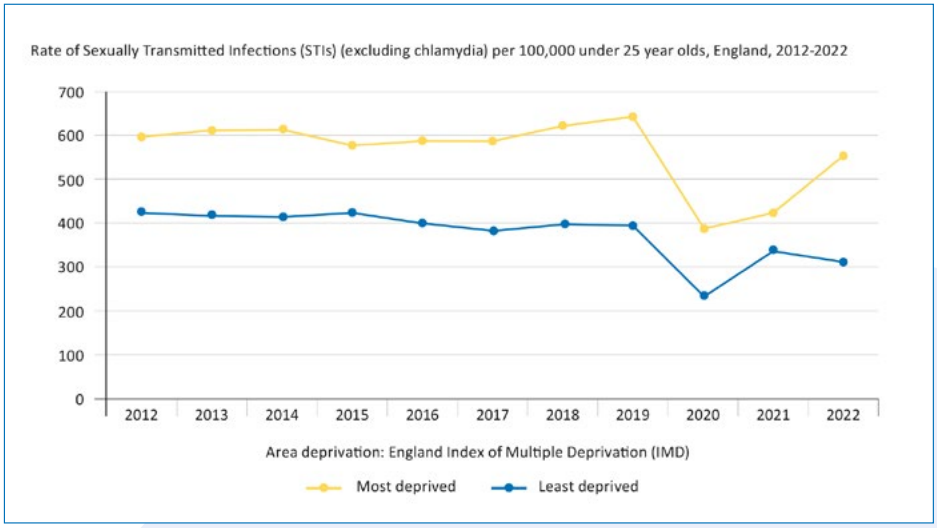
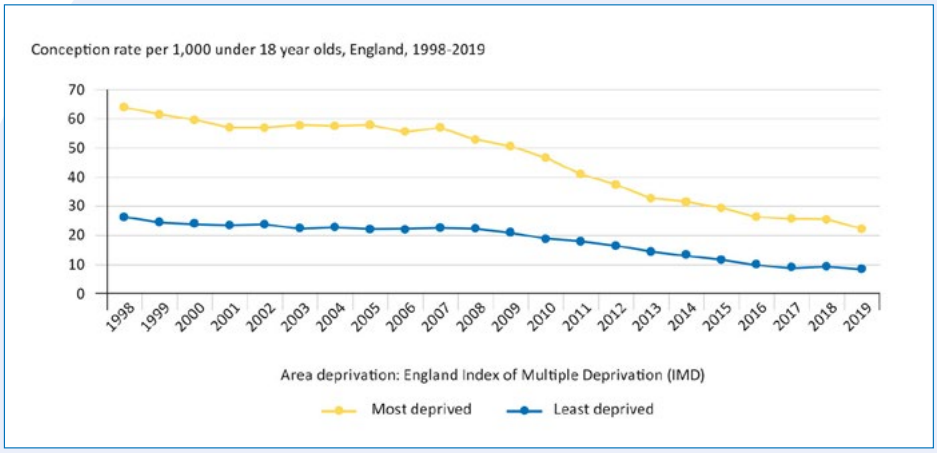


Figure 8:
Under-18 conception rates are higher in areas of deprivation in England

Source:
OHID – Sexual and reproductive health profiles



Mental health – headline health inequalities

There is much concern over increasing levels of mental health problems in young people. Repeated NHS Digital general population surveys from 2000 to 2022 have provided the most reliable data. Up to 2017, these used recognised diagnostic questionnaires to determine how likely a mental health condition would be in each child or young person. The pandemic disrupted the sequence, and later surveys are not entirely comparable because they used different kinds of measurement. Comparisons from 2017 onwards are based on the Strengths and Difficulties Questionnaire, which is not a diagnostic tool but gives an indicator of 'probable' disorder. The later surveys were run in 2020, 2021 and 2022.

The conclusion was that there had been a rise in probable mental health problems in 7-16 year olds in 2020, but nothing more since then (Newlove-Dalgado et al, 2023). It was not possible to do the longer term trends for the older age groups but there had been no rise for them since 2021. Particular concerns were raised about disordered eating. It is worth noting that the data do not entirely reflect the general impression from schools and other services that mental health problems are still going up. This may be partly to do with how mental health problems are defined and conceptualised, and a concern about general anxiety in the age group that perhaps does not reach the official threshold for 'probable disorder'.

Figure 9:
Percentage of children and young people with a probable mental disorder by age and sex, 2022

Source:
NHS Digital (2023)

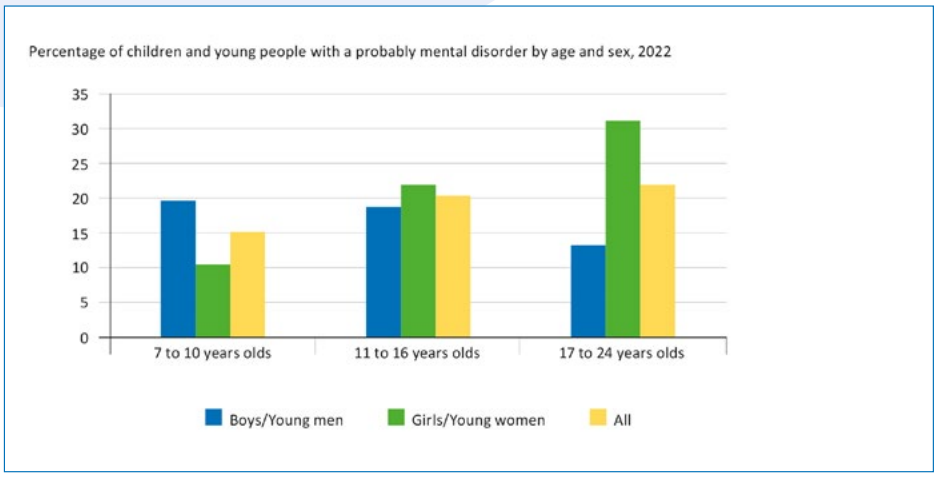
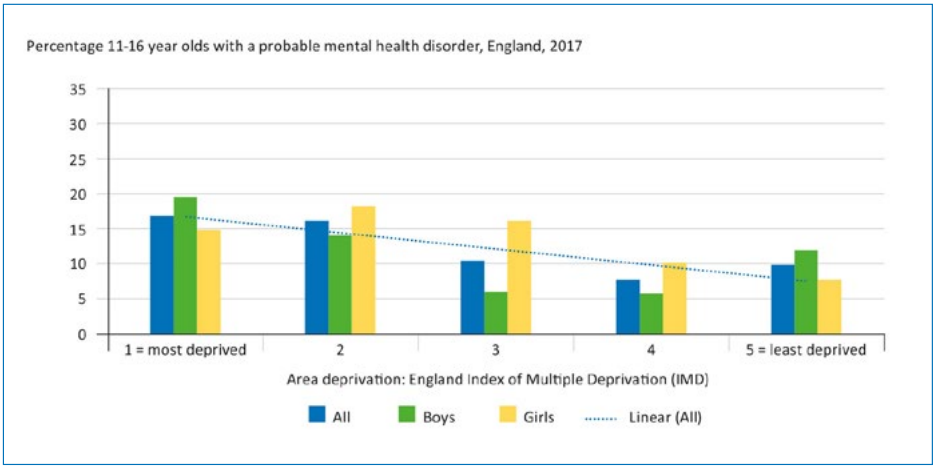


Figure 9 shows the proportion of young people in the community with a probable mental health disorder in 2022.

The extent to which these trends are related to low income has received less attention. For 11-16 year olds before the pandemic, the 2017 NHS Digital survey suggested a clear association between living in an area of deprivation and higher likelihood of mental health problems in this age group. The trend line in Figure 10 demonstrates this association. Analysis of data from the Health Behaviour in School-aged Children (HBSC) studies in European countries has also found that for young people aged 11-15 there was an association between family affluence and mental health (Weinberg et al 2021), and the same is reported in the last Welsh HBSC report (School Health Research Network, 2023).

Figure 10:
In 2017 there was a tendency for 11-16 year olds in areas of most deprivation to have more mental health problems

Source:
NHS Digital



When the NHS Digital survey was replicated in 2020, in the middle of the Covid-19 pandemic lockdowns, measurement of deprivation was different (not by IMD). Newlove-Dalgado et al (2023) do report, however, that post-pandemic young people with mental health problems were more likely to be living in a household that had experienced not being able to buy enough food or using a food bank in the past year, and lived in households that experienced a reduction in household income in the past year. No doubt family stress gets translated into anxiety in children and young people (Conger and Conger 2002).

The impact of the COVID-19 pandemic specifically on the mental health of this age group has mostly been framed in terms of the damage done by the experience of the pandemic and the restrictions it imposed on the age group, rather than damage from the disease itself. Over the last few years since the pandemic, conflicting reports from research studies have been published, including one that showed that the biggest impacts of the pandemic may even have been on those from more affluent regions. It is possible that the pandemic uprooted some of the previous connections to deprivation, affecting the whole cohort of young people who were almost universally deprived of education and peer support. Another of the issues here is the range of conditions that come under this heading, and the likelihood of different relationships with deprivation for, for example, anxiety disorders versus behaviour disorders. As noted above, suicide seems to have a minimal relationship to deprivation.

There is a growing interest in wellbeing, but the relationship to deprivation in 10-24 year olds is not well understood. A recent research study drawing on over 30,000 young people from Year 6 (age 10/11 years old) to Year 9 showed no significant associations between IMD and emotional wellbeing scores, and also no relationship with receipt of free school meals (Hazir et al, 2023). A recent Department for Education 'State of the Nation' report shows some variation by free school meals for some young people, but the trends are not very clear (Department for Education, 2023).

As with other conditions, we suspect access to services is one of the key issues here and we would anticipate a clear relationship with deprivation, but there are no representative data on, for example, access to child and adolescent mental health services (CAMHS), that we know of. However, there are likely to be big inequalities in access to treatment given the size of the treatment gap for the general population and

this needs more study. Local data analysis in NHS Midlands and Lancashire has found that young people from deprived backgrounds are more likely to have a mental health referral deemed as "unsuitable", have shorter contact time within a mental health appointment and are more likely to be re-referred to mental health services within a year despite completing their treatment plans (NHS Midlands and Lancashire Support Unit, Strategy Unit 2021). Whatever the exact detail of the rates and the associations, we can anticipate high levels of unmet mental health need in young people living in areas of high deprivation.

Health behaviours – headline health inequalities

Overall there has been a general decline in many negative health behaviours in our age group in the last couple of decades. The current cohort of young people drink and smoke much less than their predecessors (NHS Digital, 2022).

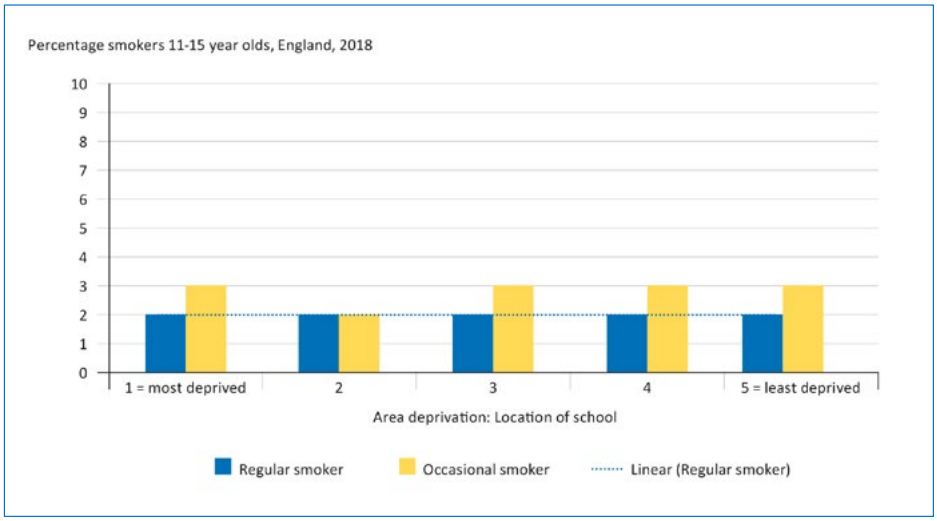
In addition, patterns in relation to deprivation for these kinds of behaviours do not necessarily reflect those witnessed in other age groups. They also vary between age groups so that the patterns of associations for 15 year olds may be different than for young people in their early 20s. At 15, smoking, alcohol consumption and drug use tend not to show much of a relationship with area deprivation. Figure 11 illustrates this in relation to smoking.

However, inequalities do start to set in by early adulthood, and for adult men and women there is a clear link with area deprivation (Office for National Statistics, 2023).

The patterns with alcohol are even more complicated. Following no relationship in adolescence, by adulthood the proportions of men and women who report drinking over 14 units of alcohol weekly increases with household income, and in areas of least deprivation. The highest proportions of non-drinkers are in low-income areas (NHS Digital, Health Survey for England 2021). However there is some evidence that although they may be less likely to drink overall, adult men and women living in the most deprived areas may be more likely to engage in heavy episodic drinking. Overall, (a) the relationship between substance abuse and

Figure 11:
Smoking is not clearly related to area deprivation in 11-15 year olds in England

Source:
NHS Digital (2019) Smoking Drinking and Drug Use Survey



inequality has to be considered from a life-span perspective as it changes over time, and (b) something seems to be happening between adolescence and adulthood for both smoking and some alcohol behaviours that creates a later association with deprivation (Ng Fat, 2017).

We need to reserve judgement on some 'new' health behaviour such as vaping, gambling and problematic phone use. There are few representative, community based data on their association to deprivation and low-income. Interestingly, early analysis has suggested that perhaps the relationship for vaping might be the reverse of that found for traditional smoking – with some evidence for more vaping in low socioeconomic groups in the teens, which disappears by adulthood (Green et al, 2020). It may not be use per se that is the critical outcome here; it may be the way it interacts with other factors to influence other issues. For example, in another recent study, low socio-economic status adolescents were generally more harmed by digital engagement, while adolescents from privileged backgrounds could avoid risks better and maximise benefits on positive outcomes like academic performance (Bohnert et al, 2023).

As noted above, sexual health and under-18 conception have always had a clear relationship with deprivation, and this remains. Youth violence and knife crime are also clearly located to place and deprivation (eg, Greater London Authority, 2021) and we can include them under the heading health behaviours too. The complication here may be that this is more of a city phenomenon, so that the association is with area deprivation in cities, rather than rural communities (eg, Jones et al, 2011).

Tooth decay is an issue that is often ignored but that too is related to deprivation and is very important for health. This is certainly the case for younger children but the relationship in adolescence is less clear. There has not been a national survey in this area for more than a decade so we are somewhat in the dark. Analysis at that time concluded that there were substantial differences in oral health by residential deprivation among adolescents (Rouxel and Chandola, 2013) but much has changed since then – possibly for the worse, in the sense of provision of NHS dentists.

In addition, diet and nutrition are becoming of increasing interest in the context of growing levels of food insecurity in children and young people. The most recent European PISA study conducted by the Organisation for Economic Cooperation and Development concluded that one in 10 UK 15-year-olds (11%) had missed meals because of poverty (BBC News, 2023).

Access to public/green space, sports facilities, role of sport and physical activity

We have not routinely covered data on the key social determinants of adolescent health in this report, but StreetGames is a doorstep sport charity with a particular interest in establishing where sport and physical activity can play a role, potential for early intervention. The data routinely reflect that access to these kinds of resources is limited in low-income areas, and also that there is a positive role for these kinds of resources in promoting both physical and mental health (Sport For Development Coalition, 2023; Geary et al, 2023). A recent systematic review commented on the limited number of studies and the risk of bias, as well as the difficulty of the varieties of green space that exist, but overall it highlighted the potential contribution of green space to adolescents' mental well-being (Zhang et al, 2020).

Finally, Sport England data show that children aged 5-16 from more affluent families were more likely than those with low family affluence to have been physically active for 60 or more minutes per day in the previous week, in 2021/22. This difference in participation has also been shown in previous years (Department for Education, 2023). Although facilities may exist, other barriers in low-income areas relate to issues such as ability to pay (Senedd Commission, 2022; Hayes, 2015).

Box 1 presents a summary of the health inequalities we've covered in this whole section and where there are clear differences for those in families or areas affected by low income.

Box 1: Summary of health inequalities affecting young people in low income areas	
Physical health	• 10-25 year old mortality • Disability • Diabetes and epilepsy • Asthma hospital admissions • Obesity • Sexual health
Mental health	• Mental health • Wellbeing • Access to services
Health behaviours	• Vaping • Impacts of digital and on-line • Tooth decay • Diet and nutrition

Policy context and horizon scanning

Policy changes and impacts on young people in low-income communities

Overall we are not feeling very positive about policy changes in relation to child health. The health inequalities white paper and the mental health white paper have both been dropped, and any specific focus on our age group seems to increasingly be lost in overarching documents that do not take enough of a developmental approach or understand the particular challenges of their life stage. The major conditions strategy is important in relation to youth health, but is an example of this. As some of the data presented above demonstrate, the patterns of associations between health and low income need to be viewed through a lifespan lens, as they may be different for adolescents in comparison to other age groups.

The Association of Medical Royal Colleges (2023) recently published a report, signed by all 24 members, calling for more focus on children and young people's health because of the dividends it would pay across the health system and into the wider economy. This is hardly a new message, and indeed one that AYPH has been promoting for over a decade.

Taking more account of young people's own perspectives is also important. Recent guidance from NHS England has explicitly called for more child and young people's voice in health care decision making, with representatives and advocates for children and young people meant to be on every Integrated Care Board. A children and young people's version of the Core20Plus5 NHS framework (for reducing health inequalities) was produced (NHS England, undated). These are all important steps in increasing the profile of child health, but they come without funding or practical steps in guiding how to use voice, adapt services, or otherwise implement these policies.

Local teams often seem unsure about how to take child and young people's health inequalities forward. Initiatives such as 'poverty proofing' services to improve access are to be welcomed (Children North East, 2021), but they have not been universally adapted and usually require passionate local leadership to make them work.

The Department for Education's current review of relationships, sex and health education (instigated partly in response to reports of inappropriate content being taught) is also an important part of the current policy context.

Horizon scanning

There are several things that we are watching with interest at the moment. One of our biggest concerns is the possibility of unintended consequences for children and young people from policies designed for adults – current discussions on vaping and cigarette replacements are an example. A recent report has suggested that the advertising of vaping as 95% healthier than smoking has sent the wrong message to children and young people who see it (wrongly) as a harmless habit to take up.

Various bodies are beginning to set out their pre-election manifesto calls in relation to child health, including the Royal College of Paediatrics and Child Health (who want an explicit consideration of the impact on children in all policy decisions). The Children's Charities Coalition (Action for Children, Barnardo's, The Children's Society, National Children's Bureau and NSPCC) launched a report in November 2023 (Children at the Table) outlining their concern for the challenges that babies, children and young people in the UK face, setting out a roadmap to inform government on how to transform their lives for the better. The Children

and Young People's Mental Health Coalition released a statement following the King's Speech in November 2023 signed by 56 organisations expressing disappointment that there was no commitment to bring forward a new Mental Health Bill to reform the Mental Health Act. Despite high level expressions of concern about youth mental health, translating this into changes in individual young people's experiences of accessing services on the ground seems to remain a major stumbling block.

A change in government may bring rather less change than some may hope if the options for raising public funds for services are limited. Specific policies that have been mentioned by the main parties have included retention of the two child benefit cap, NHS reforms such as payments for GP surgery visits, and continued local authority cuts. All of these would have negative implications for the health of young people in low income communities. There is quite a lot of support for the development of family hubs, which now have central government funding, to try to join things up for low income families with young people, but very little practical notion so far of how young people fit into this picture. Some limited funding for extending the family hub model to cover adolescent wellbeing has been announced, but it remains to be seen if this is sufficient.

The future of youth work is critical to young people's health, and an area to watch. The decimation of statutory youth services has hit low income communities very hard, and there is plenty of evidence of the positive protective role that these kinds of services can offer to children in the most challenging environments. There is also growing evidence of the 'brokering' role that youth work can play in improving access to and engagement with health services for this age group.

The lack of concrete efforts to prevent the development of obesity is also a growing issue. Although there are initiatives to develop better treatment (Complications from Excess Weight clinics), the real issues are not around individual health behaviour, but about the obesogenic environments that children from low-income families grow up in. There has been an obvious reluctance to tackle this in policy (hence the abandonment of Henry Dimbleby's National Food Strategy initiative). This is an issue that is only going to become more prominent. Societal stigma and a blame culture are barriers to the consideration of this as an issue of inequality. It is also related to the growing problems of food insecurity for this age group, who are often invisible in discussions about food banks.

Issues around housing are also likely to continue to need policy attention. The negative health impacts of insecure and inadequate housing for very young children are receiving an increasing profile, but the implications for teenagers and young adults are also critical.

Finally, social prescribing remains an issue of policy and practice significance. In the absence of resources for statutory services to deliver, the role of the voluntary sector in supporting children and families has continued to grow. There is lots that is positive about social prescribing in relation to teenagers and young adults, and the kinds of community based programmes that will appeal to this age group are important for improving access to services and making a point of connection that can lead to more help. However, there are significant issues around how to build the right infrastructure, secure charity sustainability and raise the importance of youth voice. We note the publication in December 2023 of the StreetGames and partners new social prescribing toolkit, to support professionals to provide innovative support for children and young people.

Conclusion

We are starting to accumulate data on the patterning of health inequalities for young people living in low income communities. It is clear that, on most measures, low income is related to poorer outcomes for this age group. This can be both in relation to the prevalence of disease but – just as importantly – it is related to access to services and lack of support for management of pre-existing conditions. The interesting thing is that the patterning of these inequalities may be different in adolescence, and also some outcomes may be particularly salient to their age group compared to other ages. Others may be less relevant than they are for other age groups. Understanding the particular patterns for this specific age group is important.

The policy landscape reflects a number of high level commitments to young people and to those with low income, but in practice the age group is often neglected. The lack of a home for any central policy responsibility for young people contributes to this; the issues are spread across government departments, leading to siloing and a lack of joined-up thinking.

Awareness of the health inequalities that young people experience is critical for voluntary sector organisations seeking to deliver services to the age group, and to mitigate some of the disadvantages these young people face. We may not be able to do much about the underlying cause of inequality, but removing the barriers to services is critical to improving outcomes. This will be more effective if the barriers are clearly understood. Young people who live in underserved communities need particular understanding and sensitivity if they are going to be able to respond to what services can offer. They are at a critical life stage when they begin to be independent of their families of origin, and able to exercise more agency in how they interact with services, but they are also constrained by layers of disadvantage – in their families, in their areas, and in the institutions in which they are embedded such as schools.

We have focused in this report on area deprivation, and it is worth just drawing attention to the variation of situations that this might encompass. A key policy theme at the moment, the relationship of different health inequalities to 'place' might have particular salience to young people. Not all low deprivation areas are the same – deprivation in cities may be associated with different outcomes to deprivation in rural communities. One example of this that we presented was the public health issue of youth violence. We're a long way from understanding all the nuances in young people's health inequalities, and this report can only begin to sketch the headlines at this stage.

Something that AYPH regularly stresses is the need for more young people-specific offers, rather than hoping that generic family or adult services will scoop them up. However there can be some challenges. These include the particular skills required for this work, and the need to be clear on safeguarding, rights and responsibilities in the transition to adulthood. If delivery to this age group becomes more and more the remit of the voluntary sector (through social prescribing, outsourcing youth clubs, etc), then there are workforce issues – how to recognise and address the particular challenges these young people may be facing, and how to provide the right support for, for example, youth workers. These should not become barriers, though.

On the theme of shaping the offer to respond to young people's particular needs and experiences, we conclude with some things to consider if we are trying to stop poverty-related inequalities from being a barrier to community doorstep sports services. Box 2 suggests the kinds of things to consider.

Box 2: Delivering health promotion activities to young people in low-income areas: key considerations:

- Understanding need: the key facts about health inequalities for the 10-25 age group are not well understood, but can be quite dramatic. They will vary by place and for young people with different lived experience
- Understanding the implications of the extra health burden young people in low-income areas will face, how it may interrupt their ability to communicate and participate
- Hearing young people: they will not all say the same thing about what they need and the challenges they face
- Working around the increased constraints on young people's lives in low-income areas (including transport, time constraints & caring responsibilities)

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For more information

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