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Review

Adolescence as a gateway to adult health outcomes

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ABSTRACT

Adolescence has long been regarded as a transition from childhood to adulthood. More recently it is become a concern of those wishing to avoid adverse health outcomes during middle and late adulthood. Most of this effort has been focused on behavioural risk factors such as tobacco and excessive alcohol use, physical exercise habits, dietary habits, as well as sexual and injury-related behaviours. The concern is that these habits are established during adolescence, continue into adulthood, and come to constitute ongoing risk factors for adverse health outcomes during middle and late adulthood. There is good reason to criticize this approach. These behaviours are themselves shaped by adolescents' living and working conditions and even then constitute a small proportion of the variance predicting adverse health outcomes during adulthood. More complex models of how adolescence serves as a gateway to adult health outcomes are presented. These are the socio-environmental, public policy, and political economy approaches. The argument is made that adolescence is a period during which public policy plays an especially important role in predicting future health outcomes. Yet, these public policies influence health all across the life span with adolescence providing only one of many important periods during which public policy shapes health prospects during middle and later adulthood. Ultimately one should consider a range of approaches ranging from the behavioural to the political to examine how adolescence serves as a gateway towards future adult prospects. An *Adolescent Gateway Towards Adult Health Model* is provided to assist in this process.

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Contents

1. Introduction 137
2. Behavioural risk approach 138
3. Socio-environmental approach 138
4. Public policy approach 139
5. Political economy approach 139
6. Discussion 139
7. Conclusion 140
Contributors 140
Competing interest 140
Funding 140
Provenance and peer review 140
References 140

1. Introduction

Adolescence has long been recognized as an important period of the life cycle during which the child makes the transition to the roles and responsibilities of adulthood [1]. More recently, health researchers and workers view adolescence as an important gateway towards health prospects during middle and later adulthood [2]. There are differing viewpoints about why this may be the case and not surprisingly these differing viewpoints illustrate many of the ongoing debates about the nature of health, health inequalities, the determinants of health, and the appropriate lens through which these issues are best understood and acted upon.

The *behavioural risk* approach recognizes adolescence as a period during which health-related behavioural habits are stabilized [3]. Focus is on behavioural issues of tobacco and excessive alcohol use, exercise habits, healthy diets, injury-related risk behaviours, and sexual activity. Broader issues may be considered but only insofar as they shape risk behaviours, i.e., the marketing

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of alcohol, food and tobacco products to adolescents and the provision of opportunities for exercise by community and educational institutions [3].

A *socio-environmental* approach sees adolescence as the period where one's relationship with the socioeconomic environment is established [4]. In addition to the health issues that the adolescent inherits from childhood circumstances (i.e., life-course perspective) [5], there is concern with social determinants of health (SDH) such as educational and training opportunities that enable stable and well-paying employment during adulthood. Employment is especially important as it provides the income necessary for meeting basic needs and participating in societal activities (e.g., growth opportunities, leisure, and personal fulfilment) that promote health [6].

Especially important in the socio-environmental approach and the ones that follow is the critique that the health-related behaviours of such concern to the behavioural risk approach are themselves determined by the living and working conditions adolescents experience in the present and later as adults [7]. The critique also notes that these behaviours account for a rather small proportion of the variance in health outcomes during middle and latter adulthood as compared to living and working conditions [8,9].

A broader *public policy* approach examines how adolescents' individual characteristics interact with jurisdictions' public policy environments to shape past (childhood), present (adolescence) and future (adulthood) health prospects [10,11]. In jurisdictions with little State intervention in the form of regulation of the employment marketplace and provision of benefits and supports, adolescents' social class and educational attainment become especially important determinants of securing the economic and social resources necessary for health, putting those with working class backgrounds and less education at current and future risk [12]. In contrast, in jurisdictions that promote secure and quality employment through legislation and provides a range of benefits and supports through universal entitlements, these characteristics have less impact in securing the conditions necessary for health during childhood, adolescence and adulthood [13].

A final *political economy* approach considers these issues as embedded within the political and economic structures of society and how these structures distribute economic and social resources [14,15]. Analysis is made of the societal forces that shape public policies that affect the living and working conditions necessary for health during childhood, adolescence and adulthood. Especially important may be the form of the welfare state: Adolescents living in Nordic nations (e.g., Denmark, Finland, Norway and Sweden), will have received as children – and will continue to receive as adults – a bundle of health supporting benefits and supports while those in Anglo-Saxon nations (e.g., Australia, Canada, UK, and USA) are provided with rather less of these [16,17].

This article explores these differing perspectives and provides evidence supportive of each. It also provides an integrated model of the means by which adolescence serves as a gateway to adult health outcomes and makes explicit what is usually kept implicit: how the links between adolescence and health outcomes are conceptualized have important implications for going about promoting the health of adolescents in order to avoid adverse health outcomes during middle and later adulthood.

2. Behavioural risk approach

In developed Anglo-Saxon countries such as Australia, Canada, UK and USA, the *dominant approach* to promoting health across the life-course usually involves the idea of creating "healthy lifestyles." When applied to the issue of adolescence as a gateway to health, it emphasizes behavioural risk factors such as tobacco use, excessive alcohol consumption, unhealthy diets, lack of physical activity, injury-related behaviours, and sexual activity [18–21]. These issues are of concern in other developed nations but are usually considered in conjunction with broader SDH issues (see below).

Here, studies are designed to demonstrate that adolescents who exhibit risk behaviours are more likely to exhibit those behaviours during adulthood [22,23]. And since the presence of these risk behaviours during adolescence and adulthood are associated with adverse health outcomes during middle and later adulthood – and this is especially the case for chronic diseases such as adult onset diabetes and various forms of cardiovascular disease – it is argued that it is especially important to prevent these health-threatening behaviours from stabilizing during adolescence [24].

While there is indeed evidence that adolescent risk behaviours may persevere into adulthood and be predictive of adverse health outcomes during middle and later adulthood, there is good reason to question the causal interpretations usually provided [25]. First, studies indicate these behaviours – both during adolescence and adulthood – account for only a small proportion (15–25%) of the variance associated with adverse health outcomes such as adult-onset diabetes and cardiovascular disease [8,9,26]. Second, these behaviours are embedded within the living and working conditions that adolescents and adults experience [7,27]. From an analytical framework these behaviours are viewed as consequences of these health-threatening circumstances rather than the causes of adverse adult health outcomes. Third, this approach ignores public policy environments and the political and economic forces that shape the environments that directly threaten health and spawn these behaviours [28,29].

3. Socio-environmental approach

In this approach, these behavioural risk factors are seen as embedded within the social determinants of health (SDH), the socioeconomic health-shaping environments in which people interact as children, adolescents and adults [4]. Not only are economically disadvantaged adolescents more likely to partake in tobacco use and excessive alcohol consumption, injury-related risk behaviours and sexual activity, they are less likely to adopt physical activity and optimal diets [25]. These decisions are not seen as being freely chosen "lifestyle choices" but rather as coping mechanisms shaped by the social and economic conditions in which children, adolescents, and adults live and work [30].

But of more importance is the view that these socioeconomic environments initially affect children's health and then go on to influence adolescent and later adult health by exposing the individual to differing material and social resources and psychosocial health-influencing factors such as stress, personal identity, and sense of control over one's health [5,31]. Evidence supports the view that not only are these behaviours embedded within social and economic circumstances, but once these life circumstances are taken into account, the health-related effects of these risk behaviours constitute a small proportion of the variance in adolescent and adult health outcomes [26,32].

Within this approach, the variables of primary interest are class, gender, race, and immigrant status and how these influence the socioeconomic environments adolescents experience which then go on to shape health during middle and later adulthood [6]. These environments include the social relations existing between the adolescent and family, peers, school, and community and are excellent indicators of not only the presence of behavioural risk factors that are the concern of the preceding paradigm, but also the material and social resources that are available to members of differing social classes, genders, races, and immigrant groups [25].

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