

**Report on the state
of young people's health
in the European Union**

A Commission Services Working Paper

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PREAMBLE

The series of reports on the state of health in the European Union drawn up by the European Commission provides the Member States, policy makers, analysts and researchers with a comparative overview on the health status of the general population, or of selected sub-groups, across the European Union.

The present report focuses on the health status of young people in the European Community. Youth can in fact be seen as a crucial period in life with respect to health and well-being at later ages. For purposes of devising, adopting or refining public health policies for young people, it is important to have a clear picture of the particular health risks in this population. Consequently, the findings of this report should serve as an input when it comes to designing activities aimed at young people within the future Community public health policy¹.

At present, within the framework of the series of public health action programmes of the European Community which were established under Article 129 of the Maastricht Treaty², there is a whole range of activities specifically targeted at young people (e.g. the European

¹ Cf. Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the development of health policy in the European Community – COM (1998) 230 final.

² Decision no 645/96/EC of the European Parliament and of the Council of 29 March 1996 adopting a programme of Community action on Health Promotion, Information, Education and Training within the framework for action in the field of Public Health (1996 to 2000) - OJ no L095, p. 0001-0008 of 16 April 1996.

Decision no 646/96/EC of the European Parliament and of the Council of 29 March 1996 adopting an action plan to combat Cancer within the framework for action in the field of Public Health (1996 to 2000) - OJ no L095, p 0009-0015 of 16 April 1996.

Decision no 647/96/EC of the European Parliament and of the Council of 29 March 1996 adopting a programme of Community action on the prevention of AIDS and certain other communicable Diseases within the framework for action in the field of Public Health (1996 to 2000) - OJ no L095, p. 0016-0022 of 16 April 1996.

Decision no 102/97/EC of the European Parliament and of the Council of 16 December 1996 adopting a programme of Community action on the Prevention of Drug Dependence within the framework for action in the field of Public Health (1996-2000) - OJ no L019, p 0025-0031 of 20 January 1997.

Decision no 1400/97/EC of the European Parliament and of the Council of 30 June 1997 adopting a programme of Community Action on Health Monitoring within the framework for action in the field of Public Health (1997 to 2001) - OJ no L193, p 0001-0011 of 22 July 1997.

Decision no 372/99/EC of the European Parliament and of the Council of 08 February 1999 adopting a programme for Community Action on Injury Prevention in the framework for action in the field of Public Health (1999-2003) - OJ no L046, p 0001-0005 of 20 February 1999.

Decision no 1295/1999/EC of the European Parliament and of the Council of 29 April 1999 adopting a programme of Community action on rare Diseases within the framework for action in the field of public health (1999 to 2003) - OJ no L155, p 0001-0006 of 22 June 1999.

Decision no 1296/1999/EC of the European Parliament and of the Council of 29 April 1999 adopting a programme of Community action on pollution-related diseases in the context of the framework for action in the field of public health (1999 to 2001) - OJ no L155, p 0007-0012, of 22 June 1999.

Network of Health Promoting Schools, the European Network on Young People and Tobacco, drugs and AIDS prevention activities, to name just a few).

In contrast to previous health status reports from the Commission, the present document is published as a *Commission services working paper*, which reflects its technical orientation: the report primarily aims at taking stock of the present health situation of young people in Europe, and tries to identify health trends for this population over recent years. As a subsequent step, in the light of the discussions which this report is expected to trigger – and of the feedback it will hopefully stimulate - the Commission will consider drafting *policy recommendations* aimed at improving or consolidating the health of young people.

The present working paper draws from a more comprehensive background report prepared by the German Youth Institute³; for the purposes of this working paper, the material contained in the background report has been revised, updated and complemented with support from the National Research and Development Centre for Welfare and Health (STAKES) in Helsinki, Finland⁴.

³ Horst Hackauf and Gerda Winzen. 'On the State of Young People's Health in the European Union.' German Youth Institute. Munich. 01.09.1999. 171 pages (available upon request from The European Commission, DG SANCO F/3, L-2920 Luxembourg - English language version only)

⁴ STAKES input for this report co-ordinated by Prof. Matti Rimpela

EXECUTIVE SUMMARY

As part of the series of reports on the state of health in the European Union drawn up by the European Commission⁵, the present report focuses on the health status of young people (ages 15 to 24).

Health and well-being in this age group have rarely been addressed in EU-wide comparative studies. National health information systems such as vital statistics provide valuable information, but data on aspects of health relevant to young people are not easily available. And yet, not only childhood, but also - and to a greater extent than is generally appreciated - the transition from childhood to adulthood is a crucial period during which the foundations are laid for health in future life, within the parameters of the individual's family background and economic, social, cultural and educational circumstances. Therefore, it is essential to give consideration not only to mortality, morbidity and lifestyles, but also more generally to well-being, functional capacity and quality of life.

The limited information that is available reveals the following general trends:

- There is *marked diversity within the European Union* in terms of both the status of young people's health and health trends.
- The *majority of young people enjoy good health*, and the trends from the mid-1980s to the mid-1990s suggest that the situation is likely to further improve in the future. In 1997, life expectancy at age 15 was 60.3 years for males and 66.4 years for females (years of life remaining) - an increase of two years over the last 10 years. However, some chronic conditions - such as asthma, allergic disorders, diabetes and obesity - are increasing.
- A considerable proportion of young people suffer from poverty, family breakdown, lack of social support and of educational or professional challenges, or from low quality of food, all factors which may impede healthy growth and development. The marked differences both between and within the Member States in *social and cultural determinants of health* are bound to lead to increasing inequalities in young people's health between population subgroups and countries.

The following more specific results were found:

- Each year about 30 500 lives are lost in the age range 15 to 24 in EU Member States. *Premature death* is more common in males (23 000) than in females (7 500). *Traffic accidents* are the biggest killer (about 10 000 males, 2 000 females), whilst *suicides* account for one in ten premature deaths.
- Most young people regard their own health as good. However, about one-quarter suffer regularly from *psychosomatic symptoms*, and one in ten reports a *disability* that limits daily functioning (e. g. musculo-skeletal disorders).

⁵ Previous reports: The State of Health in the European Community, Luxembourg 1996; The State of Women's Health in the European Community, Luxembourg 1997. The next general report on the State of Health in the European Community will be published towards the end of this year

- Only a rough indication can be drawn of *mental health* trends; in the 15-24 age group, almost 10% seem to experience clinically recognisable depressive symptoms, whereas – on the basis of the scarce data available - it is estimated that the overall prevalence of mental disorders in adolescence is in the region of 15 to 20%. This prevalence varies widely, and is particularly high among the most underprivileged population groups.
- The status of *reproductive health* among young people is indicated by levels of unintended pregnancies and sexually transmitted diseases (STD's). For those Member States for which complete data are available, teenage *abortion rates* per 1000 women range from 5 to 22 (8 to 28 in the age group 20-24); these rates are basically at the same level as they were in the mid-80s. Chlamydia is by far the most common of the *sexually transmitted diseases*, carried by 5-7 % of young people. Very little is known about the true incidence of *HIV infections* among 15–24-year-old people. From 1992 to 1997 the annual number of new cases of AIDS in the age group 15–24 decreased from about 1050 cases to about 460.

In the field of *life styles*, the following findings are particularly noteworthy:

- Experiments with *smoking* often start in childhood: 50-80 % of children aged 15 have tried smoking. In 1998, about one-fifth of all 15-year-olds were daily cigarette smokers. Regular smoking increases with age up to ages 18–20. Because of the addictive properties of nicotine, most young daily smokers continue to smoke regularly into middle age.
- Regular *alcohol consumption* begins at a younger age than it used to. Although the gender gap has narrowed in many Member States, boys still drink more frequently and heavily than girls. Drinking to inebriation has become increasingly common among young people in all Member States for which comparable data are available.
- Experimental *substance abuse* is common in early adolescence, but only a minority will eventually develop addictive patterns of use. Substance misuse and dependence at the age of 15–24 years is often associated with mental disorders such as depression. In the 1990s, no uniform trends in the number of deaths related to substance abuse were reported across the European Union. In the mid-1990s, among 15–16-year-olds the prevalence of experiments with cannabis ranged from 4 to 41% across the European Union; the corresponding figures for amphetamines were 1 to 13%, for cocaine 0 to 4%, for heroin 0 to 2%, for Ecstasy 0 to 9%, and for solvents 2 to 20%.
- Although reliable data on trends in *physical activity* are not available, there is evidence that many young people are not participating in sufficient levels of physical activity to attain health benefits. The rising trend in obesity is particularly alarming.

The following areas are considered *priority issues for future activity*:

- There is a clear need to improve the quality and comparability of data, to develop comparative indicators of health and to analyse both the statistical information and the research findings in the differing contexts of the individual Member States. New comparative studies on the health and well-being of young people should also cover mental, social and cultural aspects, and try to explain differences between countries by relating them to structural and/or cultural factors; they could thus play an important part in the further development of comprehensive reporting on young people's health in the EU.

- The major challenges with respect to improving young people’s health in the EU are linked to the social and regional inequalities in health that are caused by economic, social and cultural determinants of ill-health.
- Attention should be paid not only to health-related lifestyles (smoking, abuse of alcohol and other substances, nutrition, physical activity), but also to the mental health of young people. Moreover, premature deaths from accidents and suicides call for urgent preventive action.

1. INTRODUCTION

1.1. Who are young people?

- 1) The transition period from childhood to adulthood ranges from 10 to 30 years. *Adolescence* usually refers to the psychological and physiological processes of maturation between the ages of about 12 to 18. In sociological contexts the term *youth* is mainly used to cover the period from mid-teens to mid-twentiesⁱ. For practical purposes and in line with an earlier report of the Commissionⁱⁱ, the term '*young people*' used in this report refers to the age group 15 to 24 years.

1.2. Broad interpretation of health

- 2) Among young people health should be considered in its widest senseⁱⁱⁱ. The transition from childhood to adulthood is a period during which the individual lays down the foundations for future life, and thus a positive orientation to the future is one of the cornerstones of good health. At this age mortality is still low and severe chronic diseases are rare. On the other hand, some illnesses such as allergies are common and large numbers of young people suffer regularly from symptoms such as headache, neck and back pains, and tiredness. Many diseases may have their origins during this period in life, depending on the individual's family background, living conditions in childhood, lifestyles, education, fitness, coping and general well-being. Thus, in addition to mortality, morbidity and disorders, the concept of health in young people covers physical capacity (e.g. fitness, vitality), psychological functioning (e.g. positive expectations about the future, learning abilities, self-esteem), social relationships (e.g. friends, sexual life, seeking one's life mate) and environmental potentials (e.g. opportunities to acquire new information and skills, possibilities for leisure activities, the physical environment). Measuring and reporting young people's health at population level according to the WHO definition of health ('Health is not merely the absence of disease, but a state of complete physical, psychological, and social well-being.') is however extremely difficult, as comparable information on the positive and functional aspects of youth health across Europe is scarce.

1.3. Purpose, scope and structure of the report

- 3) This report summarises, at country level, the data that have been presented in published reports and statistics on health status and on the main determinants of health of young people in EU Member States, with special emphasis on trends from the mid-1980s to the mid- and late 1990s. Although the development of health during the transition from family home to adult independence is essentially a complex combination of biological, psychological, social and cultural processes, the information presented in this report is for practical reasons mainly limited to lifestyle, mortality, morbidity and disorders, i. e. to fields in which comparative information is available; however, the report also points to some other important concerns, even though the data are scarce.
- 4) The report is structured as follows: Chapter 2 presents information on population trends, fertility, and on social and cultural factors that have a bearing on young people's health prospects. Chapter 3 provides a short overview of the information sources. Chapter 4

outlines the trends in health, morbidity and mortality. Chapter 5 describes life style factors which can be considered as social and behavioural determinants of health. The main findings of the report are summarised in chapter 6, which also makes some preliminary proposals for future action⁶.

2. YOUNG PEOPLE IN THE EUROPEAN UNION

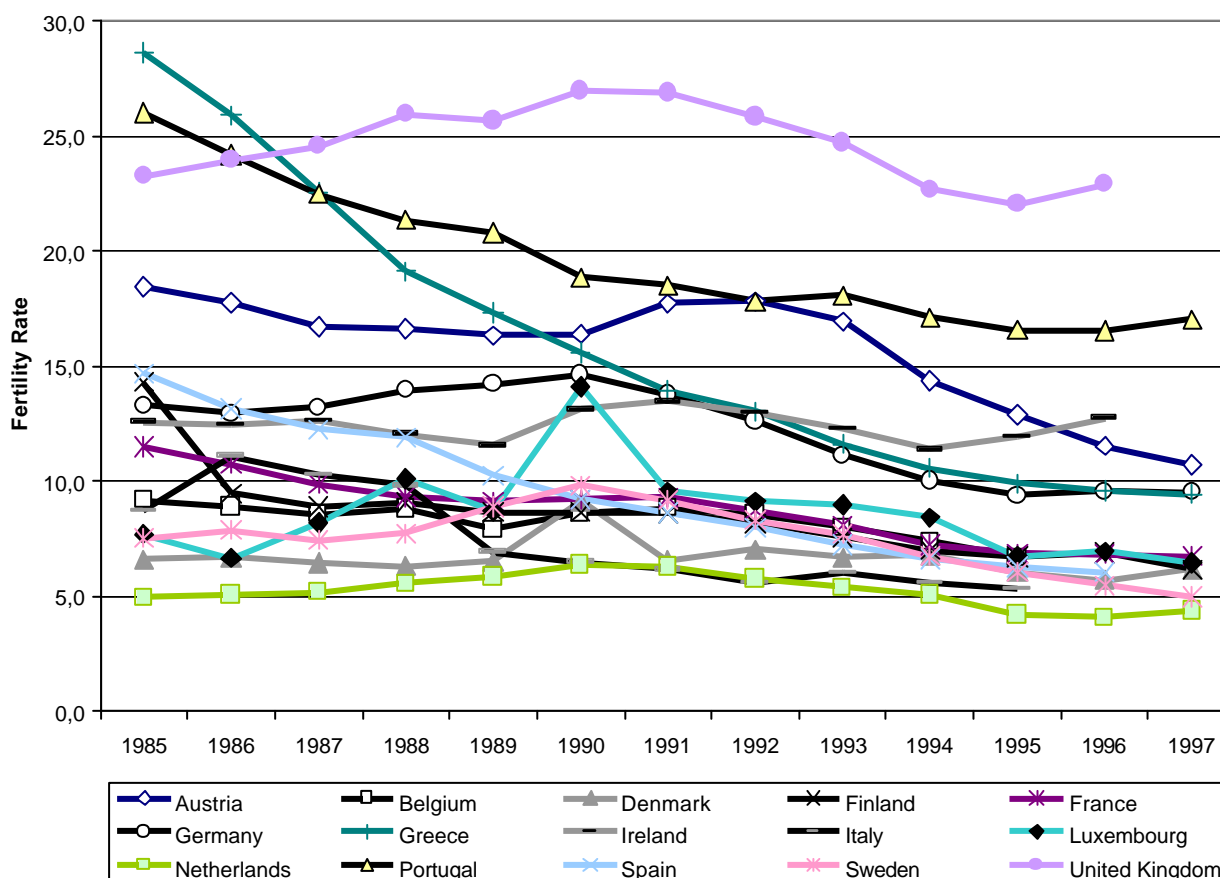
2.1. Demographic trends and family formation

- 5) The countries of the European Union have seen a progressive increase in *total population numbers* over the past ten years^{iv}. However, from 1990 to 1997, the size of the population of 15-24 year-olds decreased by 12% to 48.6 million. According to Eurostat's 1995 population projections, this declining trend is set to continue in the future. The young population has decreased in size most notably in Austria, Italy and the Netherlands, and also in Germany in the age group 20-24. In Finland the age group 20-24 has grown slightly smaller, but at the same time the numbers in the age group 15-19 have gone up. There is a similar inconsistency of trends in Portugal, but in the opposite direction. Data for Ireland point to a minor increase in the youth population since the beginning of the 1990s.

Chart 1: Fertility rate per 1000 women, age 15-19

(source: Eurostat 1999)

(data table and explanations in annex 1)

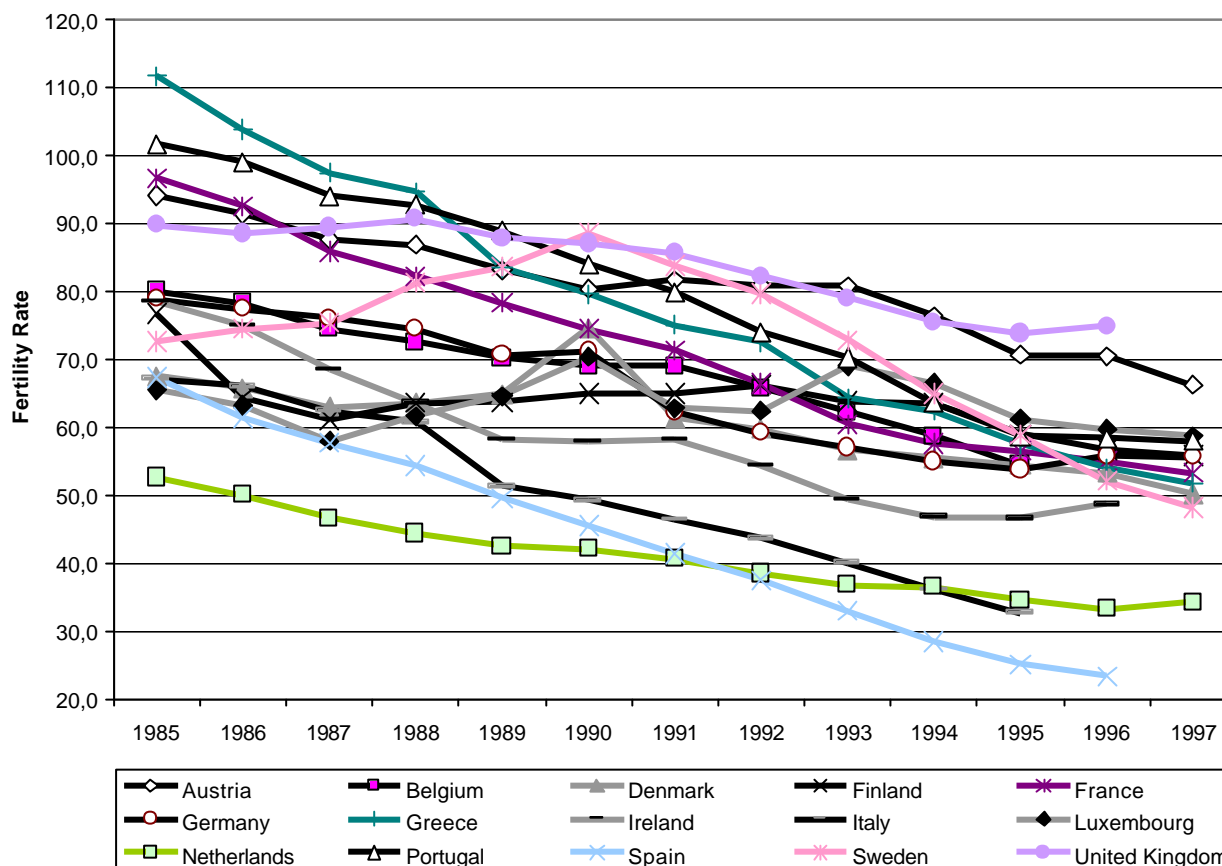


⁶ As stated in the preamble, the Commission will consider drafting more substantial policy recommendations as a result of discussions on this health status report

Chart 2: Fertility rate per 1000 women, age 20-24

(source: Eurostat 1999)

(data table and explanations in annex 1)



- 6) Fertility rates in the EU (charts 1-2) have been declining to a level at which the population, in the long-term, will no longer replace itself. These fertility changes have coincided with fundamental changes in social values and behavioural norms. The most pronounced changes in this respect have taken place in Northern countries, where marriage rates are lowest, age at first marriage and the proportion of extramarital births are highest, and where consensual unions are common. The relationship between fertility and marriage rates reveals a diverse picture across the Member States. Whereas in Northern countries relatively high fertility is combined with a low marriage rate and with a high employment rate among mothers, in Southern Europe low fertility is combined with high marriage rates.
- 7) Eurostat data show that throughout the 1990s, teenage fertility rates have been generally decreasing across the European Union, although at a greatly varying pace (chart 1). Looking at the larger time span between the mid-80s and the mid-90s, the highest decreases in teenage fertility rates are reported from Greece (-67%), Spain (-59%) and Finland (-57%), whereas most other Member States show a slower decrease; only for the United Kingdom, Denmark, the Netherlands and Ireland are the rates of the mid-90s at about the same level as those of the mid-80s. For the last few years for which data are available, figures from Ireland (for 1995 and 1996), the United Kingdom (for 1996), Portugal (for 1997), the Netherlands (for 1997) and Denmark (for 1997) show however a slight increase. In 1995, the teenage fertility rate was lowest in the Netherlands (4 live births per 1000 women) and highest in the United Kingdom (22) and Portugal (17), with a European Union average of 10. Fertility in the age group 20-24 shows a continuous and

fairly uniform downward trend throughout the European Union since the mid-80s (*chart 2*); variations between countries concern rather the levels from which this decrease is taking place, than the rate of the decrease. In 1995, fertility in this age group was lowest in Spain (23 live births per 1000 women), Italy (33) and the Netherlands (35), and highest in the United Kingdom (74) and Austria (71), with a European Union average of 50. The *proportion of births borne to 20–24 year-olds among all births*⁷ has declined considerably throughout the European Union, and to teenagers in most countries. The proportion of births borne to under 25-year-olds was highest in Austria (32%), the United Kingdom (31%), Portugal (28%) and Greece (27%), and lowest in the Netherlands (12%), Spain (15%), Italy (18%) and Ireland (18%).

2.2. Education and training

- 8) Over the past two to three decades, *education* has become increasingly important in young people's lives^v. Data from a 1995 Eurobarometer survey indicate that this change is still continuing; young people in all Member States attach great importance to their educational goals. In 1995, more than half (58%) of the young people in the European Union were in education or training (compared to 49% in 1987- *chart 6*). 28% were active with a job (*chart 3*), 8% actively seeking a job (*chart 4*) and 6% were classified as 'non-active, not in education/training' (*chart 5*). The percentage of those in education/training was highest (65-68%) in Belgium, Denmark, France, the Netherlands and Finland. The proportion of 'active with a job' was highest in Austria, Sweden and the United Kingdom (39-42%), which corresponds to the lowest percentages of those in education/training. Female involvement in upper secondary education has rapidly increased since the early 1980s: the females per 100 males ratio

Chart 3: young people (15-24), active with a job (in %)

(source: Eurostat 1997
(data table in annex 1)

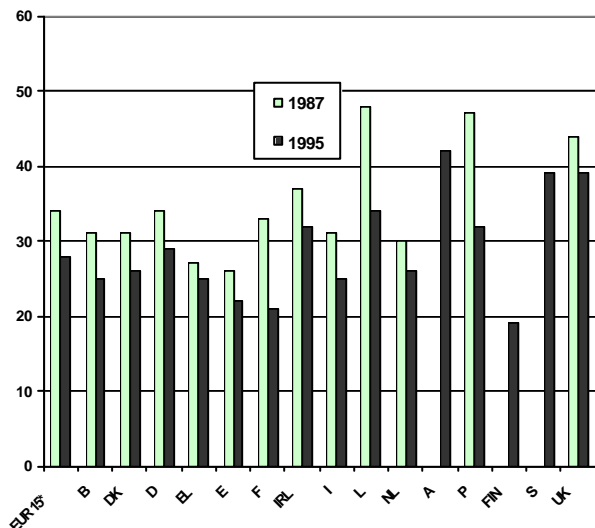
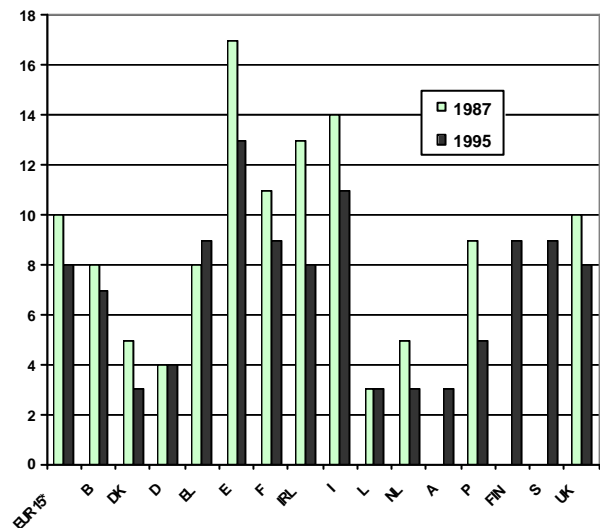


Chart 4: young people (15-24), active, seeking a job (in %)

(source: Eurostat 1997
(data table in annex 1)



⁷ Fertility in 15–19/20–24 year-olds as a proportion (%) of total fertility.

Chart 5: young people (15-24), non-active and not in education/training (in %)
 (source: Eurostat 1997)
 (data table in annex 1)

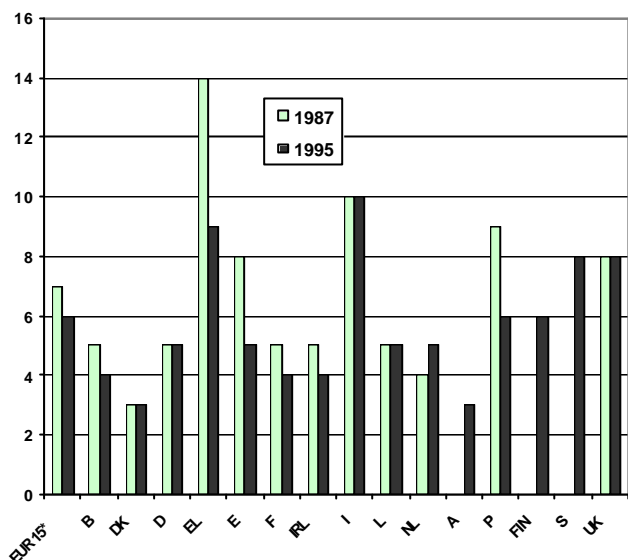
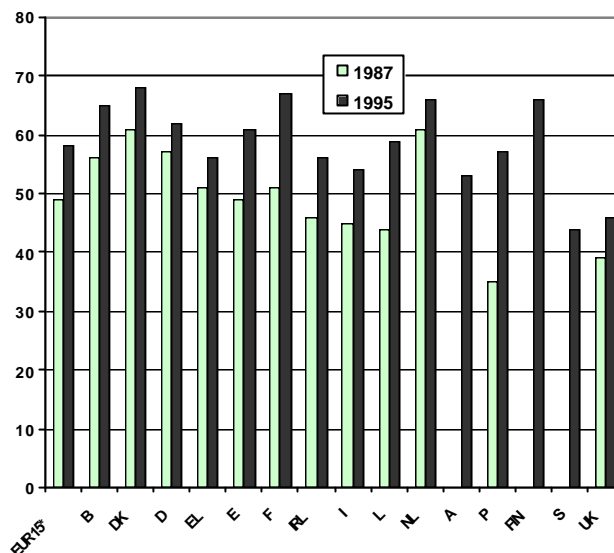


Chart 6: young people (15-24), non-active and in education/training (in %)
 (source: Eurostat 1997)
 (data table in annex 1)



percentages of those in education/training. Female involvement in upper secondary education has rapidly increased since the early 1980s: the females per 100 males ratio rose from about 75 to 102 in 1994/95, being the highest in Finland, Sweden and the United Kingdom (117-121) and the lowest in Austria, Germany and the Netherlands (84-88). The numbers graduating from vocational training as a proportion of all graduates from upper secondary education varied from 84% in Austria and 77% in Germany to less than 50% in Greece, Spain and Ireland.

2.3. From family home to independence

- 9) In most Member States young people today stay longer with their parents than they used to in the past. In 1995, more than 70% of young people aged 20–24 in Greece, Italy, Portugal and Spain lived with their parents, whereas in Finland the corresponding figure was 29%, and in the Netherlands and the United Kingdom 47%⁸.
- 10) Young people move away from their family home for various reasons; some leave to study or to take up a job, others to set up a home with a partner or to marry. During the 1960s and 1970s, when young people could still make fairly direct school-to-work transitions, it was possible for them to gain a degree of independence in relation to the family home even from the age of 15 or 16. Since then, however, the sequencing of key events in the life cycle has changed. Whereas in the 1960s young people typically first left school, then had their first sexual encounter, took a job, left home and married, in the 1990s they tend to become sexually active prior to leaving school, stay at home longer due to education or

⁸ These differences between Member States may be attributed to a series of factors (duration of education, employment situation for young people, availability of moderately priced housing, cultural reasons...)

unemployment, and marry and have children later. In the late 1980s and 1990s, the transition from parental family to independence has been further differentiated by family background: young people from families with strong academic credentials tend to move away from the family home at a younger age than those from working-class families and those with poor academic qualifications. On the other hand, it is important to make a distinction between ‘living away’ and ‘leaving home’. Many students return to their family home to spend long holidays, while young people from working-class families who leave home at an older age often do so for good^{vi}.

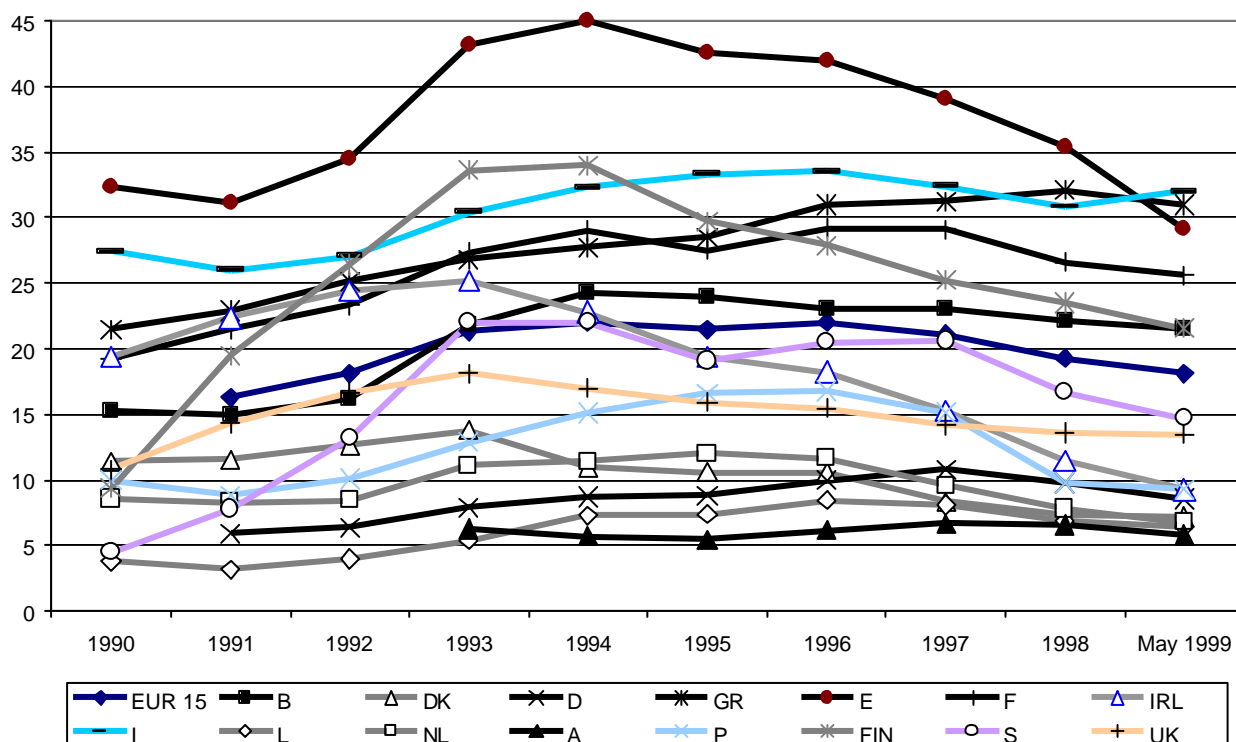
2.4. Social inequalities

- 11) The transition from school to work is often regarded as an important phase in the life cycle which holds the key to understanding the ways in which social advantages and inequalities are handed down from one generation to the next. The changing patterns of education and leaving the family home are partly explained in terms of the restructuring of the labour market. With a sharp decline in the number of unqualified and minimum-aged school-leavers, young people are remaining at school for longer periods of time, partly due to the lack of paid work. New forms of flexible working have reduced job security and many of the least qualified young people have become trapped on the labour market periphery and are vulnerable to periodic unemployment.
- 12) Most Member States have seen an increase in *youth unemployment* rates during the past two decades, especially in the early 1990s. In the European Union average, the highest unemployment rates in the age group under 25 were recorded in 1994 for men (21%) and in 1996 for women (24%). There have been marked differences between Member States: in Spain the youth unemployment rate went up to 41% for men (1994) and to 50% for women (1994), in Finland the peak figures were 36% (1993-

Chart 7: Trends in the under-25 unemployment rate (% , 1990-99)

(source: Eurostat 1999)

(data table in annex 1)



1994) vs. 34% (1993-1994), in Italy 29% (1994-1996) vs. 39% (1995-1997), whereas throughout the last ten years, the rates remained below 15% in Germany, Denmark and the Netherlands, and well below 10% in Austria and Luxembourg. Unemployment among young people has generally declined since the mid-1990s (*chart 7*). In May 1999, the rates were highest in Italy (males 28%, females 38%, aggregate 32%), Greece (22%/41%/31%) and Spain (22%/38%/29%), and lowest in Austria (5%/7%/6%), Luxembourg (7%/6%/6%) and the Netherlands (5%/9%/7%), with a European Union average at 18% (compared to a peak of 22% from 1994 to 1996).

- 13) There are few comparative studies on *poverty* among young people. Eurostat data on social conditions suggest however that young people have greater economic difficulties than other age groups. In fact, data on the socio-demographic characteristics of the *low-income population* in the European Union^{vii} indicate that the proportion of young people (16-24) is higher in the low-income group than that of young people in the rest of the population. Thus, for every 100 young people (16-24) in the rest of the population, there are 137 in the low-income population (maximum Netherlands 258, minimum Portugal 72). According to data from the European Community Household Panel^{viii}, 54% of young people (16-24) - compared to an average of 49% in the total population - live in households which have difficulties in making ends meet (maximum Greece 82% and Portugal 80%, minimum Luxembourg 19%). Similarly, 58% of 16-24 year olds - compared to an average of 46% - are dissatisfied with their financial situation (maximum Portugal 73% and Greece 72%, minimum Denmark 32% and Netherlands 34%). Moreover, compared to an average of 18%, 24% of young people (16-24) report living in overcrowded households (maximum Greece 55%, minimum Netherlands 3%).
- 14) As far as *homelessness* among young people is concerned, there are few comparative data available for Europe. A report published by the European Federation of National Organisations Working with the Homeless (FEANTSA)^{ix} states that within Europe, there is no clear trend of an increase in the number of adolescents who become homeless. Data from national reports suggest that adolescents and young adults in their early 20s do in fact have a lower tendency to become homeless than people in their late 20s and 30s. However, younger homeless people may face higher health risks, as they tend to stay away from support schemes and from shelters for the homeless; in fact, youth homelessness frequently goes along with substance abuse. Moreover, the report underlines that in many Member States, children of immigrant families are at higher risk of homelessness; reports from the Netherlands and the United Kingdom suggest that up to 40% of young homeless people belong to ethnic minorities.
- 15) Little information is available on the health consequences of the particular problems faced by young people living in *deprived peripheral areas of big cities* across Europe. Risk-seeking behaviour (*cf. chapter 5.1*) is frequent among this population, and the combined effects of dropping out of school, unemployment, social exclusion, poverty and lack of opportunities may cause particular physical and mental health risks for these young people.

2.5. Youth culture

- 16) Relatively little is known about young people's cultural patterns in different parts of the European Union, which are quite difficult to monitor comparatively. Nonetheless, the sources available do point to certain tendencies that appear to be taking place in most countries. Youth culture used to represent a form of escapism from work, and to express

resistance against established values, in the form of distinctive sub-cultures. In the Member States, most young people today are in education, while paid labour is scarce. At the same time consumer markets, new communication technologies and international media have created a global youth culture. Similar styles and products are enjoyed and consumed all over the world. Attachment to sub-cultural styles is quite loose, and it is common for young people to move from one leisure group to another in order to meet their different needs.

- 17) Regional differences in youth culture are mainly caused by the availability of consumer services and options. In rural and peripheral areas where availability of these services and options is more restricted, young people tend to spend their leisure with family and friends. Moreover, a deficient capability of young people to participate in “trendy” cultural activities may lead to some forms of social exclusion. Due to the extension of education, youth culture is dominated by students. Those young people who are excluded from education and who remain unemployed often do not have the “cultural capital” that is needed to participate in such activities, which produces further cultural gaps among young people.

2.6. Health services

- 18) Health services which particularly target young people vary largely between Member States. Whereas in most countries, preventive health services are provided at primary school level, adolescents approaching the end of secondary education are rarely examined systematically at school. In some countries, special health services are available to university students, and in some cases certain faculties, e. g. medical schools, organise systematic medical examinations for first-year students. Moreover, many public and private employers organise entry examinations for newly recruited staff. In most countries, however, there are no systematic entry points into health services for young people in particular (apart from the fact that young men are screened before being drafted into the army). To date, there has been no EU-wide research to look at the provision of health services from the point of view of young people.

2.7. Gender differences

- 19) Few studies have made an in-depth analysis of *gender differences* in health status for the 15-24 age group across Europe. Generally speaking, there is evidence that while boys are more likely than girls to have health problems up to puberty, this trend is reversed in adolescence^x. In fact, childhood mortality is higher in boys, and up to puberty boys seem to suffer more often from physical and mental problems, are presented more frequently to a doctor for psychological counselling and are prescribed more medicines than girls. However, from puberty onwards, girls tend to express greater dissatisfaction with their health (*cf. chapter 4.3*) and use medical services more often than boys, and for different reasons: while the main health problems for adolescent boys are injuries, in particular from traffic accidents, adolescent girls are reported to complain more frequently of psychosomatic disorders and emotional disturbances^{xi} (*cf chapter 4.6*). However, more detailed and comparative studies are needed to confirm and explain this shift in gender-related health status between childhood and adolescence.

3. INFORMATION SOURCES

- 20) There are several sources on trends in the health of young people in the Member States: vital statistics (birth, marriage, death), disease registers (cancer, communicable diseases), consumption data (tobacco, alcohol, food), surveys (health, morbidity, handicap, lifestyles), administrative data (use of services, abortion) etc. However, the coverage, content and reliability of data from these sources vary considerably between countries. Wherever time series data are available, Eurostat data are used in this report (fertility, life expectancy, employment, education). An additional difficulty when gathering health data for the 15-24 age group – compared e. g. to school children – lies in the fact that data on young people of this age cannot be collected through one specific setting: while some are still at school, a large proportion will be at university, others in vocational training, and large groups will be in employment or in the army, while others will be at their parents' home looking for a job. Monitoring and reporting systems covering the whole European Union or large parts of it have been established in a few specific fields (cancer⁹, substance abuse¹⁰, HIV/AIDS¹¹ and home and leisure accidents¹²).
- 21) In some fields, comparative surveys have been carried out among teenagers (Health Behaviour in School-aged Children: a WHO cross-national study, hereinafter referred to as the WHO HBSC survey^{xii}; The European School Survey Project on Alcohol and Drugs, Council of Europe/Pompidou Group^{xiii}).
- 22) However, in many areas trends are estimated on the basis of data from national surveys carried out in a few Member States, i. e. from surveys that were not intended to provide comparative data in the first place.

4. HOW HEALTHY ARE YOUNG PEOPLE IN THE EUROPEAN UNION?

4.1. Life expectancy and mortality

- 23) According to Eurostat data for 1997, *life expectancy* at age 15 – expressed in years of life remaining – was 60.3 years for males and 66.4 years for females; in other terms, an average 15-year-old boy in the European Union was expected to live to the age of 75 and a girl to the age of 81 years. Life expectancy varied widely both by gender (females having a higher life expectancy than males) and by country (*charts 8-9*). In 1995, the gender difference was biggest (over 7 years) in France, Finland, Spain, Portugal and Luxembourg, and smallest (5 years) in Denmark, Greece, Sweden and the United Kingdom. For 1997¹³, the lowest life expectancy figures (years of life remaining) for males were reported in

⁹ The European Network of Cancer Registries, hosted at the International Agency for Research on Cancer, F-Lyon.

¹⁰ The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), P-Lisbon

¹¹ The European Centre for the Epidemiological Monitoring of AIDS (CESES), F-Saint-Maurice.

¹² EHLASS (European Home and Leisure Accident Surveillance System) / EUPHIN HIEMS (European Union Public Health Information Network – Health Indicators Exchange and Monitoring System)

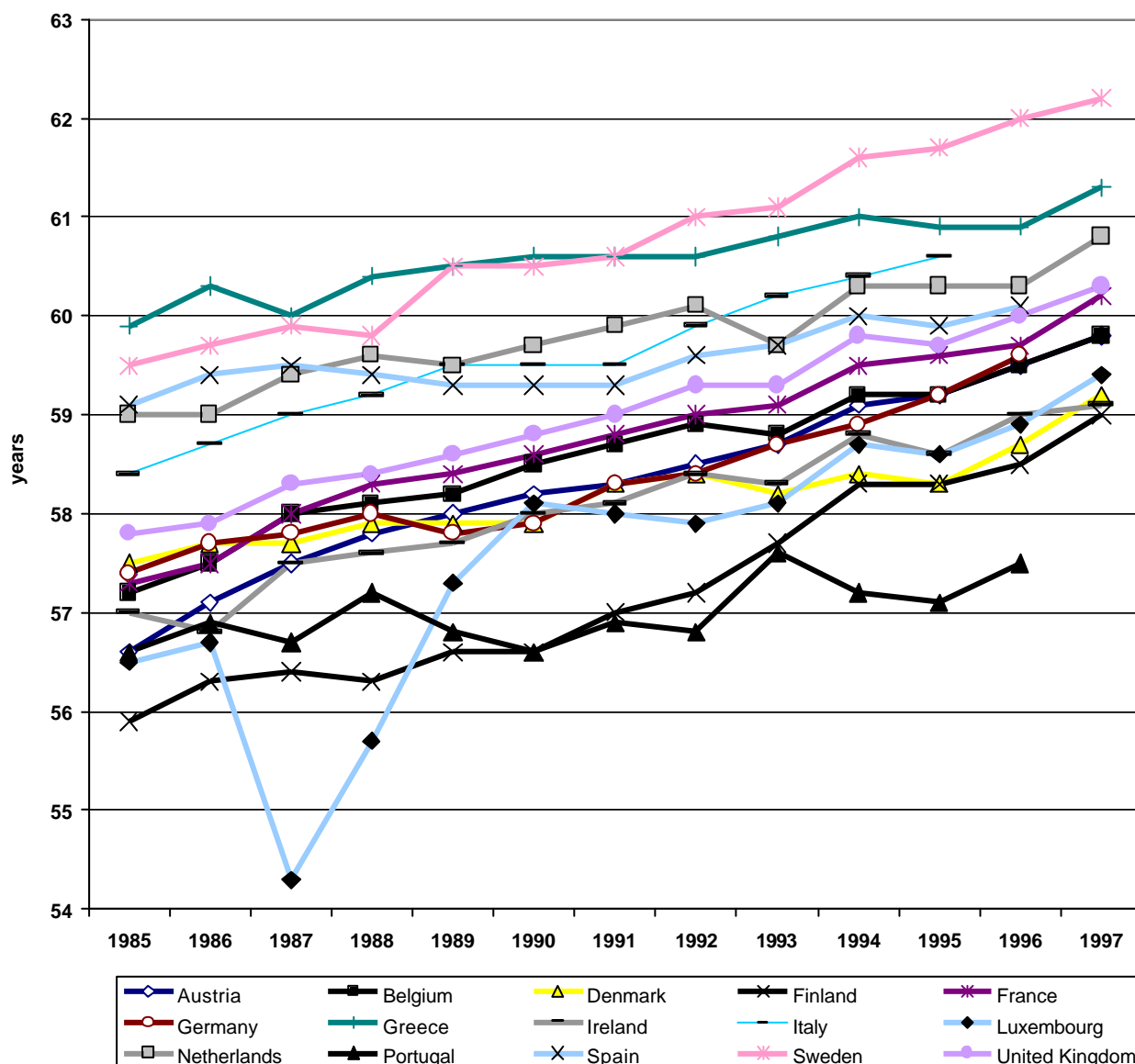
¹³ Figures for Italy are not yet available for 1996 and 1997, figures for Spain not yet for 1997

Portugal (57.5), and for females in Denmark (64.0), Ireland (64.3) and Portugal (64.6). In the same year, the highest figures for males were from Sweden (62.2) and Greece (61.3), and for females from France (67.7) and Sweden (67.2). From 1986 to 1997, the life expectancy of 15-year-old males increased in the European Union average by 2.3 years (by over 2 ½ years in Austria, France, Luxembourg and Finland, by less than one year in Spain¹⁴ and Portugal). In the same period, the corresponding average increase was 2 years for females (over 2 ½ years in Austria, less than one year in Denmark and the Netherlands).

Chart 8: Life expectancy at age 15 (years of life remaining) - Males

(source: Eurostat 1999)

(data table in annex 1)

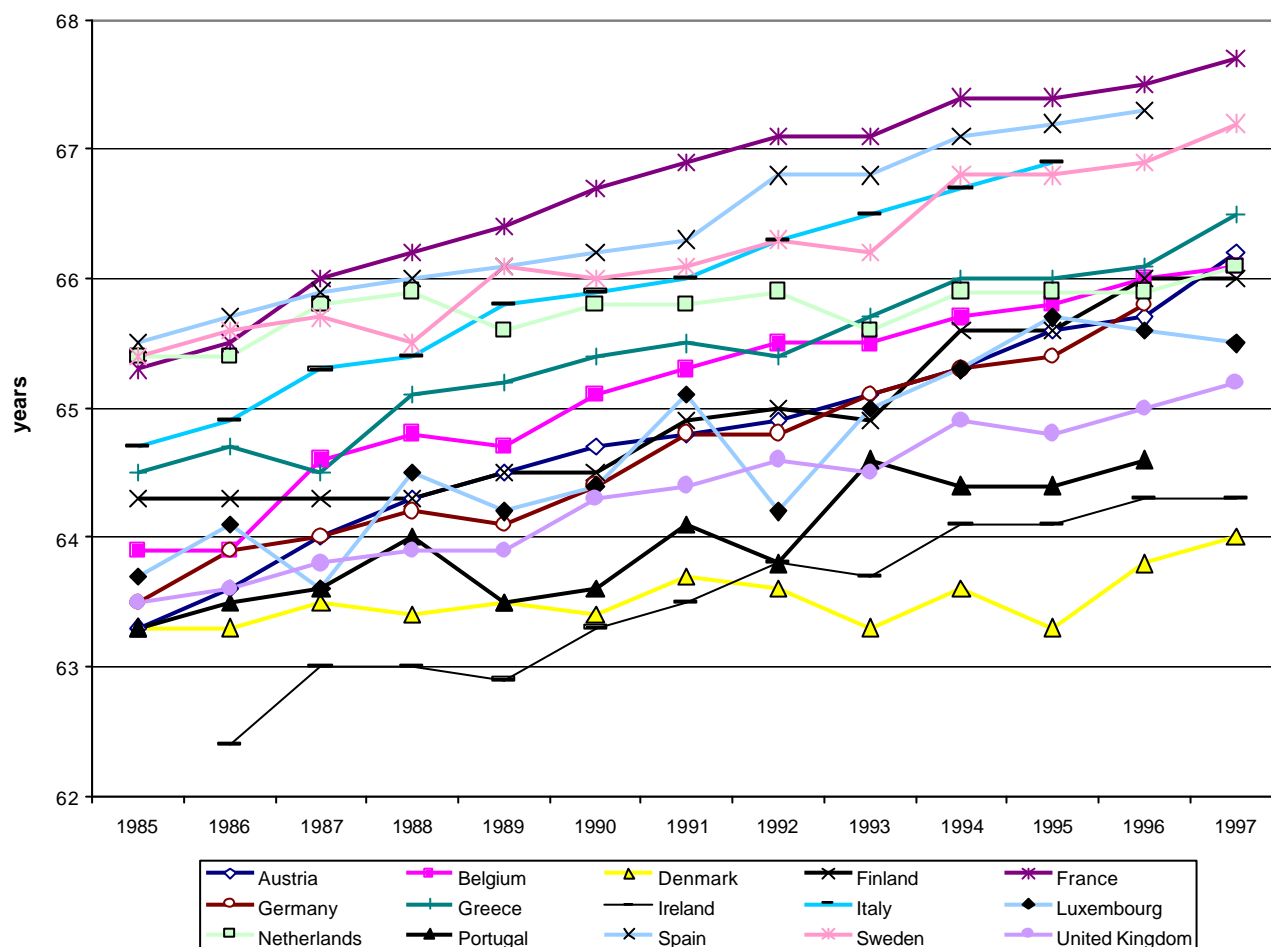


¹⁴ From 1986 to 1996

Chart 9: Life expectancy at age 15 (years of life remaining) - Females

(source: Eurostat 1999)

(data table in annex 1)



24) The risk of death at ages 15 to 24 is lower than in later phases of life, but higher than in childhood (except at infancy). In the mid-1990s, the total number of deaths at that age in EU Member States was about 30 500 a year, 23 000 for males and 7 500 for females. Slightly more than half of the deaths were from external causes such as accidents, poisonings and violence (about 80% for males and 20% for females). In the category of external causes, the main killer is traffic accidents, causing in the mid-1990s about 10 000 deaths a year for males and 2 000 for females (cf. chapter 4.5). Since the mid-1980s, the total number of deaths among young people has decreased by about 20%, mainly due to the decrease in population.^{xiv}

25) The death rate for the age group 15 to 24 varies widely by country and by gender. In 1995, the highest rates for males were reported for Portugal (159 deaths per 100,000) and Austria (116), and the lowest for Sweden (56) and the Netherlands (61). For females, the highest rates were 46 deaths per 100,000 in Portugal and 34 in Germany, and the lowest (25 to 26) in Denmark, Finland, Ireland and Sweden. The male death rates were two to three times higher than those of females. From the mid-1980s to the mid-1990s, a marked

decrease was noted in death rates for males in Austria, Denmark and Sweden, and a slight decrease in Belgium and the Netherlands. The rates for females vary considerably, which is related to the relatively small number of deaths.

26) *Accidents, poisonings and violence (external causes)* are the leading causes of death in both sexes in all Member States. There are again very marked country differences: in 1992 the highest rate for males was 87 deaths per 100 000 (Portugal) and the lowest 27 (Sweden and the Netherlands). The corresponding figures for females were 33 (Luxembourg) and 7 (the Netherlands). On average the gender differences in accidental deaths are greater than in death rates for all causes. The majority of accidental deaths are due to *motor vehicle accidents* (cf. chapter 4.5).

27) In the mid-1990s the number of lives lost due to *suicides* (cf. chapter 4.6) in the 15-24 age group was about 3000 a year for males, and about 700 for females (charts 10-11). Between Member States, *suicide rates* (charts 12-13) varied by a factor of about 10 in both genders, for males from 4 deaths per 100 000 in Greece to 37 in Finland (1995), and for females from 0.8 in Greece to 8.4 in Finland (1995). In most Member States the suicide rate for men remained fairly stable between 1987 and 1995. The rates for females vary considerably, which is related to the relatively small number of deaths.

Chart 10: Causes of death - Suicide and self-inflicted injury (E54)
Number of deaths, 15-24-year-old males

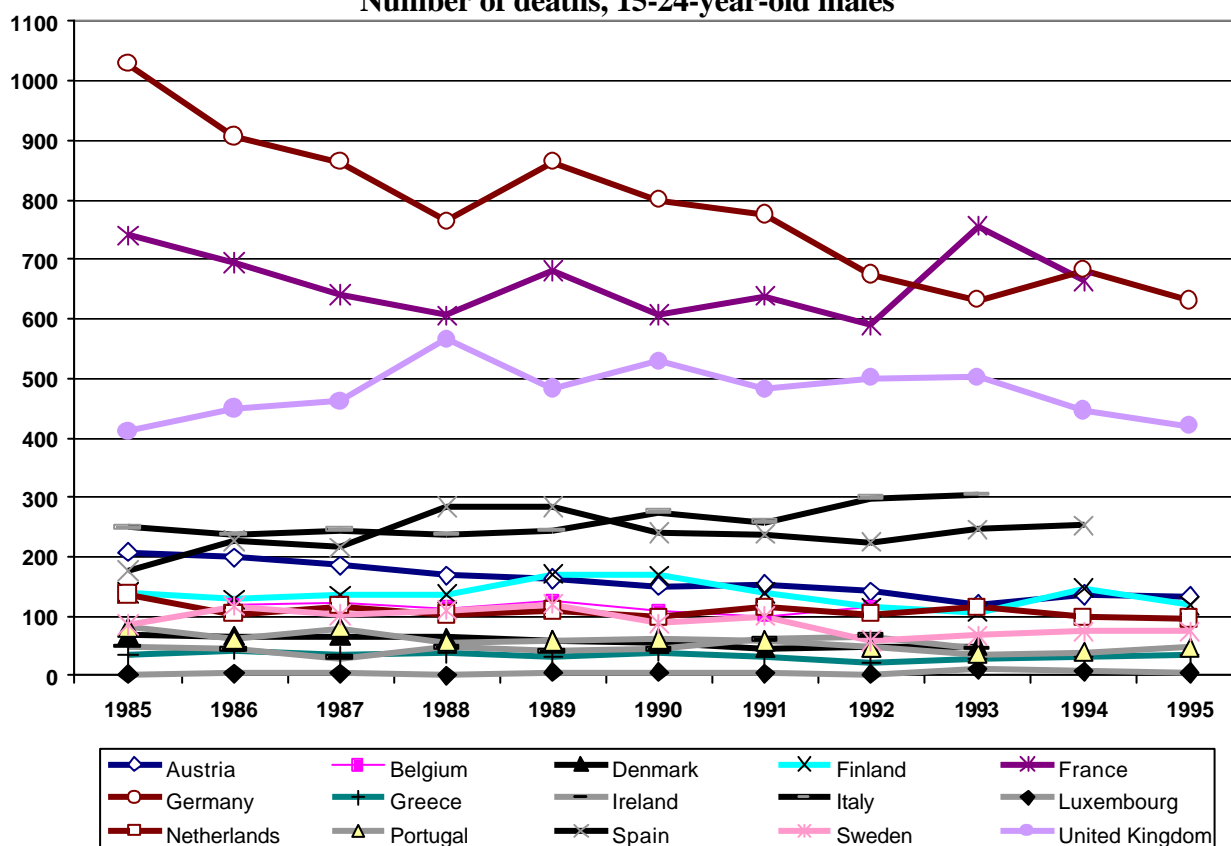


Chart 11: Causes of death - Suicide and self-inflicted injury (E54)

Number of deaths, 15-24-year-old females

(source: WHO World Health Statistics Annual)

(data table in annex 1)

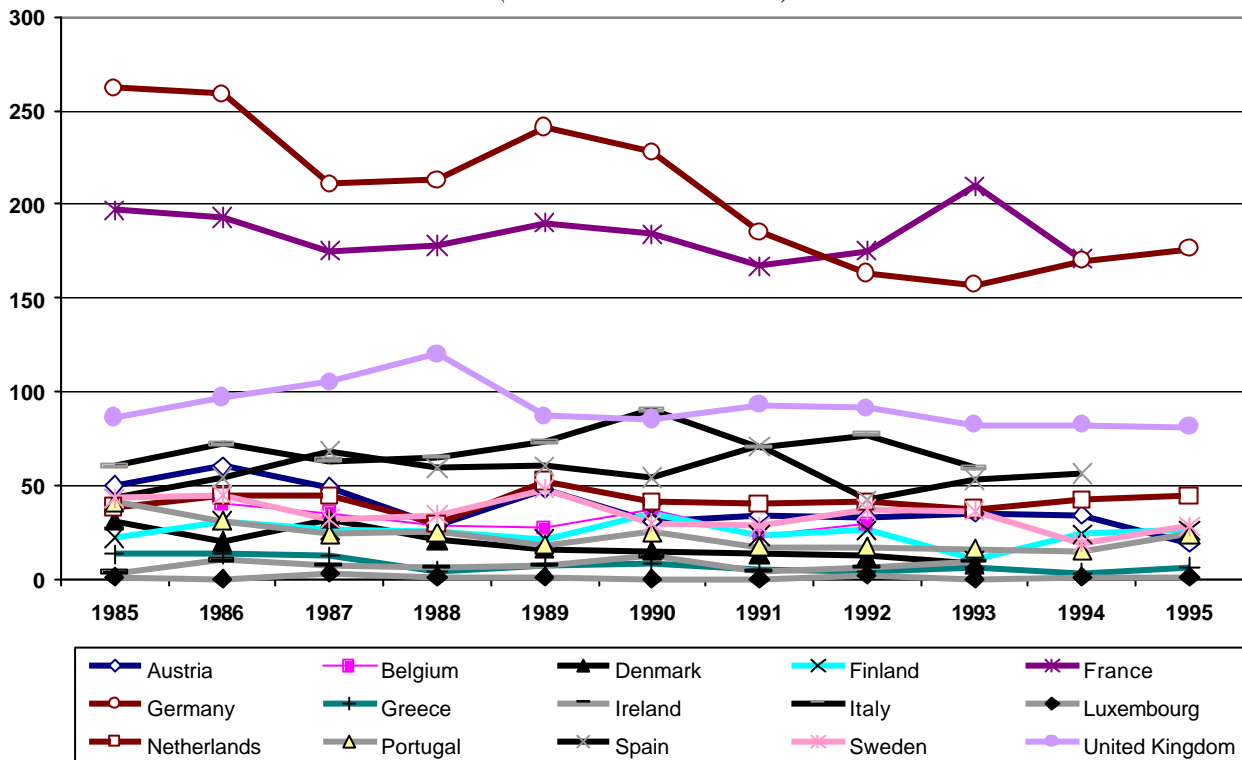


Chart 12: Causes of death: Suicide and self-inflicted injury (E54)

Death rate per 100 000 population

15-24-year-old males

(source: WHO World Health Statistics Annual)

(data table in annex 1)

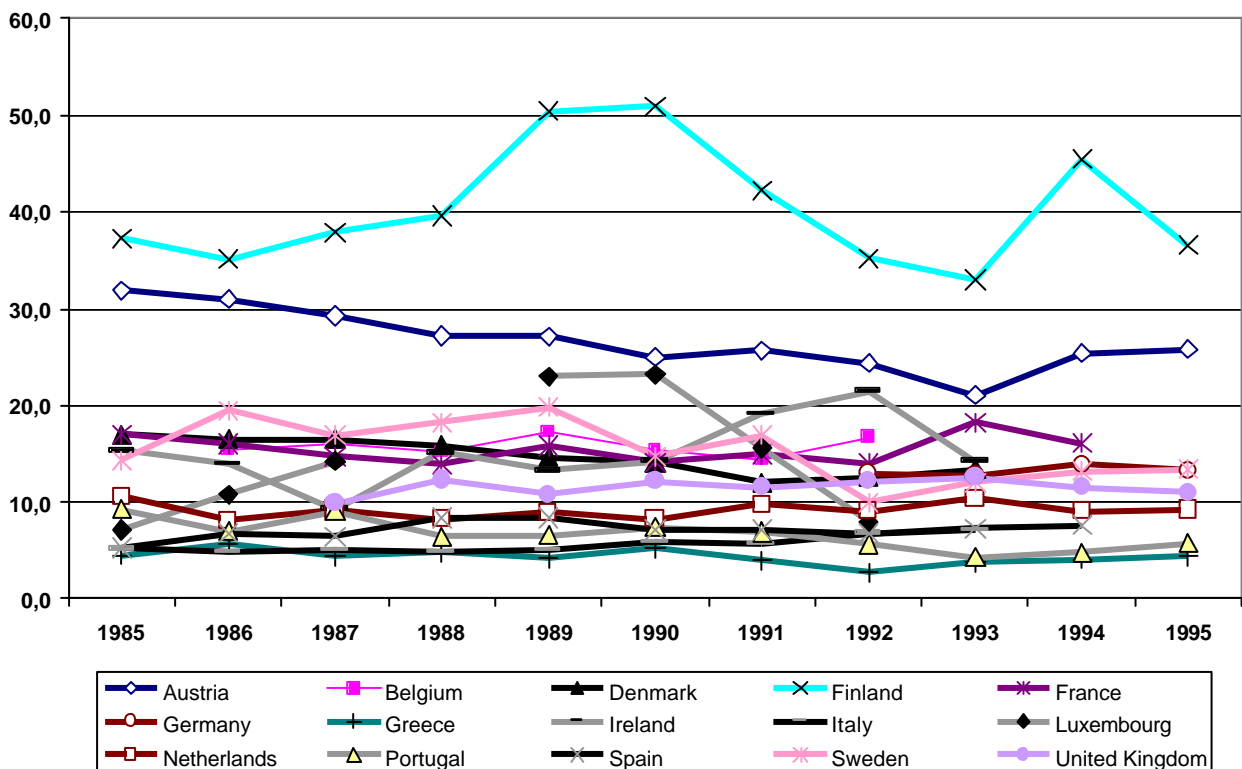
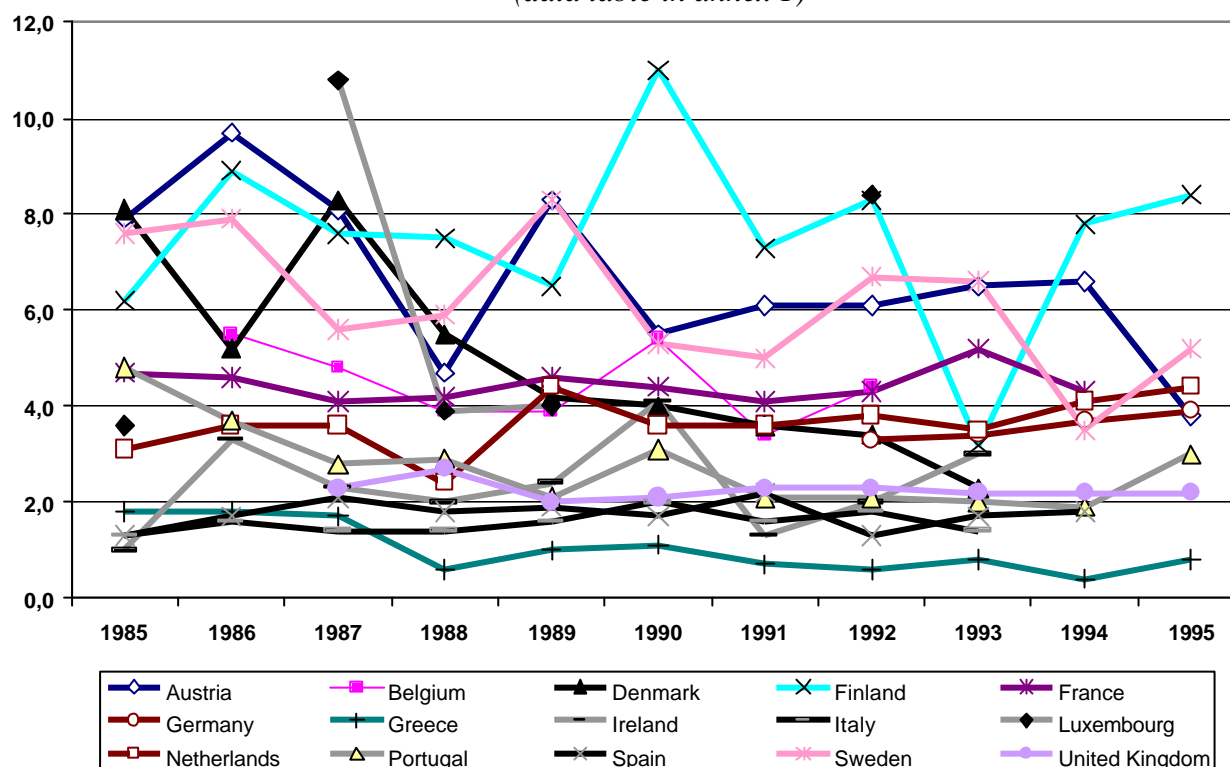


Chart 13: Causes of death: Suicide and self-inflicted injury (E54)
Death rate per 100 000 population
15-24-year-old females
(source: WHO World Health Statistics Annual)
(data table in annex 1)



28) Recent studies from Finland suggest that a common denominator behind the deaths of young people from external causes and suicides is often substance abuse, and particularly alcohol abuse. The lower the socio-economic status of the parents and the more problems the adolescent has faced during his or her educational career, the higher the risk of death at the age of 15 to 24.

4.2. Height and weight

29) Secular increase in attained *height* during the growth period is continuing in most countries, but has slowed down^{xv}. The increase in adult stature over the past decades has varied between 0.3 and 3.0 cm/decade. Almost all of the secular increase seen in adult height occurs during childhood and is more pronounced in children from low socio-economic backgrounds, thus indicating improvements in the nutritional and health status as well as in the physical and social living conditions of a population.

30) *Undernutrition* in childhood and adolescence is a potential threat to the health and well-being of new generations (*cf. chapter 5.6*). However, undernutrition has been neither diagnosed as a health disorder, nor monitored in the health statistics or the health surveys of the Member States. No data are available on its prevalence and trends.

31) *Overweight*, which is related to several disorders, is an increasing problem in the adult population and, in some countries where data for these age groups are available, also among adolescents and children. The health consequences of obesity in childhood and adolescence include psychosocial problems, increased cardiovascular risk factors, abnormal glucose metabolism, hepatic-gastrointestinal disturbances, sleep apnoea and orthopaedic complications. The persistence of adult obesity is more likely when its onset is in late childhood or adolescence, and when obesity is severe. It has also been shown that overweight in adolescence is associated with long-term mortality and morbidity. Obesity is relatively common in the European Union, especially among women and in the Southern European Member States. The prevalence of obesity has increased by about 10 to 40% in the majority of the Member States during the past ten years, and is currently in the range of 10 to 20% in men and 10 to 25% in women.^{xvi}

4.3. Perceived state of health

32) The perceived state of health is usually measured by asking respondents to rate their *health in general*. The second set of questions deals with *perceived symptoms*, often interpreted as being psychosomatic in nature, such as headache, back pain, nervousness, tiredness, sleeping difficulties, etc. The vast majority of 15-year-old Europeans who took part in the WHO HBSC 1997/1998 survey rated their health as good, and about one-third as very good. On the other hand, more than one in five teenagers suffered regularly from psychosomatic symptoms. A common research finding on perceived health is that males tend to rate their health as better and report notably less symptoms than females. Due to cultural patterns and difficulties in comparative surveys related to differences in key concepts in various languages, there are serious weaknesses in cross-national comparisons. In general, however, the perceived health of young people seems to be strongly associated with family background, lifestyles, school performance, social relations and living conditions. Poor health ratings and a high prevalence of perceived symptoms coincide with risky lifestyles, especially with substance abuse, loneliness, poor perceived atmosphere at school and a high amount of perceived school/work related problems.

33) Alterations in function are commonly assessed at three sequential stages, termed *impairment, disability and handicap*. Unfortunately, similar concepts are used differently in many reviews and surveys, which means that no comparable data are available for young people on the basis of this classification. From national surveys it appears that about one in ten young people suffer, according to their own assessment, from an impairment, disability, handicap or other chronic condition which restricts or hampers daily activities.

4.4. Common illnesses and diseases

34) The most common diseases at the age of 15 to 24 are *common colds* and *flu epidemics*. In Northern countries, most young people report at least one episode a year and about one in five report three or more episodes.

35) The most common *oral diseases*, i.e. caries and gingival infections, have generally decreased among young people in the Member States during the last 10 to 20 years. However, it is estimated that 10 to 15% of adolescents, mostly in the poorest and least educated families as well as among migrant and refugee populations, still suffer considerably from dental diseases^{xvii}.

36) *Asthma and allergic diseases* (atopic eczema, allergic rhinitis and contact dermatitis, especially nickel allergy) are the most common and rapidly increasing chronic diseases among young people, affecting more than one-third of them (at some time in their life). In fact, few diseases have seen as marked an increase in prevalence over a comparatively short span of time as *asthma*. As reported in the ISAAC study^{xviii}, in the United Kingdom about one-third of children aged 13–14 suffer from recurrent symptoms of asthma, and almost 30% in Ireland. Prevalences in Finland, Germany, Sweden Belgium and Austria are around 15%, whereas they are around 10% in southern Europe (and at only 3% in Greece). These great variations may in part be explained by environmental factors, but – as the results refer to self-reported symptoms – also by varying levels of awareness^{xix}. The overall prevalence of *allergic rhinitis* in the general population is approaching 20%, with a clear peak in the 15-24 age group^{xx}. Almost one-fifth of adolescents suffer from recurrent symptoms of *atopic eczema* in the United Kingdom and Scandinavia (one Swedish study even reports that up to 50% of girls aged 13-15 suffer or have suffered from atopic eczema), but only around 5% in parts of South Europe^{xxi}. The dramatic rise of the cumulative incidence of atopic eczema in early childhood is particularly worrying, as studies have shown that 40-60% of cases of atopic eczema first occurring in infants will persist into adulthood, with a 25% risk of developing asthma in later years (corresponding risk of developing pollen allergy 41.5%, perennial rhinitis 25%)^{xxii}.

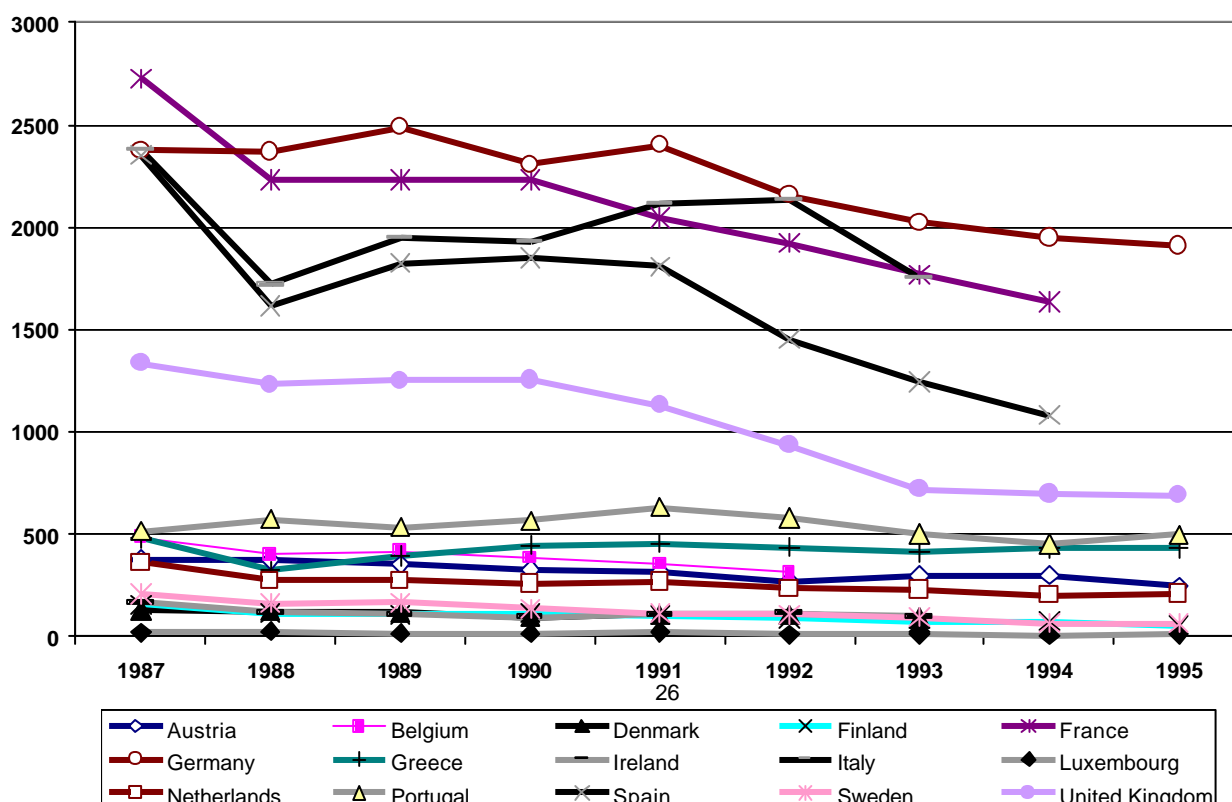
4.5. Accidents

37) Each year around 12 000 young people are killed in *traffic accidents* in the European Union, the vast majority being males^{xxiii}. In most Member States the numbers have tended to decrease (*charts 14-15*). In 1995, the male mortality rate per 100 000 varied from 61 per 100 000 in Portugal and 54 in Greece to 12 in Sweden and 18 in Finland and the United Kingdom.

Chart 14: Causes of death - Motor vehicle traffic accidents (E471)

Number of deaths, 15-24-year-old males

(source: WHO World Health Statistics Annual)

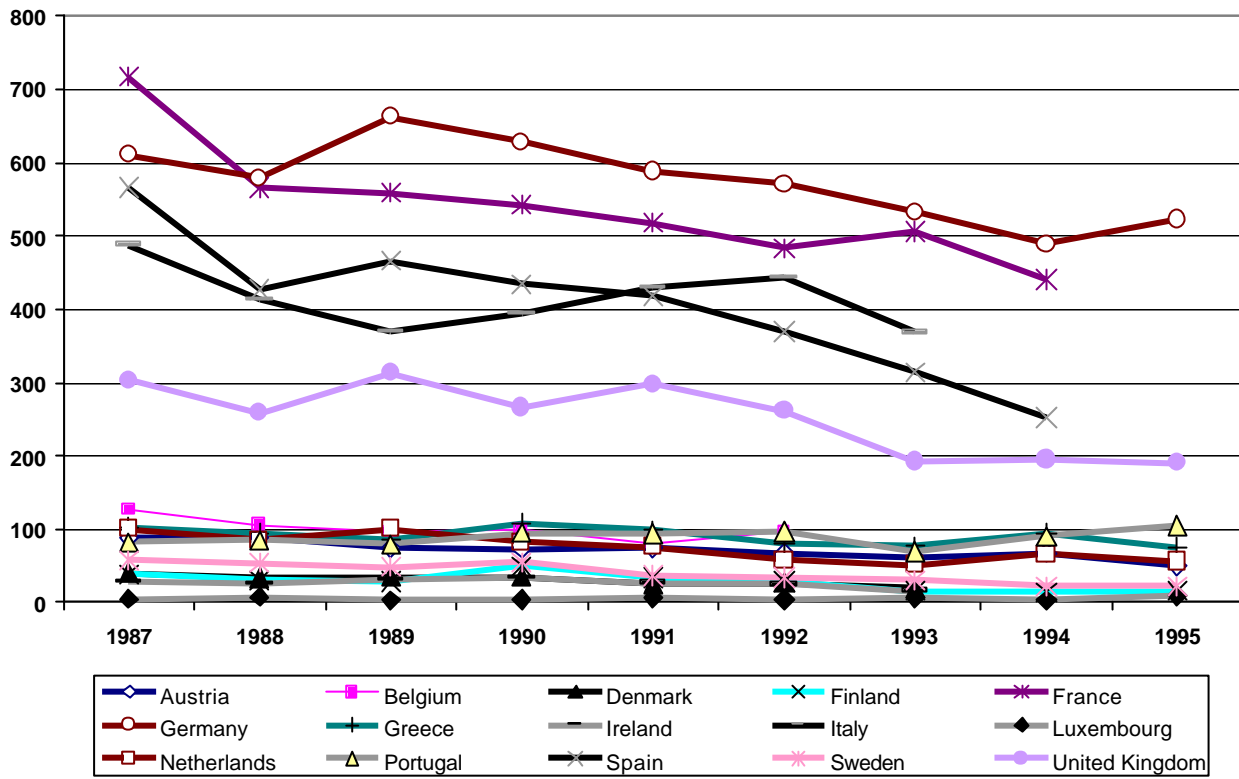


(data table in annex 1)

Chart 15: Causes of death - Motor vehicle traffic accidents (E471)

Number of deaths, 15-24-year-old females

(source: WHO World Health Statistics Annual)



(data table in annex 1)

38) The number of people *injured* in traffic accidents has decreased in Finland, Denmark, France, Luxembourg and the Netherlands, but remained stable in Belgium and the United Kingdom. There are no EU-wide data on the number of disabilities caused by traffic accidents.

39) Comparative statistics on *home and leisure accidents* in the European Union¹⁵ show that the 15-24 age group is at a slightly higher risk of suffering from such accidents than the average population. In fact, while in the European Union this age group represents 13% of the total population, it accounts for 17% of home and leisure accidents (1996/1997 data). However, only 3.8% of young people were hospitalised as a consequence of such accidents (against 7.8% in the 45-54 age group), and when they were treated as inpatients, the average length of hospital stay was shorter for the 15-24 age group than for the average population. More than 76% of all reported home and leisure accidents in the 15-24 age group are covered by the following diagnoses: contusion, abrasion, open wound, fracture, luxation/dislocation, distortion/sprain; only for distortion/sprain is the proportion of the 15-

¹⁵ EHLASS (European Home and Leisure Accident Surveillance System) database / EUPHIN HIEMS (European Union Public Health Information Network – Health Indicators Exchange and Monitoring System)

24 age group significantly higher than for all ages taken together. According to the WHO HBSC 1993/1994 survey, injuries in connection with leisure and school were more common among boys than girls. Two-thirds of all injuries required treatment by a nurse or a physician. In 15-year-old boys, 41% of all serious injuries occurred in the context of sports activities, for girls the corresponding percentage was 35.

4.6. Mental health

- 40) *Psychological and psychosocial problems* in adolescence tend to be underrecognised and undertreated. Mental disorders in young people are not as typical and discrete entities as they are in adulthood. The incidence of many disorders (depression, substance abuse disorders, suicidal behaviour, eating disorders and psychotic disorders) increases markedly from childhood to adolescence, and the prevalence continues to rise into adulthood due to recurrent cases. Although data from the Member States are relatively scarce, it is estimated that the overall prevalence of mental disorders in adolescence is in the region of 15 to 20%. It is expected to be even higher in adolescents belonging to underprivileged and poorly integrated population sub-groups, such as migrants.
- 41) *Depression* commencing in adolescence is a highly recurrent condition causing severe psychosocial impairment, and is a major public health problem. Depression in childhood and adolescence is associated with subsequent adjustment problems, underachievement in education and suicidal behaviour. According to the epidemiological data available, the lifetime prevalence of major depression is about 4% in the age group 12–17 and 9% at age 18 (twice as high in females as in males). The latest findings suggest an increase in the prevalence of adolescent depression.
- 42) Experimental *substance abuse* is common in early adolescence, but only a minority will eventually develop addictive patterns of use. *Substance abuse and dependence* at the age of 15–24 years is frequently associated with mental disorders such as depression. In addition, substance abuse among young people presents a high risk of developing severe mental disorders in adulthood.
- 43) *Suicide* is one of the three leading causes of death among young people. About 14% of all suicides occur in the age range of 15-24 (*for number of deaths and suicide rates cf. charts 10-13 in chapter 4.1*). Epidemiological findings point to a marked and unexplained international variation in both suicidal behaviour and suicide rates. Rates of attempted suicide correlate significantly with suicide rates. Whereas trends in mortality from suicides have generally levelled off among young people in the 1990s, there has been a recent increase in attempted suicide rates in young males in several Member States^{xxiv}. Although the marked variations between countries referred to above make it difficult to draw general conclusions, suicidal behaviour is often related to depressive disorders and/or substance abuse, thus highlighting the importance of interventions aiming at the prevention and treatment of depression and substance abuse.
- 44) *Eating disorders* are a major threat to normal development. About 20% of early victims become chronic cases, and mortality is about 6%. Eating disorders have become more common in adolescents during the past 20 years; among young females anorexia nervosa increased until the late 1980s, whereas bulimia is still increasing. The prevalence of anorexia nervosa stands at about 1%, and that of bulimia nervosa at 1.5-2% among adolescents. About 10 times more females suffer from eating disorders than males.

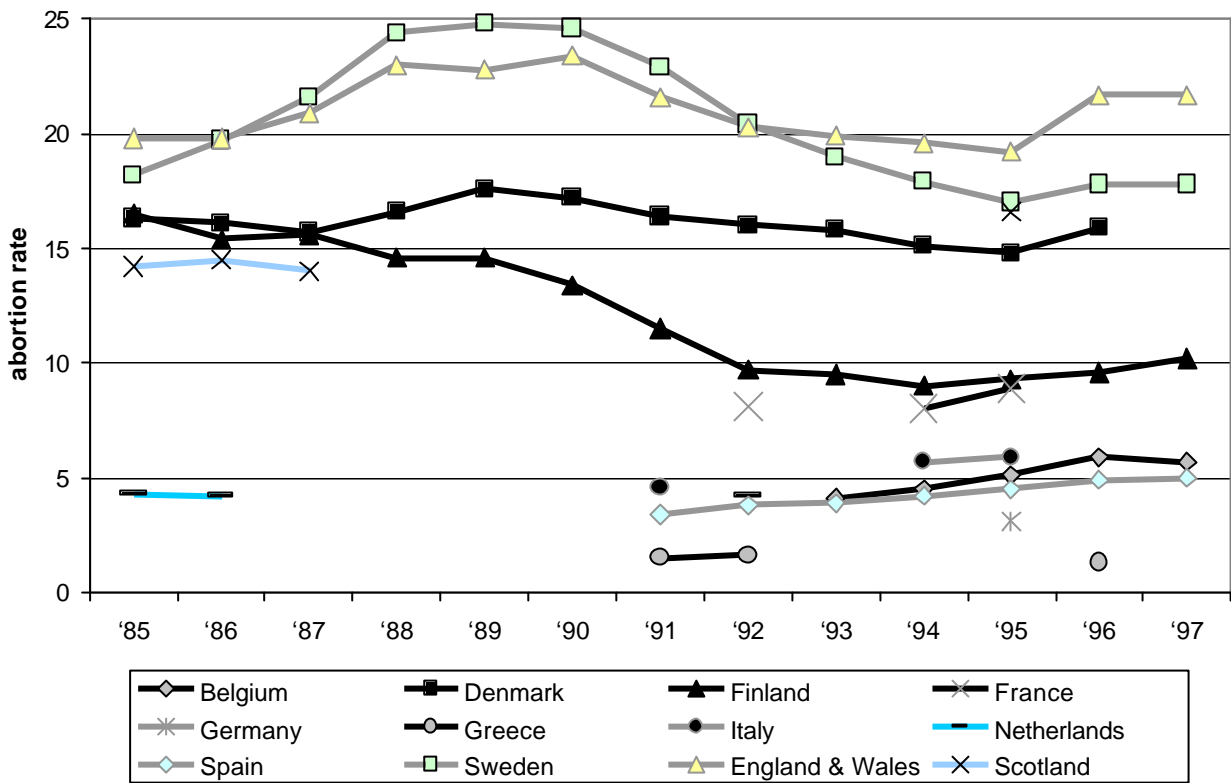
45) *Psychotic disorders* are rare in childhood, but after puberty the incidence of schizophrenia increases and peaks in early adulthood. The prevalence is between 0.5- 1% among young people. The first manic-depressive episodes generally occur in adolescence.

4.7. Sexual and reproductive health

46) The status of reproductive health among young people is indicated by levels of unintended pregnancies and sexually transmitted diseases (STD's). As long as the large majority of pregnancies in teenagers are unintended, the teenage fertility rate can also serve as an indicator of unwanted pregnancies alongside the abortion rate (*cf. chapter 2.1*).

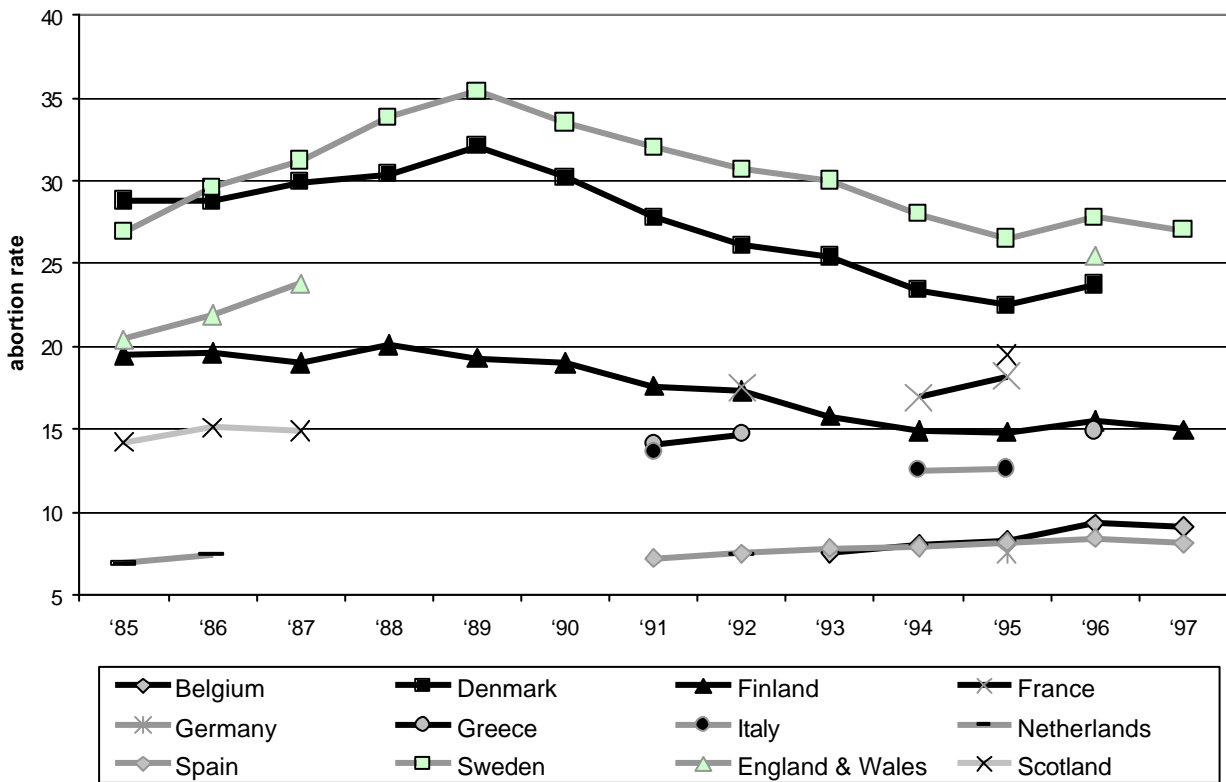
47) *Unintended pregnancies* are associated with an increased risk of poor social, economic and health outcomes for mother and child, and teenagers are at greater risk than adult women. When responsible sexual behaviour and contraception fail, abortion is often used to solve the problem of unintended pregnancy. There are no *abortion* statistics for Austria, Ireland, Luxembourg and Portugal, while data from some other Member States are incomplete (France, Germany, Greece, Netherlands and Italy). For those Member States where there are complete data, the abortion statistics highlight large differences. In 1996, for these countries, the highest *teenage* abortion rates per 1000 women (*chart 16*) were reported from England & Wales (22), Sweden (18) and Denmark (16), and the lowest from Spain (5) and Belgium (6). In the age group 20–24 (*chart 17*), for the same year, the rates were lowest for Spain (8) and Belgium (9), and highest in Sweden (28) and Denmark (24). Abortion rates in the mid-1990s are fairly similar to those of the mid-1980s^{xxv}, with the exception of Denmark (20-24 age group only) and Finland, where there has been a continuous decline.

Chart 16: Abortion rate per 1000 women, age <20



(data table, sources and explanations in annex 1)

Chart 17: Abortion rate per 1000 women, age 20-24



(data table, sources and explanations in annex 1)

- 48) Recent studies (Sweden and Finland) suggest that *chlamydia* is by far the most common of *sexually transmitted diseases (STDs)*, carried by 5-7% of young people^{xxvi}. Little is known about the trends in the incidence of chlamydia, and about the effects of intervention efforts.
- 49) *HIV* is less common but a more serious threat to both public and individual health. Very little is known about the true incidence of HIV infections among 15–24-year-old people; the European data available only cover AIDS. From 1992 to 1997 the annual number of new cases of AIDS in the age group 15–24 decreased from about 1050 cases to about 460 cases. However, HIV infections occurring in that age group will result in reported AIDS cases only later in life; in fact, the corresponding number of new AIDS cases at the age of 25–34 was almost ten times higher than in 15–24-year-olds, but also declining (from 10 000 to 5200). In 1996, about 75% of new cases were notified among males. Recently, several Member States have started collecting data on HIV infections as well (*cf. chapter 4.9*).
- 50) Careful monitoring of chlamydia, syphilis, gonorrhoea and HIV among young people serves as an important surrogate marker for the success of prevention efforts.

4.8. Chronic non-communicable diseases

- 51) *Cancer* among young people is rare, but it is the leading cause of death from diseases in this age group, accounting for 7–13% of all deaths caused by diseases. In 1995, a total 10 599 new cases of cancer (all sites except skin) were diagnosed, and 2467 deaths from cancer were recorded in the age group 15–24 years within the European Union. Both the incidence of and mortality from cancer vary considerably between Member States^{xxvii}.
- 52) It is in the 15 to 24 age group that important lifestyle choices are made (in particular with regard to smoking, nutrition, alcohol – *cf. chapters 5.2, 5.3 and 5.6*); these choices influence the risk of suffering from cancer - and also other diseases - later in life.
- 53) *Cardiovascular diseases (CVD)* are rare in young people. However, the risk factors for these diseases, including lifestyles (smoking, inadequate diet, physical inactivity), blood lipid disorders and high blood pressure have their origin in childhood and adolescence. Many biological risk indicators become visible in health check-ups at the age of 15–24. There are no comparable data from Member States on the prevalence of blood lipid disorders or hypertension at this age.
- 54) Due to changes in working conditions and lifestyles, there is a higher prevalence of both symptoms and diseases of the *musculo-skeletal system*. In fact, musculo-skeletal diseases are among the most common causes of disability in middle age. Severe low-back disorders often begin in teenage. According to recent studies from Finland, up to one in five adolescents suffer from regular shoulder and neck pain, a significant increase compared to the late 1980s.^{xxviii}
- 55) *Diabetes* (type 1) is one of the most common chronic diseases in childhood in Europe, leading to lifelong insulin replacement therapy without which diabetic patients would die soon after the onset of the clinical disease. It is a very costly disease; its lifelong costs have been estimated at around one million € per patient. In addition, it causes severe disability and increased mortality. Almost all patients develop some degree of eye disease, almost

half a severe one. One-third of diabetic children will develop diabetic nephropathy, which is probably the most serious and expensive complication of diabetes leading to kidney failure. Today in Europe, diabetes is the leading cause of kidney transplantation and dialysis. Mortality in children with diabetes is 2 to 5 times higher than that of the background population. A large number of diabetes registries have been established since the mid-1980s, covering most European countries. Childhood diabetes is slightly more common in males than females. Differences in the incidence of diabetes between populations are large. Finland has the highest incidence, now approaching 50 per 100.000 a year. The incidence of type 1 diabetes is globally increasing by approximately 3% per year. If the increase continues at this rate, the incidence of type 1 diabetes will be 40% higher in 2010 than that in 1998^{xxix}.

4.9. Communicable diseases

- 56) The incidence of communicable diseases among young people is generally lower than in the general population. Age-specific incidence data are available for most communicable diseases in several but not all Member States. An integrated dataset covering all the information available would be a useful tool in setting priorities and in drawing conclusions about the interdependence of health promotion activities and trends in communicable diseases. At Community level, a network for the epidemiological surveillance and control of communicable diseases is being progressively implemented¹⁶.
- 57) The most common *blood borne infections* are hepatitis C (HCV), hepatitis B (HBV) and HIV, associated with intravenous drug use (IDU) and risk behaviours such as needle sharing. HBV infections are more common among homosexual men compared to age-matched control populations. Very few Member States are able to monitor the age-specific incidence of hepatitis B. The World Health Organisation has recommended that HBV vaccinations be included in national vaccination programmes and given to the entire population. An ongoing EU-wide inventory will provide more detailed information on this¹⁷.
- 58) The incidence of *Hepatitis C* seems to be rising in many Member States. In several countries, a considerable proportion of newly diagnosed cases occur in those under 25 years of age. However, only limited age-specific incidence data are available and an EU-wide project has recently been launched to obtain such data in all Member States¹⁸. Chronic HCV infections may cause severe late sequelae. Ten to twenty percent of chronic carriers may suffer from serious liver diseases, including liver cancer in later life.
- 59) In several countries affected by HIV epidemics among intravenous drug users in the mid-1980s, intensive prevention programmes were set up to reduce the risk behaviour related to IDU. Such countries (e.g. Scotland, Denmark, Sweden) have seen a declining trend in HIV

¹⁶ Decision no 2119/1998/EC of the European Parliament and of the Council of 24 September 1998 setting up a network for the epidemiological surveillance and control of communicable diseases in the Community - OJ no L268, p 1 of 3 October 1998

¹⁷ Inventory of the Means of Controlling Communicable Diseases in the European Union, Norway and Switzerland. European Commission, 1998.

¹⁸ Smitskyddsinstitutet, Department of Infectious Disease Epidemiology. Setting standards for hepatitis C surveillance in Europe. A EU-sponsored project. Stockholm 1999.

infections among intravenous users in the 1990s. In some other Member States (such as Finland) a vigorous HIV epidemic has recently started among intravenous users, also affecting young people. In the Member States where IDU-related HIV infections seem to be most common (France, Italy, Spain), little information is available about trends among young people during the 1990s. Recent initiatives to start HIV reporting will help to provide more data; evaluations based on such data would help to assess the efficacy of current prevention policies.

- 60) Although the incidence and prevalence of *tuberculosis* (TB) is generally low among young people, adolescents belonging to deprived population sub-groups may well be at risk. Tuberculosis is closely related to poverty, especially to malnutrition, poor housing conditions and low hygiene standards. For example, in all Member States the occurrence of TB infections is about three times higher in migrants than in the total population. Growing multi-drug resistance further complicates tuberculosis management in certain migrant populations. Due to aggravated economic inequalities the incidence of TB is on the increase world-wide.

5. LIFE STYLE AND DISEASE

5.1. Risk behaviour and criminal activities

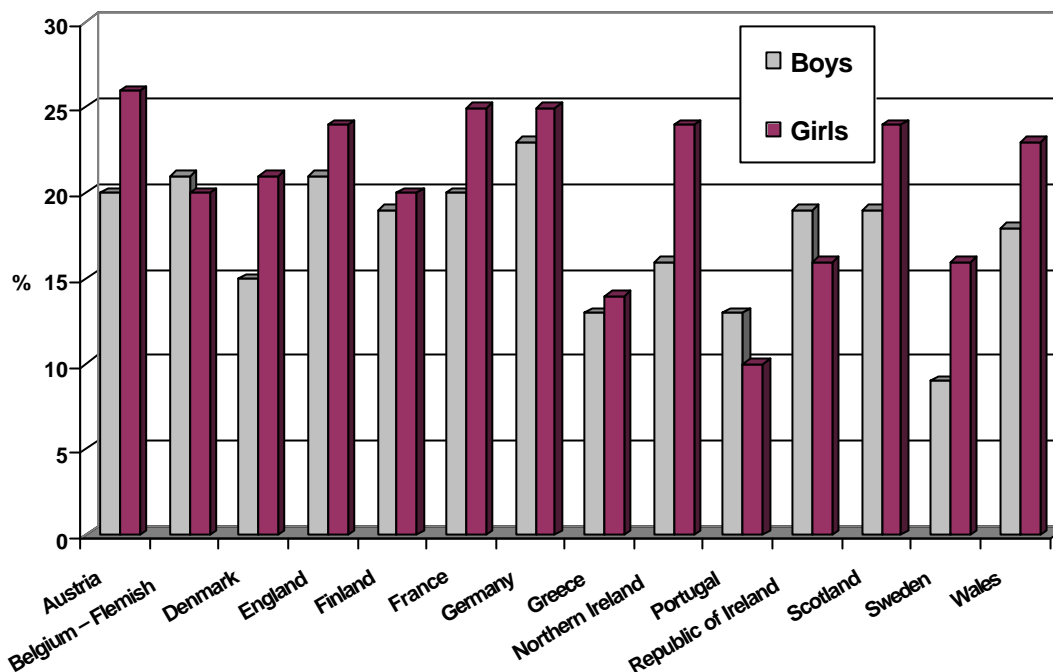
- 61) Data on risk behaviour are available from official crime statistics and self-report surveys. The former source in particular has to be treated with caution: official statistics are likely to reflect changes and, in a comparative setting, differences in crime policy to a greater extent than actual trends in crime or variation in risk-seeking, which makes international comparisons extremely difficult.
- 62) Risk-seeking behaviour is a normal part of adolescence. According to self-report surveys many young people have been involved in some sort of *criminal activity*. Criminal careers also begin in youth. Studies following young offenders have shown that often the first offence is conducted at the age of 13 to 14. The majority of all indictable crimes are committed by young people aged 15 to 24. Risk-seeking behaviour may be particularly frequent among young people living in deprived peripheral areas of big cities (*cf. chapter 2.4*).

5.2. Smoking

- 63) Smoking is a major cause of both ill health and severe chronic disease. Each year in the general population of the European Union, approximately half a million deaths are attributed to smoking. Because of the growing number of women who smoke, the number of lung cancer deaths is rising in most Member States. Even a few months of daily smoking increases the occurrence of respiratory illnesses and associated symptoms. Smokers suffer from flu and common colds more often than non-smokers. Early regular smoking is associated with an increased risk of both substance abuse and mental disorders.

Chart 18: % of 15-year-old students who report smoking daily (by gender, 1997/1998)

(source: WHO)



(data table in annex 1)

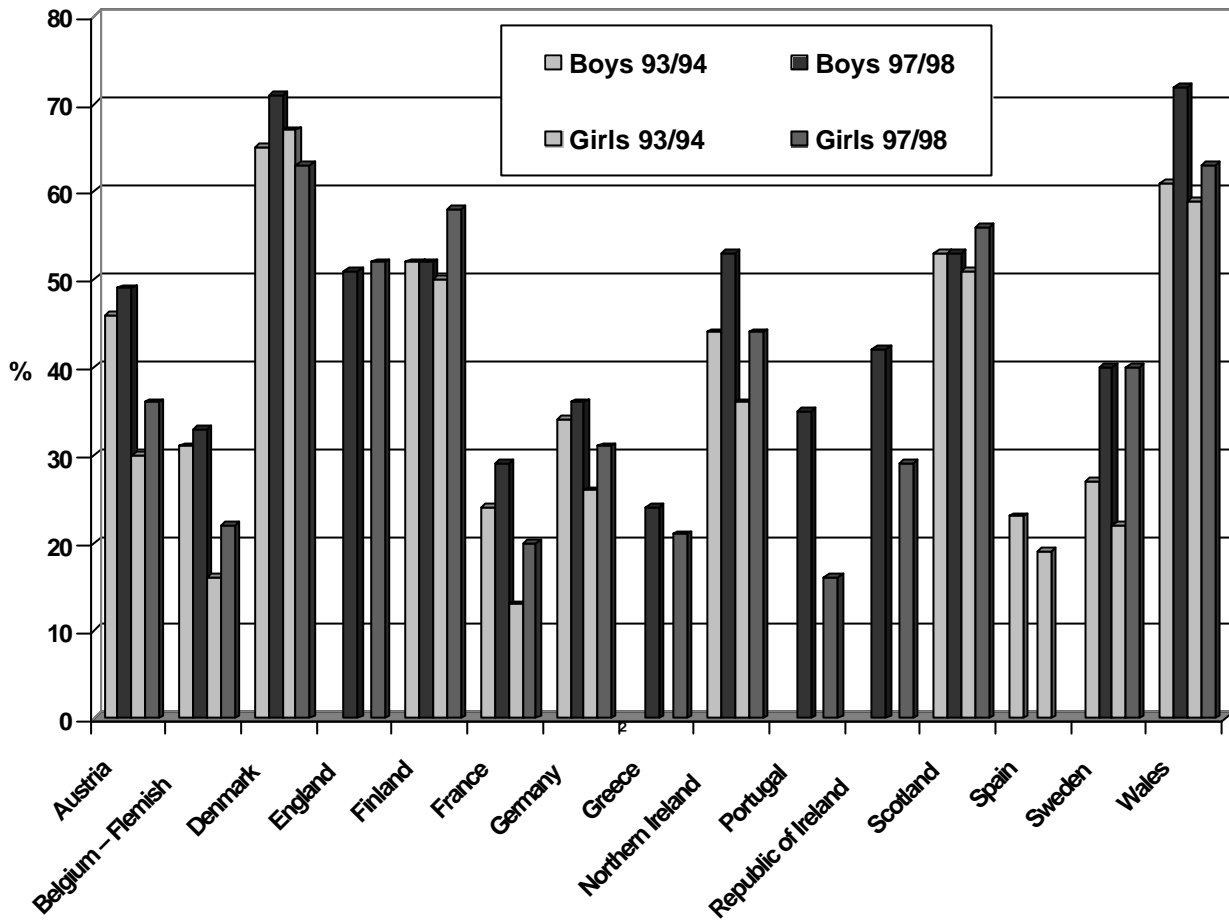
- 64) Experiments with smoking often start in childhood: the WHO HBSC 1997/1998 survey shows that in most EU countries covered, 50-80 % of students aged 15 report having tried smoking. Furthermore, according to the same survey, about one-fifth of all 15-year-olds in the EU countries covered are daily cigarette smokers (*chart 18*), the percentage being highest in Austria (boys 20%/girls 26%), France (20%/25%) and Germany (23%/25%), and lowest in Portugal (13%/10%), Greece (13%/14%) and Sweden (10%/16%). Among 15-year-olds, girls report daily smoking more frequently than boys in a clear majority of countries (however in the late 1990s, in the 15-24 age group as a whole, men smoked more than women with the exception of Spain, Sweden and Denmark). No country shows a decrease in weekly smoking among 15-year-olds since the 1993/1994 survey.
- 65) Regular smoking increases with age up to ages 18–20. Because of the addictive properties of nicotine, most young daily smokers continue to smoke regularly into middle age. Daily cigarette smoking is strongly related to poor school performance and is particularly prevalent in young people whose educational career indicates downward social mobility when compared with parental socio-economic status.
- 66) The total consumption of tobacco products decreased in the European Union during the 1990s. However, the trends in early teenage smoking have been stable or have even shown an increase in some Member States. For the age group 15–24, there are no comparable data on smoking from the Member States. For those Member States where national time-series data are available, the findings suggest a declining trend from the 1970s to the 1990s, but since then the data from several Member States suggest that this trend has stabilised or has even been reversed.

5.3. Alcohol abuse and alcohol-related harm

- 67) Even in childhood and early adolescence alcohol abuse is associated with various short-term adverse effects such as accidents, violence and poisoning, as well as with developmental and social problems. In the long term, regular abuse of alcohol is connected with increased risks of severe chronic diseases (cancer of the liver and other organs, hypertension, etc.). Society-level effects include crime and loss of productivity. At country level mortality and morbidity related to the use of alcohol correlates strongly with total alcohol consumption per capita. In Mediterranean countries and in Sweden, premature deaths from liver cirrhosis have been stable or declining, but in other Member States the trend is increasing^{xxx}. Early alcohol debut is associated with an increased risk of alcohol problems in late adolescence and adult life. Drinking patterns generally also show marked stability over time, although there is some conflicting evidence. There is however ample evidence to show the association between alcohol abuse, smoking and the use of drugs.
- 68) In most Member States, especially in Italy, Spain and France, both the volume and frequency of alcohol consumption in the whole population have declined, whereas in others (Ireland, Denmark, Luxembourg, Portugal and the United Kingdom) the figures have gone up. A higher frequency and volume of drinking is often associated with periods of economic growth and/or improved availability of alcohol. Regional differences are not as marked as they once were, nor does social status have as marked an impact on drinking as it used to. However, lower social status and a lack of social support still frequently correlate with an increased risk of alcohol abuse, and with greater difficulties of overcoming alcohol-related problems. In this context it is also to be noted that different drinking habits still prevail in different parts of the European Union, with frequent drinking of smaller amounts being predominantly a pattern in Southern Europe, and drinking to inebriation more common in the North. However, among young people drinking to inebriation has become increasingly common in all European Member States for which comparable data are available^{xxxii}.
- 69) Although young Europeans have their first taste of alcohol around much the same age as in the past, i. e. in their early teens, *regular* drinking begins at a younger age than it used to. The gender gap has narrowed in many Member States, although boys still drink more frequently and heavily than girls. According to the WHO HBSC 1997/1998 survey, 15-year-old boys exceed girls in weekly beer drinking in all countries covered; the high absolute rates of regular beer consumption among 15-year-old boys in Wales (50%), Denmark (43%), Greece (42%) and England (40%) are of particular concern. At age 15, the only countries where girls report a higher consumption of both spirits and wine than boys are Scotland, England and Wales. *Chart 19* shows that between the 1993/1994 and 1997/1998 WHO HBSC surveys, the percentage of 15-year-old boys and girls who had been drunk two times or more in their life-time has risen in almost all countries covered. In 1997/1998, more than half of 15-year-old boys and girls reported having been drunk two times or more in Denmark, Finland, England, Scotland and Wales, whereas the corresponding percentages were below 30% for boys and girls in France and Greece. The clear geographical pattern, with students from South European countries reporting low levels of drunkenness in sharp contrast to certain Northern European countries, persists in 15-year-olds reporting being drunk 10 times or more.

Chart 19: % of 15-year-old students who report having been drunk twice or more often in their lifetime (by gender, 93/94 vs. 97/98)

(source: WHO)
(data table in annex 1)



5.4. Substance abuse and misuse of medicines

70) Substance abuse and misuse of medicines pose an increasing challenge for social and health policies in all Member States. Substance abuse adversely affects the physical and mental health of the consumer. Mental disorders are prevalent not only among substance abusers but also in early experimenters. In particular, depression and substance abuse seem to be closely associated (*cf. chapter 4.6*).

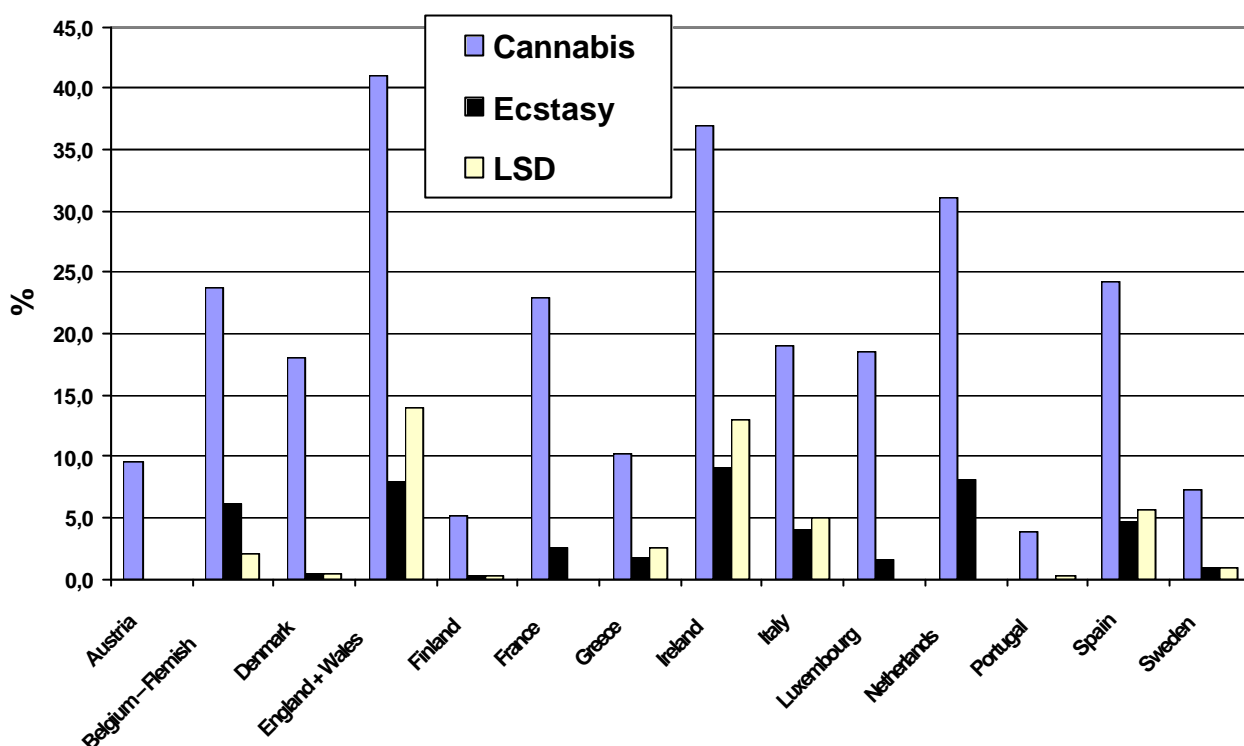
71) In 1995, according to data from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)^{xxxii}, the number of *acute drug-related deaths* in European Union countries amounted to 6 715, mainly from accidents, violence, overdoses and suicides. In the 1990s, significantly increasing trends in the number of deaths related to substance abuse were reported from Austria, Denmark, Greece, Ireland, Sweden and the United Kingdom,

as opposed to decreasing trends in Germany, France and Belgium¹⁹. One of the strongest associations between the use of illicit drugs and health problems is found among intravenous drug users (IDUs). Opiate injectors have a mortality that is 20–30 times higher than among non-drug users of the same age. Among IDUs, the prevalence of HIV infections and hepatitis differs markedly between countries, for HIV from 1 to 32 % and for Hepatitis B from 15 to 80%. Hepatitis C infection in general shows higher and somewhat more uniform rates, affecting up to 95% of IDUs.

Chart 20a: Lifetime prevalence (%) of use of cannabis, Ecstasy and LSD among 15-16 year old students in recent nationwide school surveys

(Source: EMCDDA extended annual report 1999)

(data table in annex 1)



72) Throughout the European Union *cannabis* is the most common illicit drug. Most cannabis use seems to be occasional or intermittent. There are considerable differences in patterns of cannabis use over time and between countries. During the 1990s, cannabis use has increased in most Member States. Furthermore, there seems to be a certain convergence in the level of cannabis use within the European Union. In countries with high or medium level prevalence figures (Denmark, Germany and the United Kingdom), the increase seems to have levelled off over recent years. On the other hand, countries with low initial prevalence figures (Greece, Finland and Sweden) show an increasing trend. According to EMCDDA data, in 1995, cannabis experiments among 15–16-year-olds (*chart 20a*) were still quite rare in Portugal and Finland (4-5%), but almost ten times more prevalent in Ireland and England & Wales (between 37 and 41%). In some countries, about one in five young

¹⁹ Data from different countries are not directly comparable, as there are differences in the ways cases are defined

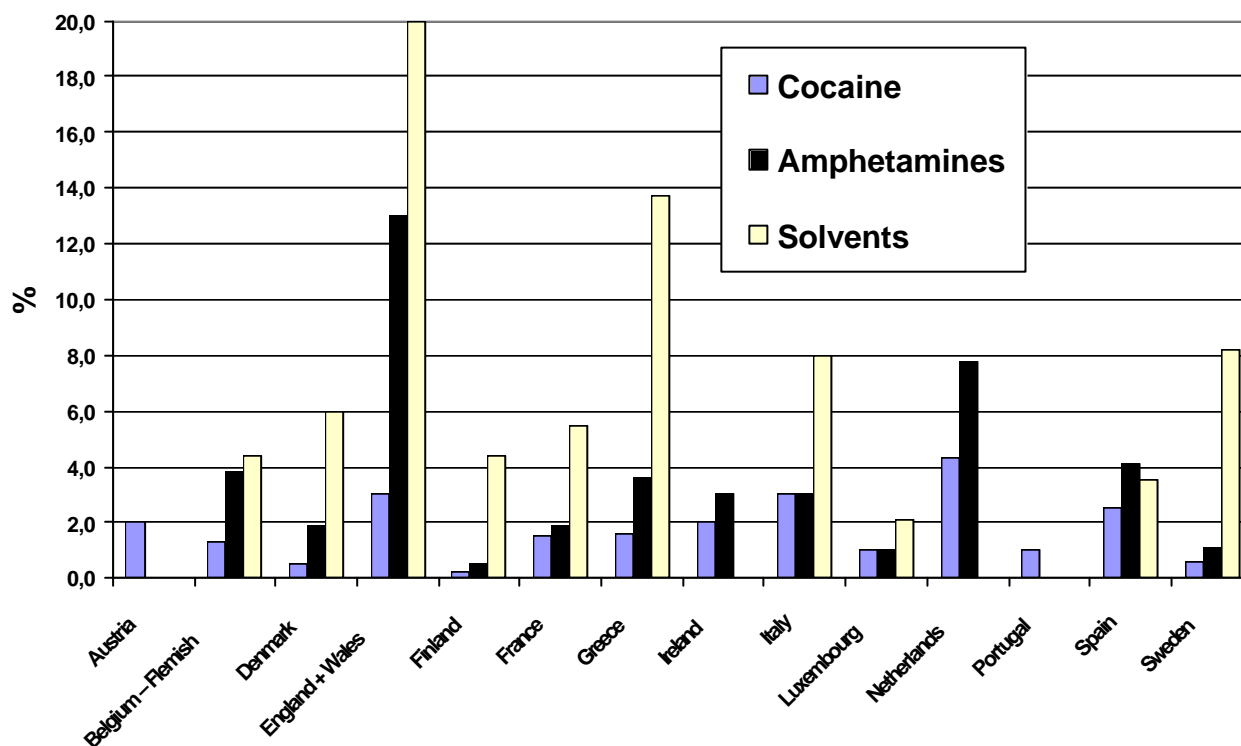
people report having used cannabis during the last 30 days. In the total adult population, 6 to 31% have ever tried and 1 to 9% have tried in the past 12 months, depending on the country.

73) As stated in the Communication from the Commission on a European Action Plan to Combat Drugs (2000-2004)^{xxxiii}, *solvents* are often the second most abused substances by adolescents. According to EMCDDA data, in the mid-1990s, the percentage of solvent experimenters among 15–16-year-olds (*chart 20b*) varied from less than 5% (Belgium - Flemish Community -, Luxembourg, Spain and Finland) to 20% (England & Wales). *Amphetamines* are tried by up to 13% of young adults; their use is continuing to rise. In 1995, the experimental use of *cocaine* (*chart 20b*) among 15–16-year-olds was comparatively low, ranging from 0 to 4%. The lifetime prevalence of *tranquilliser* or *sedative* experiments without doctor's prescription is reported to be in the area from 2 to 13%.

Chart 20b: Lifetime prevalence (%) of use of Cocaine, Amphetamines and Solvents, among 15-16 year old students in recent nationwide school surveys

(Source: EMCDDA extended annual report 1999)

(data table in annex 1)



74) A major issue in young people's drug use is the emergence, since the late 1980s, of 'dance drugs', dominated by *Ecstasy*, though also including amphetamine derivatives and LSD. These drugs became popular within the broader evolution of youth culture, and are particularly associated with clubs, raves and house parties (prevalence of experiments with ecstasy from 0 to 9% among 15-16-year-olds - *chart 20a*). Ecstasy use is no longer rising in those Member States where it appeared first, but it is still rising in others.

75) Despite the growing attention given to ‘new’ problem drugs, *heroin* continues to be a major threat to public health and safety. In general, trends in heroin use have been relatively stable: less than 1% of the adult population use it, but up to 2% of young people use it. However, the prevalence is increasing in some Member States, and several countries have reported heroin consumption by new groups of young people, both from socially integrated populations and from minority groups.

5.5. Sexual behaviour

76) The 1960s and 1970s saw rapid and quite dramatic changes in sexual behaviour in the form of a decreasing age at first intercourse and increasing use of reliable contraceptive methods. These changes started in the north of Europe and spread down southwards. They have continued in the 1980s and 1990s, albeit at a slower pace; the use of oral contraception and condoms has steadily increased and the trend towards earlier sexual debut has levelled off. This plateau started before the onset of the HIV/AIDS epidemic in the mid-1980s, but it may have been reinforced by the emergence of this new epidemic.

77) Although the sexual activity of young people has increased since the 1950s, it is important not to portray their sexual behaviour primarily as promiscuous; the majority of young people have two or fewer sexual partners, even in the cases of early sexual debut. Declining trends in STD’s in most European Union countries imply *increasing responsibility in sexual behaviour* in the 1980s and 1990s. Risky sexual behaviour in the form of multiple partners and non-use of reliable oral contraception and condoms is often associated with childhood victimisation, misuse of alcohol and other substances, and with developmental and mental disorders.

78) When measured by *age at first intercourse*, there are still marked differences between the Member States. In Mediterranean countries men start their sex lives well before marriage, while women still have the latest debut in the European Union. However, during the past few years this gender difference has quickly narrowed. In the Nordic countries, men and women have their first intercourse at about the same age. Belgium, the Netherlands and Germany are characterised by comparatively late sexual initiation for both sexes. France and the United Kingdom are more difficult to classify, having in common a clear gender inequality at the start and a rapid change in women’s behaviour. According to national surveys in the early 1990s, the median age at first intercourse varied from 17 to 18 years for males and from 17 to 20 years for females in the youngest birth cohorts. In Finland and Denmark, 20 to 30% of males and females reported having their first intercourse before the age of 16. In Greece, Belgium, France and Portugal, the corresponding percentage was at the same level for males, but around 10% or less for females. There are no comparative data on the use of oral contraception and condoms.^{xxxiv}

5.6. Nutrition

79) Nutrition is a key factor for health in all age groups. It is obvious that in underprivileged subgroups of the population many children and young people suffer regularly not only from a low quality of food, but also from lack of energy needed for healthy growth and development. A poor, unbalanced diet has serious long-term health effects such as cardiovascular diseases, cancer and diabetes. The importance of healthy dietary habits in adolescence is highlighted by studies which track behaviours to adulthood. Eating disorders

(anorexia, bulimia) are more common among adolescents, particularly among girls (*cf. chapter 4.6*).

- 80) While comparative data on young people's *dietary habits* are scarce, more is known about the situation in Europe in general. There is great diversity with respect to food cultures and eating habits in Europe. These are often referred to as northern and southern food cultures, such as the traditional Mediterranean diet in Greece, Southern Italy, Southern France and parts of Portugal and Spain. There is also some evidence of a convergence of dietary habits and cultures in Europe, with fatty foods becoming more popular in the South, particularly among young people, and lighter foods and vegetables gaining in popularity in the North. Consumption of dairy products is on the decline. On the other hand, young people in all Member States can consume the same products of international fast food chains and other international products.
- 81) There is some evidence that *special diets*, vegetarian in particular, are becoming increasingly popular among young people. It is not clear what kind of long-term health effects this will have. There are also marked differences between the Member States in eating behaviours with respect to lunch at workplaces and schools.

5.7. Physical activity

- 82) The health benefits of physical activity for adults are widely acknowledged. There are also indications of health benefits for young people who follow an active lifestyle. Physical activity is also thought to improve young people's quality of life by promoting their mental well-being and extending the range of activities in which they participate. Furthermore, it is believed that activity in childhood and adolescence plays an important role in reducing the development of osteoporosis by enhancing peak bone mass.
- 83) The WHO HBSC survey is the only data source currently available which contains international comparative data on sports activities in several Member States, albeit only for 11-15-year-olds. The data for 1997/1998 suggest that at the age of 15, in all the EU countries covered, more than 70% of boys engage in sports outside school twice a week or more often, whereas the average for girls is considerably lower; the figures represent a slight increase compared to 1993/1994 data. Reliable data on trends in physical activity of young people above 15 years are not available.
- 84) Sport activities and physical exercise decrease with age, even before the age of 15 is reached. Research has shown that sports activities and physical exercise in childhood and youth correlate with activities in adulthood.
- 85) Although further research is needed to substantiate the "ideal" amount of physical activity for young people, there is evidence that many young people are not participating in sufficient levels of physical activity to attain health benefits.

6. CONCLUSIONS

- 86) The transition from childhood and from the family home to adult independence and responsibility is a crucial phase in the individual's life course. However, health and well-being during this period of life have only rarely been addressed in EU-wide comparative studies. National health information and monitoring systems such as vital statistics provide

valuable information, but comparable data on those aspects of health that are particularly relevant to young people are not easily available.

- 87) There is a clear need to improve the quality and the comparability of data, to develop comparative indicators of health and to analyse both the statistical information and the research findings in the differing contexts of the individual Member States. Such activities need to be linked to the Community Action on Health Monitoring, with the main objective of establishing comparable health data and health indicators at European Union level. New *comparative studies* in this area should also cover more of the mental, social and cultural aspects of health; they could thus make a major contribution towards building a firmer basis for comprehensive reporting on young people's health at European level. In such studies efforts should also be made to explain differences between countries by relating them to structural and/or cultural factors.
- 88) Young people adopt their personal lifestyle during the transition from family home to adulthood under the influence of a complex mixture of economic, social, cultural and educational processes. One of the main findings of health research over the past decades points at the *major impact of lifestyle on health throughout the individual's life course*, and particularly during its latest phases. Pre-determining choices are made not only in childhood, but to a greater extent than is usually appreciated in the age range from 15 to 24. However, there is a lack of comparative information on living conditions and health-related lifestyles of young people in the European Union. More detailed information is required not only on the increasing trends of alcohol, tobacco and other substance abuse, but also for instance on changes in nutrition, physical activity and sexual behaviour.
- 89) According to data on life expectancy, mortality and major chronic diseases, *the vast majority of young people enjoy good health, and the trends from the mid-1980s to the mid-1990s suggest that the situation is set to improve further*. On average the 15-year-old male citizen in the European Union is expected to live to the age of 75, the female citizen to the age of 80 years. However, this picture is marred by the growth of certain chronic disorders; the rising trend in asthma and allergic disorders, as well as in diabetes and obesity, is particularly alarming. Premature deaths from accidents and suicides call for urgent preventive action.
- 90) The fact that the vast majority of young people do enjoy good health must not conceal that young people belonging to underprivileged population groups (e. g. refugees or asylum seekers) may face high health risks. More generally, data on trends in living conditions in childhood and adolescence, and on family background, education, labour market and lifestyles are worrying with regard to the health prospects of young people. A considerable proportion of young people does in fact suffer from poverty, family breakdown, lack of social support or from low quality of food, all factors which impede healthy growth and development. Although the unemployment situation is now improving, in many Member States more than one in five young people fail to find their place in the labour market. On the whole, this situation has given rise to marked differences - both between and within the Member States - in social and cultural determinants of health, a development which will inevitably lead to *significant inequalities in young people's health between families, population subgroups and countries*. There is in fact a marked diversity within the European Union both in the status of young people's health and in health trends. Tackling

the economic, social and cultural determinants of ill-health should therefore be placed high on the policy agenda.

- 91) On the basis of the information available, only a rough picture can be drawn of the mental health situation. Almost one in ten young people seem to experience clinically recognisable depressive symptoms, about five percent have problems with addictive substance abuse and one to two percent have eating disorders. Mental disorders and substance abuse tend to become increasingly intertwined even in early adolescence. The prevalence of mental disorders varies widely and is particularly high among underprivileged population groups. Mental health should therefore be a priority area for interventions aiming at improving young people's health.
- 92) Special emphasis should be placed on increasing preventive efforts in substance abuse.

ANNEX 1: DATA TABLES

(table numbers correspond to chart numbers in text)

Table 1: Fertility rates, age15-19 (live births per 1000 females)
(by mother's age reached during the year)
(source: Eurostat 1999) (*: provisional)

	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97
Austria	18,5	17,8	16,7	16,6	16,3	16,4	17,7	17,8	17,0	14,4	12,9	11,5	10,7
Belgium	9,2	8,9	8,6	8,8	7,9	8,6	8,8	8,6	8,0	7,4	6,7*		
Denmark	6,6	6,7	6,5	6,3	6,5	9,1	6,6	7,0	6,7	6,8	6,1	5,7	6,2
Finland	14,3	9,5	8,9	9,1	8,7	8,7	8,6	8,2	7,6	7,0	6,7	6,9	6,2
France	11,5	10,7	9,9	9,3	9,1	9,2	9,3	8,7	8,1	7,2	6,9	6,8	6,7*
Germany	13,3	13,0	13,2	14,0	14,2	14,6	13,8	12,6	11,1	10,0	9,4	9,6	9,5
Greece	28,6	25,9	22,6	19,1	17,3	15,6	13,9	13,0	11,6	10,6	9,9	9,6	9,5
Ireland	12,6	12,4	12,6	12,1	11,5	13,1	13,5	13,0	12,3	11,4	11,9	12,7*	
Italy	8,7	11,1	10,3	9,8	6,9	6,5	6,2	5,6	6,0	5,6	5,3		
Luxembourg	7,7	6,7	8,2	10,1	8,7	14,1	9,6	9,1	9,0	8,4	6,8	7,0	6,5
Netherlands	5,0	5,1	5,2	5,6	5,9	6,4	6,3	5,8	5,4	5,1	4,2	4,1	4,4
Portugal	26,0	24,2	22,5	21,4	20,8	18,8	18,5	17,8	18,1	17,1	16,6	16,6	17,0
Spain	14,7	13,1	12,3	11,9	10,3	9,2	8,6	8,0	7,3	6,6	6,3	6,1	
Sweden	7,5	7,9	7,4	7,8	8,9	9,8	9,2	8,3	7,7	6,7	6,1	5,5	5,0
United Kingdom	23,2	23,9	24,5	25,9	25,7	27,0	26,9	25,8	24,7	22,7	22,0	22,9	
EU-15	14,2	14,2	13,7	13,7	12,9	12,9	12,5	11,8	11,1	10,2	9,8*		
Iceland	27,9	39,3	37,6	40,5	29,2	30,2	28,4	22,4	17,9	18,1	17,4	16,3	19,3
Norway	13,2	13,4	13,3	13,4	12,5	12,2	12,1	11,6	10,9	10,4	9,7	9,9	9,1

Table 2: Fertility rates, age 20-24 (live births per 1000 females)
 (by mother's age reached during the year)
 (source: Eurostat 1999) (*: provisional)

	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97
Austria	94,0	91,3	87,5	86,7	83,0	80,3	81,6	80,9	80,7	76,2	70,6	70,4	66,2
Belgium	79,9	78,2	74,5	72,5	70,1	69,0	69,0	65,7	62,3	58,7	54,5*		
Denmark	67,5	65,7	63,0	63,6	64,8	74,6	61,3	59,7	56,6	55,5	54,5	53,2	50,2
Finland	76,7	64,2	61,1	63,6	63,6	64,9	64,9	66,2	63,8	63,5	59,0	56,7	55,8
France	96,6	92,4	85,9	82,3	78,2	74,5	71,3	66,4	60,4	57,5	56,4	55,0	53,3*
Germany	78,8	77,4	76,0	74,4	70,7	71,1	62,2	59,2	57,0	54,9	53,7	55,8	55,6
Greece	111,6	103,8	97,5	94,5	83,4	79,5	75,0	72,5	64,2	62,4	57,6	53,9	51,7
Ireland	78,5	75,0	68,5	63,5	58,2	57,9	58,2	54,3	49,3	46,7	46,6	48,6*	
Italy	67,1	66,0	62,4	60,7	51,3	49,2	46,4	43,6	40,0	36,1	32,6		
Luxembg.	65,4	63,1	58,0	61,6	64,6	70,3	62,8	62,3	69,0	66,4	61,2	59,7	58,7
Netherlds.	52,5	50,0	46,6	44,3	42,5	42,0	40,6	38,4	36,8	36,5	34,6	33,2	34,2
Portugal	101,7	99,0	94,0	92,7	88,8	84,0	79,9	73,9	70,2	63,6	58,7	58,3	57,9
Spain	67,3	61,4	57,7	54,3	49,5	45,5	41,4	37,4	33,0	28,4	25,1	23,3	
Sweden	72,6	74,4	75,3	81,2	83,5	88,6	83,8	79,7	72,8	64,9	58,8	52,1	48,1
United Kingdom	89,7	88,5	89,4	90,6	87,8	87,0	85,6	82,2	79,0	75,5	73,8	74,8	
EU-15	80,5	77,9	75,0	73,5	68,9	67,4	63,3	59,8	56,0	52,5	49,9*		
Iceland	105,6	110,4	123,7	125,5	114,7	118,9	103,6	92,5	95,5	91,9	87,7	87,1	84,6
Norway	86,8	85,4	83,2	86,5	86,3	85,3	82,1	77,7	73,6	70,7	70,0	68,2	65,5

Table 3: Changes in the status of active, with a job¹⁾ young people aged 15-24 (in %), EUR 15, 1987 and 1995

	EUR 15*	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1987	34	31	31	34	27	26	33	37	31	48	30	n/a	47	n/a	n/a	44
1995	28	25	26	29	25	22	21	32	25	34	26	42	32	19	39	39
Diff. 87-95	-6	-6	-5	-5	-2	-4	-12	-5	-6	-14	-4	n/a	-15	n/a	n/a	-5

Table 4: Changes in the status of active, seeking a job young people aged 15-24 (in %), EUR 15, 1987 and 1995

	EUR 15*	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1987	10	8	5	4	8	17	11	13	14	3	5	n/a	9	n/a	n/a	10
1995	8	7	3	4	9	13	9	8	11	3	3	3	5	9	9	8
Diff. 87-95	-2	-1	-2	0	1	-4	-2	-5	-3	0	-2	n/a	-4	n/a	n/a	-2

Table 5: Changes in the status of non-active and not in education or training young people aged 15-24 (in %), EUR 15, 1987 and 1995

	EUR 15*	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1987	7	5	3	5	14	8	5	5	10	5	4	n/a	9	n/a	n/a	8
1995	6	4	3	5	9	5	4	4	10	5	5	3	6	6	8	8
Diff. 87-95	-1	-1	0	0	-5	-3	-1	-1	0	0	1	n/a	-3	n/a	n/a	0

Table 6: Changes in the status of non-active and in education or training²⁾ young people aged 15-24 (in %), EUR 15, 1987 and 1995

	EUR 15*	B	DK	D	EL	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1987	49	56	61	57	51	49	51	46	45	44	61	n/a	35	n/a	n/a	39
1995	58	65	68	62	56	61	67	56	54	59	66	53	57	66	44	46
Diff. 87-95	9	9	7	5	5	12	16	10	9	15	5	n/a	22	n/a	n/a	7

1) With a job: any person having done paid work for one hour or more during the reference week.

2) To compile this table account has been taken of all full-time and part-time education or training. Sandwich courses and alternating training such as apprenticeships are included under this heading. Only training given exclusively at the workplace is excluded. The rates are therefore over-estimated compared with those indicated above.

*) estimate.

n/a: data not available.

Reading note: By way of example, 32 of every 100 young Irish people had a job, 8 were seeking one, 4 were non-active and 56 were in education or training in 1995.

Source: European Commission: Youth in the European Union, Eurostat, Luxembourg, 1997, p. 19.

Table 7: Trends in the under-25 unemployment rate¹ in %, EUR 15, 1990-1999																
	EUR 15	B	DK	D	GR	E	F	IRL	I	L	NL	A	P	FIN	S	UK
1990	n/v	15,3	11,4	n/a	21,5	32,3	19,3	19,4	27,4	3,8	8,6	n/v	10,0	9,4	4,5	10,8
1991	16,3	14,9	11,6	5,9	22,9	31,1	21,5	22,4	26,0	3,2	8,3	n/v	8,8	19,5	7,8	14,3
1992	18,1	16,2	12,7	6,4	25,1	34,5	23,3	24,4	27,1	4,0	8,5	n/v	10,1	26,4	13,2	16,7
1993	21,3	21,8	13,8	7,9	26,8	43,2	27,3	25,2	30,4	5,4	11,1	6,3	12,9	33,6	22,0	18,1
1994	22,0	24,2	11,0	8,7	27,7	45,0	29,0	22,8	32,3	7,3	11,4	5,7	15,1	34,0	22,0	17,0
1995	21,5	23,9	10,6	8,8	28,5	42,5	27,5	19,4	33,3	7,4	12,0	5,5	16,6	29,7	19,1	15,9
1996	22,0	23,1	10,6	10,0	31,0	41,9	29,2	18,2	33,5	8,5	11,7	6,2	16,8	27,9	20,5	15,5
1997	21,1	23,0	8,4	10,8	31,2	39,1	29,1	15,3	32,4	8,1	9,6	6,7	15,1	25,2	20,6	14,2
1998	19,3	22,1	7,4	9,8	32,1	35,4	26,6	11,5	30,8	6,9	7,8	6,6	9,8	23,5	16,7	13,6
1999*	18,1	21,6	7,2	8,6	31,0	29,1	25,6	9,3	32,0	6,4	6,8	5,8	9,3	21,6	14,7	13,5
1) Unemployment rate: The unemployed as percentage of people in the labour force (annual averages).											n/a: data not available. * = May 1999					
Unemployed Person: Person out of work who is available to start work within two weeks and is actively seeking a job; according to the internationally accepted definition.																
Source: Eurostat: Eurostat Yearbook '97, Luxembourg; Unemployment in the European Union, EC economic data pocket book, 5/1999																

Tables 8-9: Life expectancy at age 15 (years of life remaining)

(source: Eurostat 1999)

Males

	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97
Austria	56,6	57,1	57,5	57,8	58,0	58,2	58,3	58,5	58,7	59,1	59,2	59,5	59,8
Belgium	57,2	57,5	58,0	58,1	58,2	58,5	58,7	58,9	58,8	59,2	59,2	59,5	59,8
Denmark	57,5	57,7	57,7	57,9	57,9	57,9	58,3	58,4	58,2	58,4	58,3	58,7	59,2
Finland	55,9	56,3	56,4	56,3	56,6	56,6	57,0	57,2	57,7	58,3	58,3	58,5	59,0
France	57,3	57,5	58,0	58,3	58,4	58,6	58,8	59,0	59,1	59,5	59,6	59,7	60,2
Germany	:	57,4	57,7	57,8	58,0	57,8	57,9	58,3	58,4	58,7	58,9	59,2	59,6
Greece	59,9	60,3	60,0	60,4	60,5	60,6	60,6	60,6	60,8	61,0	60,9	60,9	61,3
Ireland	57,0	56,8	57,5	57,6	57,7	58,0	58,1	58,4	58,3	58,8	58,6	59,0	59,1
Italy	58,4	58,7	59,0	59,2	59,5	59,5	59,5	59,9	60,2	60,4	60,6	:	:
Luxembourg	56,5	56,7	54,3	55,7	57,3	58,1	58,0	57,9	58,1	58,7	58,6	58,9	59,4
Netherlands	59,0	59,0	59,4	59,6	59,5	59,7	59,9	60,1	59,7	60,3	60,3	60,3	60,8
Portugal	:	56,6	56,9	56,7	57,2	56,8	56,6	56,9	56,8	57,6	57,2	57,1	57,5
Spain	59,1	59,4	59,5	59,4	59,3	59,3	59,3	59,6	59,7	60,0	59,9	60,1	:
Sweden	59,5	59,7	59,9	59,8	60,5	60,5	60,6	61,0	61,1	61,6	61,7	62,0	62,2
United Kingdom	57,8	57,9	58,3	58,4	58,6	58,8	59,0	59,3	59,3	59,8	59,7	60,0	60,3
EU 15	:	58,0	58,3	58,5	58,6	58,7	58,8	59,1	59,2	59,6	59,6	59,9	60,3
Iceland	60,6	60,9	60,7	60,1	61,7	61,2	60,4	62,4	62,7	62,5	61,8	61,9	62,1
Norway	:	58,8	58,7	59,0	59,3	59,4	59,7	59,9	59,9	60,5	60,4	60,9	61,0

Females

	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97
Austria	63.3	63.6	64.0	64.3	64.5	64.7	64.8	64.9	65.1	65.3	65.6	65.7	66.2
Belgium	63.9	63.9	64.6	64.8	64.7	65.1	65.3	65.5	65.5	65.7	65.8	66.0	66.1
Denmark	63.3	63.3	63.5	63.4	63.5	63.4	63.7	63.6	63.3	63.6	63.3	63.8	64.0
Finland	64.3	64.3	64.3	64.3	64.5	64.5	64.9	65.0	64.9	65.6	65.6	66.0	66.0
France	65.3	65.5	66.0	66.2	66.4	66.7	66.9	67.1	67.1	67.4	67.4	67.5	67.7
Germany	:	63.5	63.9	64.0	64.2	64.1	64.4	64.8	64.8	65.1	65.3	65.4	65.8
Greece	64.5	64.7	64.5	65.1	65.2	65.4	65.5	65.4	65.7	66.0	66.0	66.1	66.5
Ireland		62.4	63.0	63.0	62.9	63.3	63.5	63.8	63.7	64.1	64.1	64.3	64.3
Italy	64.7	64.9	65.3	65.4	65.8	65.9	66.0	66.3	66.5	66.7	66.9	:	:
Luxembourg	63.7	64.1	63.6	64.5	64.2	64.4	65.1	64.2	65.0	65.3	65.7	65.6	65.5
Netherlands	65.4	65.4	65.8	65.9	65.6	65.8	65.8	65.9	65.6	65.9	65.9	65.9	66.1
Portugal	:	63.3	63.5	63.6	64.0	63.5	63.6	64.1	63.8	64.6	64.4	64.4	64.6
Spain	65.5	65.7	65.9	66.0	66.1	66.2	66.3	66.8	66.8	67.1	67.2	67.3	:
Sweden	65.4	65.6	65.7	65.5	66.1	66.0	66.1	66.3	66.2	66.8	66.8	66.9	67.2
United Kingdom	63.5	63.6	63.8	63.9	63.9	64.3	64.4	64.6	64.5	64.9	64.8	65.0	65.2
EU 15	:	64.4	64.7	64.9	65.0	65.1	65.3	65.6	65.6	65.9	66.0	66.2	66.4
Iceland	66.0	66.1	65.5	65.4	65.8	65.9	66.7	66.2	66.1	66.6	65.9	66.6	66.9
Norway	:	65.5	65.4	65.3	65.6	65.5	65.8	65.9	65.8	66.2	66.2	66.5	66.5

**Table 10: Causes of death
Suicide and self-inflicted injury (E54)**

Source: WHO World Health Statistics Annual
Number of deaths, males, ages 15-24

	1987	1988	1989	1990	1991	1992	1993	1994	1995
Austria	185	168	163	150	153	142	119	136	134
Belgium	121	113	126	109	100	114			
Denmark	67	64	58	55	46	47	49		
Finland	135	137	170	169	139	115	107	147	118
France	641	606	681	607	639	589	756	663	
Germany	863	764	863	800	775	674	632	682	630
Greece	34	37	32	40	31	21	29	33	35
Ireland	29	47	41	44	61	67	45		
Italy	245	237	243	275	258	298	304		
Luxembourg	4	0	6	6	4	2	10	7	5
Netherlands	117	102	109	98	114	103	115	98	95
Portugal	80	56	58	62	58	47	36	40	48
Spain	216	284	284	240	238	225	246	253	
Sweden	102	110	120	88	100	58	68	74	75
United Kingdom	461	565	482	528	481	500	501	445	419
Total	3300	3290	3436	3271	3197	3002			

**Table 11: Causes of death
Suicide and self-inflicted injury (E54)**

Source: WHO World Health Statistics Annual
Number of deaths, females, ages 15-24

	1987	1988	1989	1990	1991	1992	1993	1994	1995
Austria	49	28	48	31	34	33	35	34	19
Belgium	35	28	27	37	23	29			
Denmark	32	21	16	15	13	12	8		
Finland	26	25	21	35	23	26	10	24	26
France	175	178	190	184	167	175	210	171	
Germany*	211	213	241	228	185	163	157	170	176
Greece	12	4	7	8	5	4	6	3	6
Ireland	7	6	7	12	4	6	9		
Italy	63	65	73	90	70	77	59		
Luxembourg	3	1	1	0	0	2	0	1	1
Netherlands	44	29	52	41	40	41	37	42	44
Portugal	24	25	18	25	17	17	16	15	24
Spain	68	59	60	54	71	42	53	56	
Sweden	32	34	48	30	28	37	36	19	28
United Kingdom	105	120	87	85	93	91	82	82	81
Total	886	836	896	875	773	755			

* only Federal Republic of Germany/old "Länder"

Table 12: Causes of death
Suicide and self-inflicted injury (E54)

Source: WHO World Health Statistics Annual

Death rates per 100 000 population, males, ages 15-24

	1987	1988	1989	1990	1991	1992	1993	1994	1995
Austria	29,3	27,2	27,1	25,0	25,7	24,4	21,1	25,4	25,8
Belgium	16,0	15,2	17,3	15,3	14,4	16,7			
Denmark	16,5	15,9	14,6	14,1	12,0	12,6	13,4		
Finland	37,9	39,6	50,4	50,9	42,2	35,2	33,0	45,5	36,6
France	14,7	13,9	15,8	14,1	15	14,0	18,2	16,1	
Germany*						13,0	12,7	13,9	13,3
Greece	4,4	4,8	4,2	5,2	4,0	2,7	3,8	4,1	4,4
Ireland	9,3	15,1	13,3	14,2	19,1	21,5	14,2		
Italy	5,1	4,9	5,1	5,9	5,7	6,8	7,1		
Luxembourg	14,2	0,0	23,0	23,2	15,6	7,9			
Netherlands	9,2	8,2	8,9	8,2	9,8	9,1	10,4	9,1	9,2
Portugal	9,1	6,4	6,6	7,4	6,9	5,7	4,3	4,8	5,8
Spain	6,4	8,4	8,4	7,1	7,1	6,8	7,3	7,6	
Sweden	16,9	18,2	19,8	14,7	16,9	10,0	12,0	13,2	13,4
United Kingdom	9,9	12,3	10,8	12,2	11,5	12,2	12,6	11,5	11,0

Table 13: Causes of death
Suicide and self-inflicted injury (E54)

Source: WHO World Health Statistics Annual

Death rates per 100 000 population, females, ages 15-24

	1987	1988	1989	1990	1991	1992	1993	1994	1995
Austria	8,1	4,7	8,3	5,5	6,1	6,1	6,5	6,6	3,8
Belgium	4,8	3,9	3,9	5,4	3,4	4,4			
Denmark	8,3	5,5	4,2	4,0	3,6	3,4	2,3		
Finland	7,6	7,5	6,5	11,0	7,3	8,3	3,2	7,8	8,4
France	4,1	4,2	4,6	4,4	4,1	4,3	5,2	4,3	
Germany*						3,3	3,4	3,7	3,9
Greece	1,7	0,6	1,0	1,1	0,7	0,6	0,8	0,4	0,8
Ireland	2,3	2,0	2,4	4,1	1,3	2,0	3,0		
Italy	1,4	1,4	1,6	2,0	1,6	1,8	1,4		
Luxembourg	10,8	3,9	4,0	0,0	0,0	8,4			
Netherlands	3,6	2,4	4,4	3,6	3,6	3,8	3,5	4,1	4,4
Portugal	2,8	2,9	2,1	3,1	2,1	2,1	2,0	1,9	3,0
Spain	2,1	1,8	1,9	1,7	2,2	1,3	1,7	1,8	
Sweden	5,6	5,9	8,3	5,3	5,0	6,7	6,6	3,5	5,2
United Kingdom	2,3	2,7	2,0	2,1	2,3	2,3	2,2	2,2	2,2

* old "Länder" only

Table 14: Causes of death - Motor vehicle traffic accidents (E471)*(Source: WHO, World Health Statistics Annual)*

Number of deaths: Males, ages 15-24

	1987	1988	1989	1990	1991	1992	1993	1994	1995
Austria	379	373	352	327	317	272	298	302	245
Belgium	486	402	419	385	356	313			
Denmark	133	126	117	96	108	109	92		
Finland	158	115	110	116	106	89	70	75	58
France	2728	2232	2231	2233	2047	1923	1770	1637	
Germany	2376	2370	2490	2309	2403	2156	2023	1949	1909
Greece	484	324	395	448	456	438	412	433	432
Ireland	167	117	110	95	110	116	98		
Italy	2381	1722	1948	1930	2116	2135	1751		
Luxembourg	22	28	19	19	23	11	14	10	11
Netherlands	364	276	276	260	269	236	229	204	211
Portugal	515	574	535	567	634	581	501	455	500
Spain	2355	1615	1827	1852	1811	1455	1246	1081	
Sweden	210	164	167	138	116	110	95	65	66
United Kingdom	1338	1232	1253	1256	1129	935	720	699	690
Total	14096	11670	12249	12031	12001	10879			

Table 15: Causes of death - Motor vehicle traffic accidents (E471)*(Source: WHO, World Health Statistics Annual)*

Number of deaths: Females, ages 15-24

	1987	1988	1989	1990	1991	1992	1993	1994	1995
Austria	88	90	74	73	75	67	61	68	50
Belgium	127	106	97	99	81	97			
Denmark	40	34	35	35	26	27	19		
Finland	39	30	29	50	34	29	16	14	16
France	718	567	559	543	518	484	506	441	
Germany	611	579	663	628	588	571	533	489	523
Greece	103	95	86	108	99	81	77	95	75
Ireland	29	26	31	34	27	25	16		
Italy	488	413	370	394	430	444	369		
Luxembourg	5	8	3	4	7	4	7	3	9
Netherlands	101	85	101	82	76	58	51	66	56
Portugal	82	85	80	95	94	97	70	91	105
Spain	567	427	467	435	418	370	314	253	
Sweden	58	54	49	55	37	34	30	22	22
United Kingdom	303	259	313	266	298	262	192	195	191
Total	3359	2858	2957	2901	2808	2650			

Tables 16-17:
Abortion rate per 1000 women, by age-group,
According to country and year

Age <20

	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97
Belgium									4,1	4,5	5,1	5,9	5,7
Denmark	16,3	16,1	15,7	16,6	17,6	17,2	16,4	16,0	15,8	15,1	14,8	15,9	
Finland	16,5	15,4	15,6	14,6	14,6	13,4	11,5	9,7	9,5	9,0	9,3	9,6	10,2
France*§								8,1		8,0	8,9		
Germany*											3,1		
Greece							1,5	1,6				1,3	
Italy*							4,6			5,7	5,9		
Netherlands	4,3	4,2						4,2					
Spain§§							3,4	3,8	3,9	4,2	4,5	4,9	5,0
Sweden	18,2	19,7	21,6	24,4	24,8	24,6	22,9	20,4	19,0	17,9	17,0	17,8	17,8
England & Wales	19,8	19,8	20,9	23,0	22,8	23,4	21,6	20,3	19,9	19,6	19,2	21,7	21,7
Scotland**	14,2	14,5	14,0								16,6		

Age 20-24

	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97
Belgium									7,5	8,0	8,3	9,3	9,1
Denmark	28,8	28,8	29,9	30,4	32,1	30,2	27,8	26,1	25,4	23,4	22,5	23,7	
Finland	19,5	19,6	19,0	20,1	19,3	19,0	17,6	17,3	15,8	14,9	14,8	15,5	15,0
France*§								17,5		16,9	18,2		
Germany*											7,5		
Greece							14,1	14,7				14,9	
Italy*							13,6			12,5	12,6		
Netherlands	6,9	7,4						7,4					
Spain§§							7,2	7,5	7,8	7,9	8,2	8,4	8,1
Sweden	26,9	29,6	31,2	33,8	35,4	33,5	32,0	30,7	30,0	28,0	26,5	27,8	27,0
England & Wales	20,4	21,9	23,8									25,5	
Scotland**	14,2	15,1	14,9								19,5		

* Incomplete national statistics

**Includes abortions performed in England and Wales

§ Age defined as age attained during the year

§§ source for 1996 and 1997 rates: Ministry of Health

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Tables 18-19: Percentages of 15-year-old students who report smoking daily, and of 15-year-old students who report having been drunk twice or more often in their lifetime (by gender)

	Daily smoking (%)		Having been drunk twice or more often (%)			
	Boys 97/98	Girls 97/98	Boys 93/94	Boys 97/98	Girls 93/94	Girls 97/98
Austria	20	26	46	49	30	36
Belgium – Flemish	21	20	31	33	16	22
Denmark	15	21	65	71	67	63
England	21	24		51		52
Finland	19	20	52	52	50	58
France*	20	25	24	29	13	20
Germany*	23	25	34	36	26	31
Greece	13	14		24		21
Northern Ireland	16	24	44	53	36	44
Portugal	13	10		35		16
Republic of Ireland	19	16		42		29
Scotland	19	24	53	53	51	56
Spain			23		19	
Sweden	9	16	27	40	22	40
Wales	18	23	61	72	59	63

*: represented only by regions

Source: 1993/1994: King A, Wold B, Tudor-Smith C, Harel Y. The Health of the Youth: A Cross-national Survey. WHO Regional Publications. European Series; No 69. WHO Regional Office for Europe. Copenhagen, 1996

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Table 20: Lifetime prevalence of use of different illegal drugs among 15-16 year old students in recent nationwide school surveys

(Source: EMCDDA extended annual report 1999)

	Year	Sample size	Cannabis (%)	Solvents (%)	Amphetamines (%)	Ecstasy (%)	LSD (%)	Cocaine (%)	Heroin (%)
Austria	1994	2.250	9,5	n.a	n.a	n.a	n.a	2,0	
Belgium (Flemish)	1998	9.211	23,7	4,4	3,8	6,2	2,1	1,3	0,7
Denmark	1995	2.571	18,0	6,0	1,9	0,5	0,4	0,5	2,0
England + Wales	1995	7.722	41,0	20,0	13,0	8,0	14,0	3,0	2,0
Finland	1995	2.300	5,2	4,4	0,5	0,2	0,3	0,2	0,1
France	1997	9.919	23,0	5,5	1,9	2,5	n.a	1,5	1,4
Greece	1998	8.557	10,2	13,7	3,6	1,8	2,6	1,6	0,8
Ireland	1995	1.849	37,0	n.a	3,0	9,0	13,0	2,0	2,0
Italy	1995	1.641	19,0	8,0	3,0	4,0	5,0	3,0	2,0
Luxembourg	1998	660	18,5	2,1	1,0	1,5	0,0	1,0	0,5
Netherlands	1996	10.455	31,0	n.a	7,8	8,1	n.a	4,3	1,3
Portugal	1995	4.767	3,8	n.a	n.a	n.a	0,2	1,0	0,9
Spain	1996	19.191	24,3	3,5	4,1	4,6	5,6	2,5	0,8
Sweden	1998	5.455	7,2	8,2	1,1	1,0	1,0	0,6	0,6

ANNEX 2: REFERENCES

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