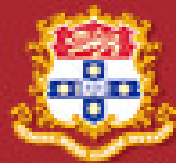


The Well-Being and Aspirations of Australian Adolescents and Young Adults with a Long-term Health Condition, Disability or Impairment

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Introduction

This brief report compares the well-being and aspirations of Australian adolescents and young adults who report having a long-term health condition, disability or impairment with that of their peers. The report is part of the background work undertaken in the context of an ARACY Research Network grant '*Achieving Better Health Outcomes for Youth with Chronic Health Conditions: a Pan disciplinary approach*'.

The report uses a framework for conceptualising well being that is based on the UN Convention of the Rights of Persons with Disabilities and indicators extracted from Wave 4 (2004) of the survey of *Household Income and Labour Dynamics in Australia* (HILDA).^a

^a This paper uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is managed by the Melbourne Institute of Applied Economic and Social Research (MIAESR). The findings and views reported in this paper, however, are those of the author and should not be attributed to either FaHCSIA or the MIAESR.

Background

The last three decades have witnessed an increasing interest in the measurement, study and use of the concept of 'well-being' in relation to social policy. While initially focusing on economic indicators (e.g., gross national product, income), by the late 1970s social indicators based on the subjective appraisal of satisfaction with life or subjective well-being (SWB) had risen in prominence.^{1 2}

More recently the field of 'positive psychology' has emerged in reaction to the overwhelming focus on remediating psychopathology that permeates much of applied psychology. It too shares a focus on understanding psychological 'well-being'. The coalition of these distinct traditions in the field of 'hedonic psychology'³ has provided a powerful rhetorical basis for claims that SWB or happiness should be seen as *the* yardstick by which the impact of economic and social policies should be evaluated.⁴

It has been apparent for some time, however, that SWB appears to have only an indirect and somewhat tenuous link with 'objective' life circumstances. Processes of adaptation appear to ensure that SWB remains relatively constant over time even though external circumstances may change.^{5 6} The relative insensitivity of SWB to 'objective' life circumstances presents major problems for the use of SWB in evaluating the impact of economic and social policies, especially policies addressing issues of social justice. As the Nobel Laureate Amartya Sen has argued

*'Concentrating exclusively on mental characteristics (such as pleasure, happiness or desires) can be particularly restrictive when making interpersonal comparisons of well-being Our desires and pleasure-taking abilities adjust to circumstances, especially to make life bearable to adverse situations. ...deprived people tend to come to terms with their deprivation because of the sheer necessity of survival, and adjust their desires and expectations to what they unambitiously see as feasible ... [as such] the deprivation of the persistently deprived may look muffled and muted.'*⁷

Partly in response to such difficulties and dissatisfaction with reliance on purely economic indicators of well-being, well-being has been increasingly conceptualized within a broader human rights or human development framework.⁸⁻¹¹ For example, the conceptualization and measurement of well-being in the recent Unicef report on the well-being of children in the world's rich countries is explicitly guided by the UN Convention on the Rights of the Child.⁸

In this report we have used the UN Convention of the Rights of Persons with Disabilities^b to identify domains of well-being. We have then used data extracted from the survey of *Household Income and Labour Dynamics in Australia* (HILDA) to compare the well-being and aspirations of Australian adolescents and young adults with long term health conditions, disabilities or impairments and their non-disabled peers.

^b <http://www.un.org/disabilities/index.asp>

The Survey and the Participants

Data were extracted from Wave 4 (2004) of the survey of *Household Income and Labour Dynamics in Australia* (HILDA).^c HILDA is a non-refreshed panel survey originating from a national probability sample of approximately 7,500 Australian households in 2001 (Wave 1). Continuing panel members include all panel members of Wave 1 households, any children subsequently born to or adopted by panel members and all new entrants to a household who have a child with an existing panel member. In addition, information is collected on temporary panel members (people who share a household with a continuing panel member in wave 2 or later) as long as they share a household with a continuing panel member. Wave 4 was selected as this wave included 'youth issues' as a special topic.

Information was collected in Wave 4 on just under 7,000 households. All household members aged 15 or above are invited to participate in a personal interview. Wave 4 data includes interviews with 3,423 people in the age range 15-29. Of these, 558 (16.3%) participants identified themselves as having a long term health condition, disability or impairment. Basic demographic characteristics of the sub-samples of participants with and without a self-reported long term health condition, disability or impairment are presented in Table 1. Information on the specific types of health conditions, disabilities or impairments reported is presented in Table 2.

	Present	Absent	Significance of difference
Age			
15-19	37%	33%	n.s.
20-29	63%	67%	
Sex (% female)	49%	49%	n.s.
Born in Australia	90%	82%	OR=2.12***
Indigenous status	7%	4%	OR=2.07***
OR = Odds ratio ^d *** p<0.001 ^e			

^c <http://melbourneinstitute.com/hilda/>

^d The odds ratio is an indicator of the strength of the association between two variables. For example, these results suggest that the odds of having a disability were just over twice as great if the person was born in Australia.

^e P values are indicators of the *statistical* significance of the difference between the two groups. It indicates that the probability that these differences (or larger) would occur by chance alone are less than 0.001 (1 in 1,000).

Table 2: Self-Reported Conditions, Impairments, Disabilities and Activity Limitations	
Conditions, Impairments, Disabilities	
Other	38%
Learning/understanding	8%
Nervous/emotional	7%
Chronic/recurring pain	7%
Limited use of feet/legs	6%
Vision (not corrected by glasses)	5%
Blackouts	4%
Shortness of breath	5%
Mental illness	4%
Hearing	4%
Limited use of arms/fingers	3%
Head injury/stroke/brain damage	2%
Speech	2%
Difficulty gripping	1%
Disfigurement/deformity	1%
Activity Limitations	
Work	35%
Mobility	11%
Self-care	7%
Communication	3%

Indicators of Well-Being

We used the UN Convention of the Rights of Persons with Disabilities to identify potential domains of well-being and then identified items contained within HILDA that could be employed as indicators of well-being within these domains. A list of the indicators is presented in Table 3. In addition, we extracted data on three general indicators of subjective well-being: (1) self-reported life satisfaction (single item 10 point rating scale); (2) mental health status (scoring 50 or below on the mental health subscale of the SF-36)^{12 13}; (3) self-efficacy (the Pearlin Mastery Scale).¹⁴

The Results

Well Being

Detailed results are presented below in Table 3. In summary, adolescents and young adults with a self-reported long term health condition, disability or impairment had significantly lower well-being than their peers on 31 of the 38 indicators of well-being. On no indicator did adolescents and young adults with a self-reported long term health condition, disability or impairment have significantly higher well-being than their peers.

Adolescents and young adults with a self-reported long term health condition, disability or impairment were more than twice as likely as their peers to:

- Be dissatisfied with their friendships
- Have poorer general health
- Have less vitality
- Use tobacco
- Be unemployed
- Be dissatisfied with their employment opportunities and job prospects
- Live in areas in which they were concerned about their safety
- Report themselves to be 'poor' or 'very poor'
- Be dissatisfied with their life overall
- Have poorer mental health

Table 3: Well-Being of Participants with and without a Self-reported Long Term Health Condition, Disability or Impairment				
<i>UN Convention Article</i>	<i>Indicator</i>	<i>With</i>	<i>Without</i>	<i>Significance of difference</i>
19: Living independently and being included in the community	Living independently of parents (age 21-29)	77%	81%	n.s.
	Social support	39%	51%	OR=0.63***
	Social contact with friends/relatives	74%	79%	OR=0.77*
	Satisfaction with friendships	84%	92%	OR=0.48***
	Satisfaction with feeling part of the local community	61%	69%	OR=0.71**
23: Respect for home and family	Living with partner (age 21-29)	40%	45%	n.s.
	Has and is caring for children (age 21-29)	26%	24%	n.s.
24: Education	Studying full time (age 15-20)	54%	64%	OR=0.67**
	Completed Y12 at secondary school	44%	56%	OR=0.61***
	Has Diploma or higher academic qualification	14%	23%	OR=0.54***
25: (Poorer) Health	Low self-reported health	19%	7%	OR=3.28***
	Low general health	28%	10%	OR=3.59***
	Low vitality	44%	26%	OR=2.26***
	Use of tobacco	33%	18%	OR=2.23***
	Use of alcohol	42%	56%	OR=0.57***
27: Work and Employment	Employed full time (age 21-29)	44%	62%	OR=0.48***
	Employed full or part-time (age 21-29)	66%	84%	OR=0.37***
	Job satisfaction	89%	89%	n.s.
	Satisfaction with their employment opportunities	65%	82%	OR=0.37***
	Satisfaction with their future job prospects	81%	90%	OR=0.48***
28: (Less) Adequate Standard of Living and Social Protection	Neighbourhood deprivation	27%	19%	OR=1.58***
	Neighbourhood hostility and aggression	12%	8%	OR=1.68**
	Neighbourhood burglary and theft	16%	16%	n.s.
	Low satisfaction with safety	13%	5%	OR=2.63***
	Exposure to adverse life events	42%	39%	n.s.
	Overcrowded housing	17%	12%	OR=1.42**
	External condition of housing	8%	6%	OR=1.53*
	Low satisfaction with home	17%	11%	OR=1.64***
	Housing tenure (renting)	44%	38%	OR=1.26*
	Income poverty	26%	17%	OR=1.70***
	Financial strain	6%	2%	OR=2.64***
Hardship	40%	27%	OR=1.74***	

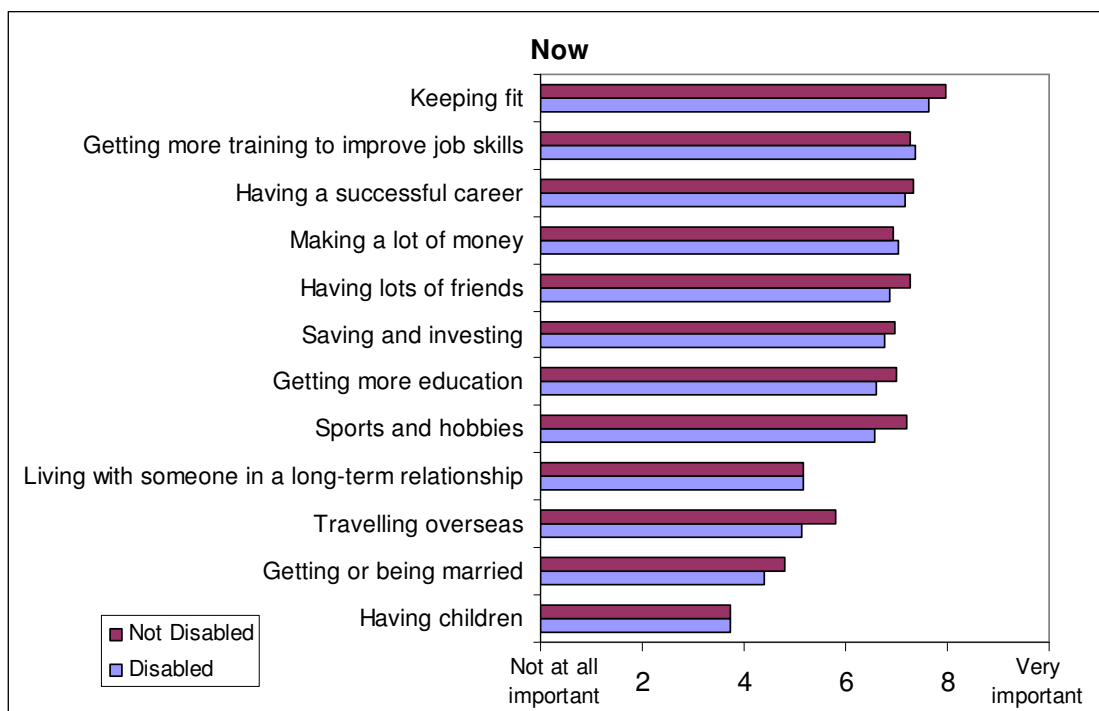
Table 3: Well-Being of Participants with and without a Self-reported Long Term Health Condition, Disability or Impairment				
<i>UN Convention Article</i>	<i>Indicator</i>	<i>With</i>	<i>Without</i>	<i>Significance of difference</i>
29 & 30: Participation in Political, Public, Cultural Life, Recreation, Leisure & Sport	Member of community-based organisation	34%	42%	OR=0.73**
	Satisfaction with spare time activities	71%	78%	OR=0.70**
	Attendance at religious services	25%	29%	n.s.
Indicators of subjective well-being	Higher overall life satisfaction	78%	90%	OR=0.39***
	Poorer mental health	19%	10%	OR=2.13***
	Higher self-efficacy	41%	55%	OR=0.57***
OR = Odds ratio ^f n.s. non-significant difference * p<0.05, ** p<0.01, *** p<0.001 ^g				

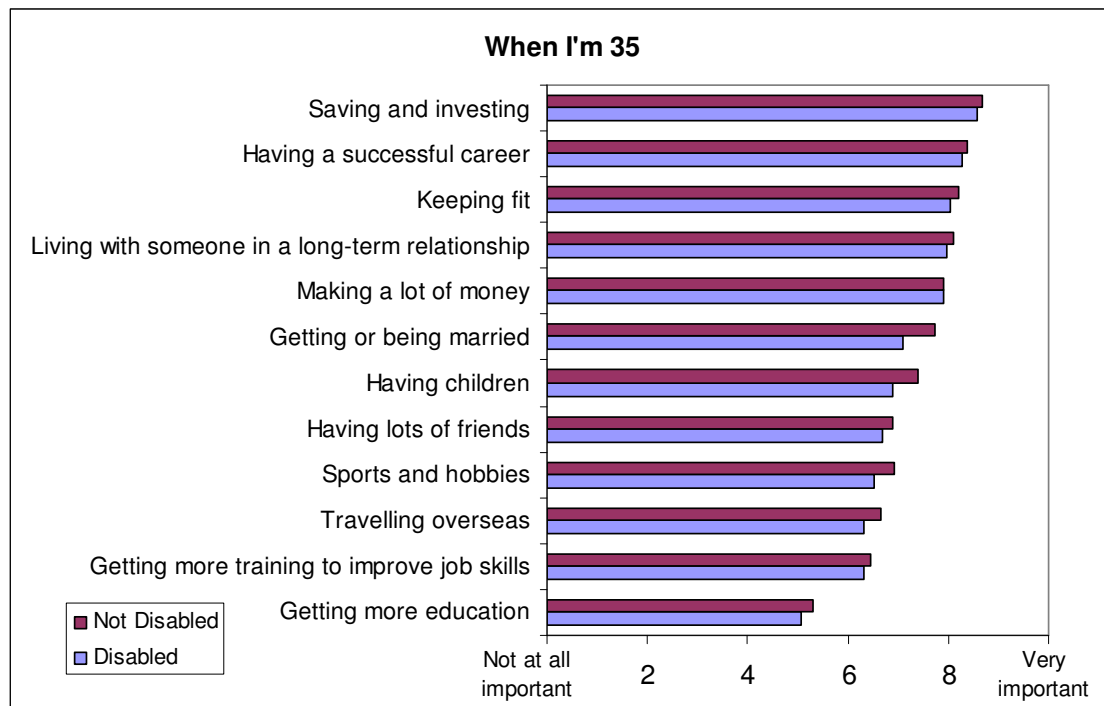
^f The odds ratio is an indicator of the strength of the association between two variables. For example, these results suggest that the odds of having a disability were just over twice as great if the person was born in Australia.

^g P values are indicators of the *statistical* significance of the difference between the two groups. It indicates that the probability that these differences (or larger) would occur by chance alone are less than 0.001 (1 in 1,000).

Aspirations

Participants were also asked about how important a range of things were to them now, and how important they thought these things would be when they were 35. The relative priority ratings of young people with disabilities and their peers are given in the following figures. As can be seen, overall the differences between young adults generally and those with long-term health condition, disability or impairment are marginal.





There were however a number of *statistically* significant differences between the groups. Young people with long-term health condition, disability or impairment placed less importance than their peers currently on

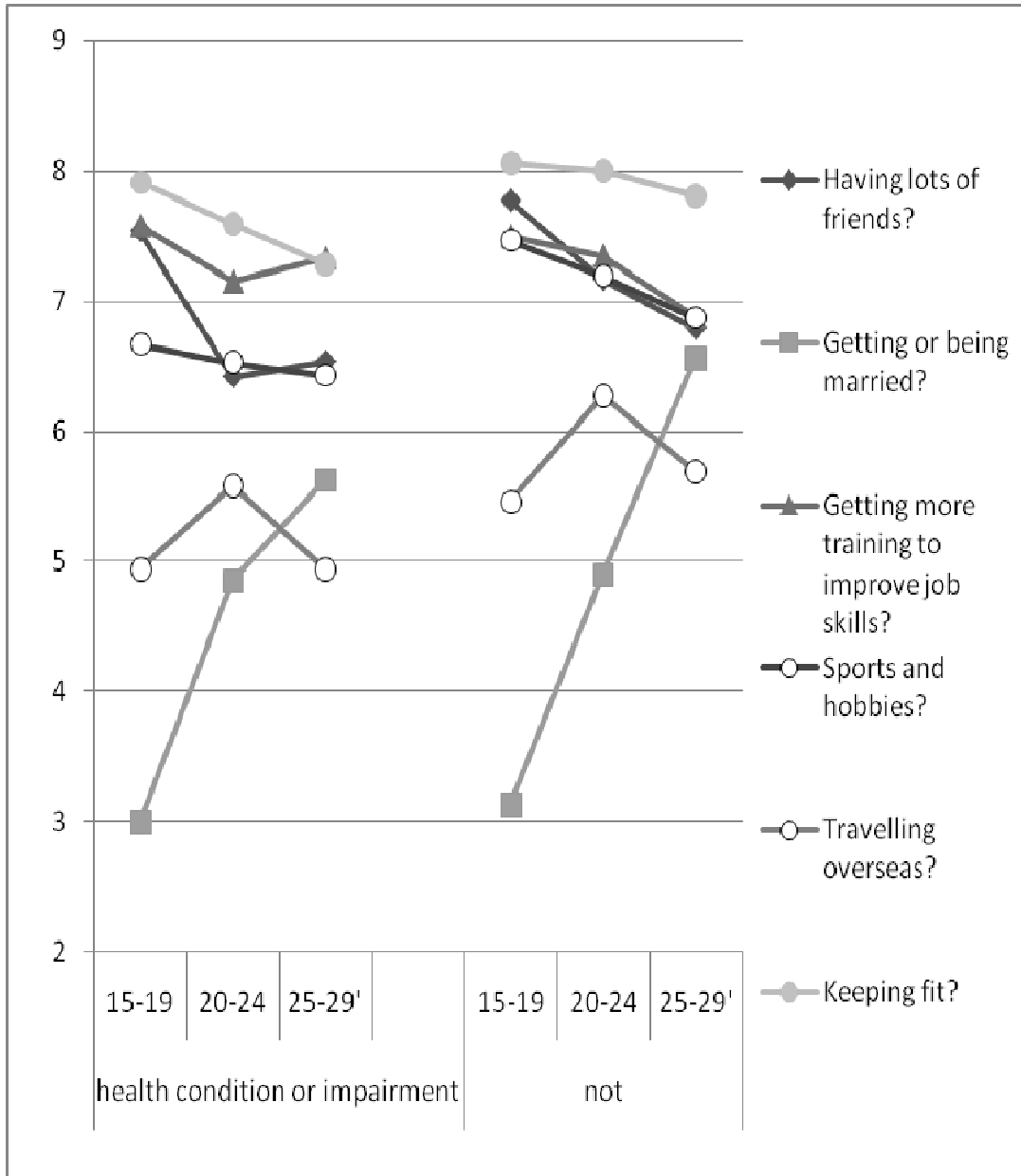
- Travelling overseas ($p < 0.001$)
- Sports & hobbies ($p < 0.001$)
- Getting or being married ($p < 0.01$)
- Having lots of friends ($p < 0.05$)
- Keeping fit ($p < 0.05$)
- Getting more training to improve job skills ($p < 0.05$)

Looking forward to when they were 35 young people with long-term health condition, disability or impairment placed less importance than their peers on

- Getting married ($p < 0.001$)
- Sports and hobbies ($p < 0.01$)
- Having children ($p < 0.05$)

There were, unsurprisingly, significant changes in peoples' current and future aspirations with age. For example, overall the importance of having a large number of friendships reduced with age while the importance of marriage increased with age. However, there were few (if any) systematic differences between young people with long-term health condition, disability or impairment and their peers in the nature of these changes. The following figure shows the

average rating (on a scale of 1 to 10) of the importance for different age groups of the six items for which there were (overall) statistically significant differences between young people with long-term health condition, disability or impairment and their peers with regard to their current importance.



Conclusions

The results of these simple comparisons attest to the level of disadvantage and discrimination currently faced by Australian adolescents and young adults with a self-reported long term health condition, disability or impairment. These differences in well-being are clearly not matters of choice. Overall, young people with long-term health condition, disability or impairment have very similar aspirations to their peers. They are, however, significantly more likely than their peers to be:

- socially isolated
- excluded from the labour force and to have fewer educational qualifications
- experience poverty and hardship
- live in poorer neighbourhoods
- have poorer health (including mental health)
- less satisfied with their lives

The link between long-term health condition, disability or impairment and health may not be surprising. It would be a wrong, however, to view this association simply in terms of it being an inevitable consequence of peoples' impairments. Low standard of living, unemployment, poor education and social isolation have all been identified as important social determinants of health.¹⁵⁻¹⁷ In other words, young Australians with long term health condition, disability or impairments are much more likely than their peers to live under conditions that are known to place peoples' health and well-being in jeopardy.

The results also provide an indication of the task ahead in addressing the rights of young Australians with long-term health condition, disability or impairment.

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