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Health inequalities and contemporary youth: Young people's accounts of the social determinants of health in an 'austere meritocracy'

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Abstract

Young people coming of age amidst widespread socio-economic uncertainty have a unique vantage from which to interpret how social, economic and environmental factors might influence health and the generation of health inequalities. Despite this, only a small number of existing studies of 'lay' understandings of health inequalities have focused on young people. This arts-based qualitative study builds on that body of research, in the context of the UK, to explore how young people make sense of health inequalities. Across two sites, Glasgow and Leeds, six groups of young people (39 in total) took part in online workshops to explore their perspectives. Throughout they engaged with population health research evidence; contributed to group discussions and responded creatively, via visual and performance art and by articulating their own views and experiences. In this paper, we explore how individual and structural explanations for health inequalities emerged, employing concepts from sociological studies of youth to shed light on these accounts.

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In particular, we argue that the concept of 'austere meritocracy', the persistence of narratives of aspiration and hard work as key to success against an increasingly hostile socio-economic backdrop, helps explain young people's perspectives on health inequalities in the UK.

KEYWORDS
arts-based research, discourse, health inequalities, lay perspectives, meritocracy, young people

INTRODUCTION

> Throughout recent history young people have carried a particular burden of representation, holding together society's hopes and fears. In times of social change and economic crisis, this contradictory positioning of youth intensifies as they become both the cause of society's problems and the stakes upon which the nation's future depends.
>
> (Mendick, 2018, p. 165).
>
> I feel the adults know more than they're letting on and they need to be honest with us because…they keep saying, oh we're the future, […] we're going to be independent one day and they're going to be looking at us when they're in the care homes or whatever and they're going to go on at us to change the future. But they're not telling us what's actually out there to help us change it.
>
> (Glasgow A, she/her, 16a).

Over the past two decades, socioeconomic uncertainty has become a defining feature of many OECD countries and the backdrop to young people's experiences and transitions (OECD, 2020). In the UK, repercussions of the 2008 global financial crisis were followed by wide-ranging social and economic upheaval arising from the COVID-19 pandemic, which has subsequently transitioned into a cost-of-living crisis characterised by rising living costs. Although the extent of the impact of these successive crises on population health has yet to be fully understood, recent analyses suggest 'austerity' policies (cuts to public spending across social security and key public services) are substantially contributing to stalling life expectancy and increasing inequalities in health across the UK (McCartney et al., 2022), with further deterioration to population health and exacerbation of inequalities expected (Broadbent et al., 2023). Young people, coming of age and entering the workforce amidst these increasing inequalities and widespread socioeconomic uncertainty, have a unique vantage from which to interpret how social, economic and environmental factors might influence health.

Previous analyses in Youth Studies have sought to explore contemporary youth experience in pre-pandemic unsettled times. Analysing contradictions that flow from a pervasive neoliberal discourse of meritocracy combined with bleak social and economic outlooks, Mendick et al. (2018) refer to 'austere meritocracy'. Their work builds on educational research concerned with narratives of meritocracy and aspiration that emphasise singular accounts of success (e.g. in high-achieving educational qualifications or well-paid professional occupations), despite the

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'impossibility of "success" for all' (Spohrer, 2016, p. 1). Mendick et al.'s (2018) concept of 'austere meritocracy' describes the tension between aspiration as a central motif of contemporary UK politics and the backdrop of austerity measures that combine to limit young people's opportunities, an example of Berlant's (2011) 'cruel optimism': 'the condition of maintaining an attachment to a problematic object in advance of its loss' (p. 21). The 'austere meritocracy' prioritises '"hard work", "optimism" and "resilience"' (p. 11) for success and downplays the influence of external constraints and structural determinants to emphasise individual responsibility. In Mendick et al.'s (2018) study, young people's narratives largely affirm the persistence of this narrative, with relatively few glimpses of resistance described. Indeed, despite some recognition of structural drivers of opportunity, these are frequently framed as challenges or constraints to be overcome by individuals. In this paper, we discuss how young people's accounts of health inequalities describe causes of ill health in ways that align with these individualised framings, while simultaneously resisting such explanations via social and structural explanations of population health, often brought to light through reflections on the COVID-19 pandemic.

CITIZENS' PERSPECTIVES ON DRIVERS OF HEALTH INEQUALITIES

Citizens' understandings of health inequalities and how they are generated have been explored through qualitative and mixed-methods research, including a small number of studies focusing on young people (Backett-Milburn et al., 2003; Fairbrother et al., 2022; Shortt & Ross, 2021; Watson & Douglas, 2012). Work to synthesise this broader research base (at all ages) suggests that people experiencing disadvantage provide accounts of the material–structural determinants of health, which align with broader research understandings (Popay et al., 2003; Smith & Anderson, 2018). However, there remains resistance within communities most negatively affected to acknowledge the extent of health inequalities (Popay et al., 2003), which Smith and Anderson (2018) argue in their review may be the result of attempts to resist both the stigma of poor health and poverty, and the disempowerment that can come from recognising how circumstances shape health. Recent research, focusing on young people, similarly finds sophisticated understandings of the complex interweaving pathways between social determinants and health outcomes. Fairbrother et al.'s (2022) work on young people engaged in youth groups and living in areas of England categorised as deprived highlights participants' descriptions of material, psycho-social and behavioural pathways through which health inequalities are produced and emphasises their understandings of how these pathways interact. Fairbrother et al.'s (2022) research is, to some extent, aligned with a broader body of research exploring young people's perspectives on the ways neighbourhoods, place and place-based communities shape health. Engaging with young people in Dundee, Glasgow (Shortt & Ross, 2021) and Aberdeen (Watson & Douglas, 2012), these studies similarly indicate sophisticated accounts of how neighbourhoods impact health in multiple, intersecting ways. However, there is variation across these studies regarding the extent to which young people's narratives focus on the individuals, institutions and systems that perpetuate and benefit from the unequal distribution of income, power and wealth—the antecedents to inequalities in health and wellbeing across the population. Taken together, these place-based studies suggest that young people articulate sophisticated understandings of determinants of health within their neighbourhoods and beyond, and that there is at least potential to explore young people's views on the role of policymaking in shaping the resulting health inequalities.

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Existing UK research exploring young people's perspectives on health inequalities draws on the perceptions and experiences of those living in areas categorised as deprived or disadvantaged across Scotland and England (Fairbrother et al., 2022; MacDonald & Shildrick, 2013; Shortt & Ross, 2021; Watson & Douglas, 2012), with one notable exception comparing the perspectives of children from contrasting socioeconomic groups (Backett-Milburn et al., 2003). Involving and understanding the experiences of those most negatively impacted by growing social inequality and enduring health inequalities in the UK is increasingly recognised as critically important to researchers and policymakers as a means of addressing ethical concerns, deepening understandings and promoting collective action to redress inequalities (Elliott et al., 2016). Reflecting on their meta-ethnography of lay understandings of health inequalities (which similarly identified studies focusing on disadvantaged communities), Smith and Anderson (2018) urge researchers to explore perspectives across wide-ranging social positions to avoid the implicit assumption that these are the only communities for whom inequality matters (especially given the wider public support required to redress inequalities). Within research focusing specifically on young people, one study that has taken this broader approach is Backett-Milburn et al.'s (2003) project focusing on children aged 9–12 from two contrasting areas of the same Scottish city—one affluent and one deprived. This generated accounts that reflected different experiences of childhood alongside similarities in perspectives on the site, production and consequences of inequalities. Such findings emphasise the importance of research that considers the various and intersecting dimensions of participants' social positions and identities, including life stage.

Young people's understandings of health inequalities may be shaped, in part, by their life stage and experiences. Their perspectives, whilst likely to cover wide-ranging explanations of the drivers of health inequalities, might also suggest issues that are most important or tangible to their life stage. Using biographical interviews with disadvantaged groups of young people in Northeast England, MacDonald and Shildrick (2013) identify health and wellbeing as factors that shape and are shaped by youth transitions. They describe the compounding of negative experiences (including repeat bereavements), pressures of living in disadvantaged neighbourhoods and the resultant trauma, arguing that this plays a key role in ill health and shapes crucial transition points in life trajectories. Further, social relationships feature strongly in research focused on children and young people (Backett-Milburn et al., 2003; Shortt & Ross, 2021). Following disruptions to relationships during the COVID-19 pandemic (Long et al., 2022) and disproportionate impacts on young people relating to employment, education and mental health (The Princes Trust, 2022), accounts of these contemporary influences require further attention.

The roles of stigma and agency have been discussed in the literature on public understandings of health inequalities, both explicitly, as contributing factors to health inequalities and as potential explanations for a reluctance to acknowledge the existence of health inequalities (see Smith & Anderson, 2018). Stigma also features as a determinant of health explicitly identified by young people (Backett-Milburn et al., 2003; Shortt & Ross, 2021; Watson & Douglas, 2012) and in efforts to understand why young people sometimes downplay the effects inequalities may have on them personally (Backett-Milburn et al., 2003; Watson & Douglas, 2012). Multiple studies present this as an example of participants' work to exert individual agency while acknowledging structural and material influences on health that seem beyond their control (Backett-Milburn et al., 2003; Watson & Douglas, 2012). Mendick et al.'s (2018) exploration of young people's aspirations in the context of austerity similarly focuses on assertions of agency and how these reflect and resist contemporary notions of

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meritocracy. Written in a pre-pandemic era, we argue that Mendick et al.'s (2018) conceptualisation warrants revisiting in a post-pandemic UK context, in which young people are faced with yet more uncertainty requiring them to navigate another financial and social crisis, while making decisions about their futures following major disruptions to their education, employment, relationships and aspirations. Exploration of young people's understandings of the drivers of health inequalities alongside descriptions of their current life stage and future plans offers a vital perspective on what an austere meritocratic society means for young people, and how it might continue to shape their lives and wellbeing into adulthood.

AIM

The overarching aim of this study was to explore young people's understandings of the social determinants of health and health inequalities. In this paper, we focus on how concepts of meritocracy and individual agency are presented or resisted in young people's discussions. With the timing of the research coinciding with the global COVID-19 pandemic, our aim was also to consider how this contemporary context was reflected in young people's accounts of health inequalities.

METHODS

Arts-based methods and creative partnerships

To explore young people's understandings of health inequalities, we took a broadly participatory approach that employed arts-based research (ABR) methods, which have been widely used to engage a range of under-served communities in research (Coemans & Hannes, 2017). In line with the characteristics of much ABR, as boundary-crossing and collaborative in both disciplines and expertise (Leavy, 2018), we formed partnerships with arts organisations: Impact Arts in Glasgow and Opera North and Leeds Playhouse in Leeds, organisations experienced in community engagement and creative capacity-building with young people. Working with each organisation's programme managers and arts practitioners, the project design was refined into a programme of 4-day workshops for groups of up to 10 young people. This plan was then adapted for online delivery due to COVID-19 restrictions, again building on the arts organisations' expertise.

Sampling and recruitment

Working with the creative partner organisations, six groups of young people (aged between 14 and 21 years) were invited to take part. Rather than recruiting based on specific demographic characteristics, groups of young people with shared interests or experiences, who were in contact with creative partner organisations either directly or through other community groups, were invited to take part via email or WhatsApp. Project information was supplied to all interested young people in text and video form. Lead facilitators then followed up with interested young people to confirm participation. Each participant was then provided (by post) with full project information, schedules, public health evidence, a range of art materials for both

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participating and personal use, gifts (such as a customised tote bag) in appreciation of participation and compensation of £100 in recognition of their time. A total of 39 young people participated in the project, 21 in Glasgow and 18 in Leeds (Table 1 provides an overview).

The eventual sample reflected our aim of engaging young people across a range of social positions. The young people who took part drew on a diversity of experiences of inequalities in relation to identity, life experiences and socioeconomic circumstances.

Workshops

Workshops took place between October 2020 and May 2021, using Zoom. Four 1-hour sessions were held each day, with breaks in between. Young people took part in private spaces (largely within their homes) and were provided with laptops/tablets if these were not already available to them. Facilitation was led by creative practitioners and youth workers, with resources and provocations co-developed with the researchers, two of whom offered facilitation support, answered questions and observed sessions.

The first workshop in Glasgow acted as a pilot. Activities, discussion topics and artistic methods were honed for subsequent groups, based on participant feedback. Broadly, the first 2 days focused on exploring understandings of health and inequalities (the focus of this paper), whereas days three and four focused on potential solutions (Fergie et al., 2023). Each day involved warm-up games and activities (featuring creative engagement techniques); engagement with research evidence (through videos, Kahoot! quizzes and online/paper-based resources); large and small group discussion (responding to evidence, reflecting on polling or responding to whiteboard contributions); and responsive creative practice and art-making (capacity-building sessions, individual and group development work, facilitator feedback and collaborative development). The Glasgow groups employed predominantly visual arts (drawing, printmaking and collages), whereas the Leeds groups focused on creative writing and performance (speech writing, mime and spoken word), reflecting the expertise of each partner organisation. The workshop content was driven by young people's interests and concerns. On the final day of workshops, each group held a showcase webinar to share creative outputs with a small audience of invited guests, including artists and creative professionals, researchers working in health inequalities and community/youth engagement professionals.

Prior to beginning the workshops, the purpose and process of the research was discussed, and guidelines for engagement were co-produced with participants. Written consent was obtained from all participants, for workshop participation and for sharing of creative outputs. Young people only included artworks in the research they were happy to share. Ethical approval was granted by the University of Glasgow College of Social Sciences Research Ethics Committee, application number 400200006.

Analysis

This process resulted in extensive qualitative data, including transcripts of group discussions, chat files, ethnographic notes and creative materials (dialectograms, creative writing, photographs and doodles). All text files were imported into NVivo. Taking a broadly abductive approach to analysis (Timmermans & Tavory, 2012), first and third authors read and re-read all materials, then developed a coding framework. Initial coding identified domains/levels of

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TABLE 1 Overview of groups and participants.

Workshop dates	City (group identifier)	Age range	Group origins	Participant pronouns and group size
October 2020	Glasgow A (GA)	14–17	Previous participants of a creative community programme for young people living in areas of deprivation; at risk of leaving school; living with a disability or mental health condition; or not in employment, education or training	He/him $n = 5$ She/her $n = 4$ Total $n = 9$
February 2021	Leeds A (LA)	14–20	Current participants in a community outreach project in a diverse neighbourhood with rich social history of immigration	He/him $n = 1$ She/her $n = 5$ Total $n = 6$
March 2021	Leeds B (LB)	17–21	Current participants in an alternative education programme delivered through creative practice	He/him $n = 2$ She/her $n = 3$ Total $n = 5$
April 2021	Glasgow B (GB)	14–19	Previous participants of a youth arts programmes focused on employability and confidence-building	He/him $n = 1$ She/her $n = 3$ They/them $n = 1$ Total $n = 5$
April 2021	Leeds C (LC)	14–17	Previous participants in activities aiming to empower young women or support mental health	She/her $n = 6$ They/them $n = 1$ Total $n = 7$
April 2021	Glasgow C (GC)	16–19	Previous participants in an employability programme	He/him $n = 2$ She/her $n = 5$ Total $n = 7$

health determinants (based on Whitehead and Dahlgren (1991)), then given the salience of responsibility and agency in the data, key concepts detailed in Mendick et al.'s (2018) 'austere meritocracy' (meritocratic ideals and hostile socioeconomic context) were incorporated into the coding framework alongside emergent priorities raised by participants. CV and GF coded a selection of data from each workshop, and refinements were made to the coding scheme before CV coded all data sources. Creative materials produced by young people were reviewed and grouped according to the identified themes, and analysed alongside transcripts and descriptions by participants, allowing us to triangulate between visual and textual data sources in ways similar to previous research drawing on participant artworks (Kearney & Hyle, 2004).

FINDINGS

Young people's explanations for the existence of health inequalities combined references to the social determinants of health with narratives of individual and collective responsibility. Although some narratives stretched across the lifecourse, the experiences of children and young

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people dominated. Below we present the key themes of discussions, from the individual to the political, highlighting consensus, tensions and nuances. Within each section, we reflect on the reproduction of narratives of individual responsibility and meritocracy vis-à-vis the hostile socioeconomic context against which these discourses are set.

Offering and resisting individual-focused explanations

Given the exposure of contemporary young people to narratives of meritocracy, and the burden of responsibility this implies (Mendick et al., 2018), it is perhaps unsurprising that the notion of good health as a product of hard work and healthy living (resulting from individual decision-making) featured in all groups. Initial interpretations of health as the product of lifestyle choices, including eating well and exercising regularly, were suggested in most early group discussions. For example, one participant suggested that 'it really depends on lifestyle choices, so having a healthy, balanced diet can help massively'. (LA_P3, Leeds A, she/her, 14). Good health was also linked to individual mindsets and mentality:

> GB_P4: I think perspective can be quite self-destructive if you don't realise what it's doing to you; if you don't take control of that I think it's a very self-destructive thing. [...] it's such a massive contributor to mental health.
>
> (Glasgow B, he/him, 19).

In addition to good diet and physical activity, having the right 'perspective' (GB_P4, Glasgow B, he/him, 19), 'mindset' (GC_P1, Glasgow C, she/her, 19) or 'mentality' (LC_P4, Leeds C, she/her, 16) was raised by participants across discussions in ways that imply health outcomes are influenced by people's attitude to health. This aligns with Mendick et al.'s (2018) account of the way positive psychology features in narratives of success in an educational context, with the effect of medicalising and individualising the social and economic challenges that young people are facing.

'Unhealthy' behaviours and lifestyles were also discussed, with some participants positioning themselves in opposition to peers in their neighbourhoods, who were described as drinking alcohol, smoking or using drugs; all behaviours that were associated by participants with wider anti-social behaviours, negatively impacting on neighbourhood safety:

> ***GA_P2***: The only good thing that happened for me in lockdown was the fact that I felt lockdown actually was pretty much made for me, because I never go outside very much, with my pals or anything. Because of where I live, because of the people, they drink a lot, smoke, everything.
> ***Facilitator***: Does that make you want to stay at home, [GA_P2]?
> ***GA_P2***: Yeah. Because of the place that I'm from, pretty much everyone just smokes and drinks, go out, throw bottles at everything.
> ***[...]***
> ***GA_P8***: Honestly, some of the young people, I would go on Snapchat and it's an embarrassment. Like I just see people partying and all that and people getting drunk and doing whatever with their pals. It's actually just embarrassing, especially during lockdown.

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GA_P2: Somebody jumped on top of my dad's car last year, and it was one of the people that went out smoking and drinking. They jumped on the roof of my dad's car and they managed to dent a lot of it.
GA_P3: No need, not. Nobody.
GA_P6: I know, exactly.
GA_P2: It's not healthy.
(Glasgow A, he/him, 15; he/him, 17; she/her, 16; he/him, 17)

This moralising discussion reached broad consensus across the nine participants in Glasgow A around what constitutes 'bad' youth behaviour, the antithesis of healthy, hard-working ideals. When questioned by facilitators further on impressions of those characterised as behaving in these ways, one person reflected: 'it's not the parents' choice that they're like this, it's their choice. And if they want to grow up in…that's their problem, we can't really blame anything else but them' (GA_P3, Glasgow A, she/her, 16). These individualistic perspectives, and articulations of 'good' and 'bad' behaviours, align with expectations of austere meritocracy, which push young people to prove that they demonstrate the values of 'thrift, responsibility and sacrifice as opposed to immediate pleasure, selfishness and irresponsibility', (Mendick et al. p. 25). In these ways we see reproduction of (uncritical) meritocratic discourse in relation to health by young people. However, these perspectives were not static over the course of workshops, nor consistently held to by individuals or groups.

Discussions often became animated when focusing on how health behaviours and social practices were linked to socioeconomic circumstances. In some groups, participants questioned the achievability of idealised health behaviours, including around diet. For example, in Leeds A:

LA_P1: Because not everyone has access to food. 'Cause I work for a charity and we send out food to those people in our community that can't afford the bare necessities of nutrients and vegetables and stuff. So not everyone can actually have access to all them things. It just depends on the circumstances that we're in.
(Leeds A, she/her, 19)

This participant's perspective provides a useful example of socioeconomic constraints on health behaviours, linking to wider concerns that rising food bank use in the UK is a public health crisis, with those impacted by food insecurity amongst the most marginalised in society and the charity food provision they can access likely exacerbating existing inequalities due to it being nutritionally deficient (Garthwaite, 2016; Loopstra, 2018). Several participants across groups seemed intuitively concerned that individualised narratives related to healthy diets obscured these highly pertinent inequalities (at a time of increasing food insecurity (Spring et al., 2022)).

Likewise, some participants identified constraints in discussions of physical activity and leisure activities. For example:

LC_P8: …if there's lots of clubs in that area, you're more likely to go if there's lots of opportunities, and also it can depend on […] if you're like middle or upper, you're more likely to exercise because you can afford to go to the gym or you can afford to go swimming or you usually live in areas where there are more opportunities because you've got more money.
(Leeds C, she/her, 15)

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Such comments, which entangled the needs for both individual resources and access to local amenities to engage in physical activities seen as health-benefitting, suggest nuanced understandings of the pathways through which health inequalities are produced, highlighting the kinds of intersections noted in other work on young people's perspectives (Fairbrother et al., 2022), and aligning with broader theoretical interpretations (Link & Phelan, 1995). Taken together, these explanations for differences in health behaviours across populations highlight the importance of socioeconomic determinants and offer a counter-narrative to individualistic interpretations of health resulting from lifestyle choices and mindsets.

At times, the entanglement of life circumstances with unequal places and health outcomes was explicitly recognised. For example, the following participant explained how her challenging life circumstances meant it was impossible to 'live in high life expectancy places' personalising the (often) abstract concept of health inequalities in ways that highlight the reality of this social injustice:

> GA_P7: My dad died when I was really young so I only stay with my mum. But she's got a lot of medical problems so she can't work at all. So we live in a council flat and the benefits and like EMA [UK means-tested benefit for secondary school students]. That's how we get by, basically. So it's hard. We can't live in high life expectancy places because we don't have the money to.
>
> (Glasgow A, she/her, 17)

Similarly, discussing other people, another participant suggested 'they don't have a job, they're going to have to rely on benefits meaning they're going to end up in a poorer place of Glasgow, meaning their life expectancy is going to go down' (GA_P3, Glasgow A, she/her, 16). Although these findings echo Fairbrother's account of young people's discourses 'moving away from more populist individualised, neoliberal explanations for inequalities' (Fairbrother et al., 2022), it is important to note that these extracts from our study still maintain a sense of individual responsibility, albeit for securing the social and economic conditions necessary for good health (as opposed to making healthy lifestyle choices). Taking on responsibility for not achieving the individual or area-based socioeconomic advantages that predicate good health is a potentially troubling development, in line with the pervasion of meritocratic discourses in contemporary young people's experiences (Mendick et al., 2018). It underlines Smith and Anderson's (2018) concern that efforts to promote awareness of socioeconomic health inequalities may unintentionally increase the stigma experienced by communities labelled as 'deprived'. Indeed, our findings suggest that any such work needs to be accompanied by efforts to communicate the impact of historical and contemporary policies on health outcomes (see Garnham, 2017). In these ways, researchers might support discussions around structural explanations of health inequalities that facilitate conversations about policy responses (Fergie et al., 2023; Smith et al., 2021).

Looking beyond the individual: Social support and relationships

Across groups and discussions, young people suggested a broad concern with the lifecourse, and how experiences of social support and relationships across childhood and youth shape future health. In several groups, the importance of the early years was stressed, particularly how

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family circumstances can influence health and how childhood experiences form the basis for health and wellbeing in adulthood.

> GB_P5: …if maybe a parent isn't doing well and from a very young age you had to kind of take on responsibility, when you get older that can affect you. Or if parents fight a lot or if there's issues going on or just certain ways people are shaped in their childhood or certain things that they do that their parents do that they pick up or other people just the ways they live. Because if you took somebody who has, like, five siblings and they only have one parent, versus somebody who has both parents and no siblings, they'd be incredibly different. Not necessarily bad, they'd just be different because everyone's kind of shaped differently from their family's backgrounds and stuff like that.
>
> (Glasgow B, they/them, 17)

This extract illustrates the nuanced explanations some participants across workshops provided for how health in later life could be shaped by health in the early years, including through parental mental health, family composition and relationship breakdown and intergenerational influences, offering another alternative to the narrative of individual responsibility for health and dominant adverse childhood experiences narratives (Kelly-Irving & Delpierre, 2019). Indeed, this extract also reflects sensitivity many young people demonstrated in describing tangible and near-contemporary experiences for themselves and other participants, including attempts not to stigmatise by suggesting influences of family composition were 'not necessarily bad' but 'different'. This contrasts with some policy narratives on the early years and lifecourse influences on health, which Pantazis et al. (2006) has identified as attributing inequalities to subversions of cultural norms in relation to family structures, with divorced or lone parents often constructed as automatically deficient.

Relationships with friends and family also featured prominently in participants' discussions of contemporary influences on their health, for example:

> ***LC_P1***: … if you have a good support system, it's going to have an impact on your mental and your physical health.
> ***Facilitator***: Yeah. Can you give an example of what it means to have a good support system?
> ***LC_P1***: Like having your friends support the decisions that you make and not like putting you down for things that you do if they don't like what you're doing.
> ***Facilitator***: Yeah, absolutely, yeah, thank you. And [LC_P5], do you want to add anything to that?
> ***LC_P5***: I think it's just nice to have people around you, especially some people in the pandemic didn't really have anyone around them, it would just be nice if they had anyone to talk to.
>
> (Leeds C, she/her, 15; she/her, 17)

An emphasis on 'good support' for decision-making was common across group discussions. Accounts of positive relationships varied and although mentions of family, school peers and neighbourhood communities were common, accounts also featured youth groups, religious communities, LGBTQ+ communities and online networks. Figure 1 features a detail from

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FIGURE 1 Featuring line drawing of a smartphone turned horizontally with a thumb hovering over the screen showing the game Among Us and an incoming message from 'Line' that reads 'Among fam [heart] UwU'; above the drawing text reads 'Playing Among Us & meeting cool people'. (Glasgow C, she/her, 19).

artwork created to reflect experiences of lockdown, conveying the artist's appreciation for her 'Among Fam [heart] UwU [emoji conveying warmth/affection]', suggesting the importance of the interactions she has with other players of the Among Us game app, considering the online community a 'Fam[ily]'.

Our findings around the prominence of relationships in young people's discussions of the generation of health and health inequalities resonate with previous research suggesting the importance of social connection in young people's accounts (Backett-Milburn et al., 2003; Shortt & Ross, 2021) and the negative consequences of disruption to these connections, via traumatic experiences such as bereavement (MacDonald & Shildrick, 2013). Indeed, our findings suggest the enduring prominence of positive relationships as health-promoting in young people's narratives of health in the context of the pandemic and the disproportionate disruptions to social connections these young people experienced (Long et al., 2022). Given these circumstances, and the adaptations, to online modes of social connection, it seems important to recognise the potential for proliferating sites of inequalities, including digital accessibility. Our findings also provide insight into multiple conceptions of young people's health-promoting relationships, supporting calls for more systematic consideration of the influence of relational processes in adolescence on the emergence of health inequalities in early adulthood, which often persist throughout the lifecourse (Due et al., 2011). Furthermore, in these discussions of early years influences, social support and relationships, young people's views were less likely to features the individual burden of responsibility for good health that align with Mendick et al. (2018) notion of 'austere meritocracy'. Rather, their narratives here tended to promote community and collectivism in the pursuit of good health for all, and concern and sympathy for those without access to supportive relationships and communities.

Considering wider determinants of health: Focusing on meritocratic domains of education and employment

The complex interplay between reproducing and resisting individualistic narratives was, however, apparent as workshop discussions progressed around the wider social determinants of health. Although discussions ranged across determinants, with a focus on income (reflected in

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the opening findings section around health behaviours), young people's reflections often drew on their current circumstances and upcoming transitions, with a tendency to focus on education and employment emerging in most groups. Given the timing of workshops, October 2020 to May 2021, the context of the pandemic (which, in the UK, entailed home learning for many as well as a high-profile dispute about inequalities built into the algorithms used to determine exam results [Coughlan, 2020]) featured heavily in discussions.

The notion that education should be a central priority for all young people was expressed across several groups, with hard work and academic success positioned as key to a bright future.

This sentiment was expressed in Leeds B 'if you didn't, like, have education you won't get nowhere in life' (Leeds B, she/her, 19), and echoed passionately in other groups, for instance:

> LA_P3: Education is like the most important thing, because if you have education then you can almost get like any job you want. Like your future is basically on like education [...] as Nelson Mandela's quote, like education is the most powerful weapon which you can use to change the world.
>
> (Leeds A, she/her, 14)

The importance of education in young people's accounts of their everyday life and envisaged futures is well-aligned with the discourse of meritocracy, as prescribing socially acceptable pathways to successful adulthood through academic performance (Mendick et al., 2018). Commonly, participants went on to talk over how education was linked to other key determinants of health, including income, employment and housing: 'like with good education, you're more likely to get a job which would provide housing' (LC_P8, Leeds C, she/her, 15). This construction of success, with education cited as a route to financial security, at once positions individuals as responsible and justifies class differences. It is incumbent on the individual to achieve a level of education that can provide opportunities to secure stable employment, income and housing. This narrative, emerging from discussion of the social determinants of health, is well-aligned with Mendick et al. (2018) description of the pressures articulated by young people in accounts of securing futures through educational attainment.

Some contributions to discussions suggested the approved routes to success within the school environment conspired to leave those not following idealised educational routes, or achieving optimal outcomes, feeling 'judged'. For example, one participant in Glasgow A commented:

> GA_P8: I feel that school looks down upon people who don't have the same qualifications as others [...] Because at the end of the day, people can be so judgemental, especially within the school environment. And it's just kind of all talk and you'll get people that are complaining about certain exam results, yet there are people like me who couldn't even get to finish their exams. [...] I don't know, I just feel the school environment can be kind of judgey and if you leave or if you don't get a certain amount of grades, like you're automatically just going to become nothing, just gonna be a ned [a young person seen as delinquent].
>
> (Glasgow A, he/him, 17).

Despite this critique of the school system, and the inequality it perpetuates, this participant returned to the notion of individual responsibility, with his account reflecting a concern to overcome the constraints of the education system. This resonates with Mendick et al. (2018)

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observation that young people's accounts of structurally generated disadvantages 'tended to be subsumed within individualised frameworks in which participants emphasised their own responsibility' (p. 28).

Conceptions of transitions from education (via hard work) to employment also featured in discussions. Across the groups, young people rehearsed established pathways that aligned with meritocratic ideals. For instance, in Leeds A: 'if you go to a good university and you have a good degree, then you would get a stable job', (LA_P3, Leeds A, she/her, 14). However, some participants challenged these notions somewhat based on their experiences and those of their peers. For example, in response to LA_P3's comment, one young person wrote in the Chat, 'What about experience?' and followed up in discussion:

> LA_P6: You can still go to university, get a degree, and then just because you've got a piece of paper that says you've got a qualification and you know how to talk about this certain topic, it doesn't mean you'll get a job straight away. Like, there's loads of people that have, like, got a degree in something [...] then they still struggle to find a job. [...] yeah, you can, I'm not saying you can't, but the majority of people struggle to find experience. That's the truth.
>
> (Leeds A, he/him, 20)

Acknowledgement of the challenging labour market, despite best efforts to secure qualifications, illustrates well the tension of meritocratic ideals against a hostile socioeconomic context that offers both limited opportunities and increased uncertainty. Mendick et al. (2018) discuss the increasing costs and decreasing returns of education and a resulting focus on hard work amidst 'the broken contract between the economic and education systems' (p. 53). In our more recent context, this 'broken contract' is perhaps exemplified in the grading algorithm that effectively systematised place-based inequalities in educational outcomes (Coughlan, 2020). Indeed, participants commonly discussed increasing uncertainty derived from the pandemic and its wide-reaching impacts on further/higher education and the labour market as tangible examples of external forces limiting opportunities for young people, building upon the pre-existing constraints discussed by the young people featured in Mendick et al. (2018) work.

Above, we have discussed young people's talk about education and employment as key determinants of health, dominant in their discussions due to their current priorities and concerns. Participants' reproduction of meritocratic discourses alongside accounts of their perceptions and experiences of constraints were evident throughout, with most participants unified in agreement around those most universal pandemic-related constraints. Articulation of these constraints, however, was often in terms of how they should be overcome in accordance with the burden of individualised responsibility that Mendick et al. (2018) have suggested characterises young people's experiences in the UK.

Tracing influences of social and economic policy and policymakers

Despite discussion of key social determinants (notably education and employment) as largely the responsibility of individuals, counter-narratives emerged as young people also identified the determinants of health in policy decisions. Echoing pandemic-related debates among public health professionals, the importance of the interactions between government policies, living and working conditions, and health experiences were discussed:

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> GB_P4: Yes, [lockdown] helped everyone's health but it's only helping in the short term if they don't have a job to go back to. So, I mean, we've shut down the world but at what cost? Like, yes, we're safe from the virus but are we safe from all the problems that unemployment's going to cause, or the mental aspect of being locked in your own four walls for a year, over that now. I think there's a lot of longer lasting damage in a way than people are realising. […] It's less about stopping the virus at this point and more about minimising the damage because either way it's going to have a massive effect on people.
>
> (Glasgow B, he/him, 19)

Across several groups, discussions of inequalities in power and influence over decisions, and how these impacted people both in terms of risk of COVID-19 and living conditions was discussed. In Glasgow A, key workers were praised, whereas politicians were strongly criticised:

> GA_P3: It's people like these that need to be recognised, not stupid parliaments. Like, honestly, we already recognise them. They're on the telly all the time and we don't really understand what they're saying. But teachers are there to help you. They put themselves in danger. So do the NHS…not just…like, the binmen and janitors and all that, they all put themselves at risk as well during this coronavirus […]. Like, honestly these people are the ones that deserve to have praise and deserve to have a pay rise or to… deserve to actually have support because they're working their butts off trying to feed their family and pay for their house and maybe even a bit on the side for a wee fancy holiday. Well, the parliament already sit on their butts all day and they think that it's alright to get more money [referring to media coverage of UK MPs' pay rise]. It's just bang out of order.
>
> (Glasgow A, she/her, 16).

Concerns with inequalities in pay, and who makes decisions related to this, were widespread. Across all groups, participants discussed and explored the position of 'key workers' in the UK, as publicly valued but underpaid, epitomising the unfairness of socioeconomic inequalities and subsequent health inequalities. These discussions, often some of the most passionate in each group, highlighted participants' sense of the political drivers behind inequalities. Rather than accepting current systems of governance and decision-making as an unchangeable reality, they suggested that more could be down to equalise incomes and privileges, potentially driven by stark comparisons that surfaced during the pandemic, such as between key workers and politicians as described above.

Similarly, questions were raised in some groups around who was being prioritised in decision-making during the pandemic:

> GB_P4: I think that they speak about small businesses every time but what about anything other than businesses? What about people that are relying on their part-time work or the people that are living off of state benefit, what was happening with us? We're being told, yeah, now you're losing your benefit you got from COVID [Universal Credit uplift of £20], but now you're not, but now you are—give us a solid answer. Stop speaking about businesses and start speaking about individuals.
>
> (Glasgow B, he/him, 19)

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This participant expressed frustration with the government's focus on the wellbeing of businesses rather than people, as well as the uncertainty exacerbated by frequent changes in policy. A general lack of trust in government to prioritise the needs of those currently underserved or disadvantaged in society was evident across groups, with concerns expressing that those in power were too distant from the negative impacts of policy decisions, and from the people most affected. Ambivalence towards people in power was also reflected in some of the creative outputs produced by young people. In Glasgow A, for example, participants designed 10-pound alternative banknotes. One design, pictured below (Figure 2), featured a self-portrait of the artist.

In describing her work to the group, she explained the decision to portray herself was because she did not 'know who is worthy to be on a banknote', echoing a general distrust in figureheads who represent established power hierarchies, aligning with citizens' jury-based research involving adults in conversations about health inequalities in the UK before the pandemic (Smith et al., 2021). Here, our findings go beyond existing qualitative research, which suggests young people's accounts of health inequalities feature limited (Fairbrother et al., 2022) or locally bounded (Watson & Douglas, 2012) discussions of power relations. Indeed, while our participants stressed young people's responsibility to negotiate and overcome constraints around education and employment in ways that align with Mendick et al. (2018) observations, as discussions brought politics and policy into more direct focus, far stronger critiques emerged. Indeed, young people seemed disillusioned by political figures and the current socioeconomic context; a disillusionment that seemed partially related to pandemic policy responses but also grounded in discussions of longer-term, entrenched inequalities and how these might predicate inequalities in health.

CONCLUDING DISCUSSION

Broadly, our findings align with Fairbrother et al. (2022), suggesting that young people's understandings of the generation of health inequalities are nuanced and align well with scholarly understandings, with many instances in both studies of participants articulating the linkages and pathways through which social determinants influence health. The emphasis our participants placed on the importance of relationships and social support for good health also aligned with previous research (Backett-Milburn et al., 2003; Shortt & Ross, 2021). In contrast to some earlier studies (e.g. Shortt & Ross, 2021), likely reflecting our research design and that participants were contributing from home environments (rather than the wider neighbourhood focus of Shortt & Ross's study), there was minimal reflection on the commercial determinants of health. Perhaps more surprisingly, in the context of the pandemic, health services did not feature prominently in our participants' accounts of how health inequalities are generated, in contrast to survey-based research on adults (Kane et al., 2022). Overall, however, our participants provided accounts of health inequalities that were sophisticated, multi-factorial and which align with many research-led accounts of health inequalities (Marmot et al., 2020). Indeed, our participants frequently resisted individual explanations related to choices and lifestyles, and instead identified a wider range of responsibilities and influences on health, that work to incorporate nuanced explanations of individual differences, social determinants and implications of policy decisions. However, the positioning of responsibility for health inequalities did not always mirror these accounts (or, therefore, research-led explanations of the fundamental causes of health inequalities).

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FIGURE 2 £10 note design featuring: large '£10' printed in orange and pink, a self-portrait of the artist, orange circles and zig zag lines (Glasgow A, she/her, 16[b]).

In some ways, our findings align with Smith and Anderson's (2018) meta-ethnography, which suggests that, despite sophisticated understandings of the social determination of health, people often deny the existence of health inequalities. Smith and Anderson (2018) argue that this likely reflects an attempt to resist the dual stigma of poverty and ill health, and the sense of disempowerment that can arise from recognising how circumstances shape health. However, although we found willingness to acknowledge health inequalities as illustrated via references to 'high life expectancy places', alongside key social determinants, this acknowledgement was not always accompanied by a focus on the structural or systematic nature of health inequalities. Our analysis of the data collected for this project suggests that, while this may partially reflect an effort to maintain agency, it also reflects the importance of understanding the wider social discourses and narratives that shape people's understandings. Specifically, we argue that the emphasis on individual agency embedded within the 'austere meritocracy' discourse described by Mendick et al. (2018) in relation to young people's accounts of education is also evident in contemporary accounts of health. This aligns with research (e.g. Halliday et al., 2020) calling attention to the importance of public discourses in shaping lay accounts of health inequalities. However, the 'austere meritocracy' discourse goes beyond previously identified discourses of fatalism, individual responsibility, blame and stigma, functioning to extend individual responsibility for proximal determinants of health (such as lifestyle-behaviours) to key social determinants of health, such as education and employment, in ways that acknowledge the hostile and unequal socioeconomic context, yet nonetheless position individuals as responsible. This suggests that researchers working with public understandings of health inequalities ought to pay more attention to unpacking evolving public discourses that shape the ways in which people think about health and its determinants.

It is also important to note that where conversations in our workshops explicitly focused on policy and politics, our young participants had plenty to say about the structural and systemic factors that shape health, including specific pandemic policy responses. It was clear that, as Smith et al. (2021) found with the adult participants in their citizens' juries, trust in politicians and decision-makers is low. This makes unpacking the emphasis on individual responsibility more complex; although our sense is that the emphasis on individual responsibility partially reflects the impact of a widespread public discourse of 'austere meritocracy', it may also be shaped by a lack of belief in any viable alternatives. If young people do not believe the politicians and decision-makers in charge of employment, education, health and economic policy are able and willing to improve the contexts in which people live, they are unlikely to spend much time discussing their responsibility to make change.

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Our study had several limitations. The study generated nuanced discussions among young people across a range of issues related to the social determinants of health and the generation of health inequalities, often facilitated by the provision of some stimulus evidence or activity. However, because of the participatory approach, and a concern for participants to discuss issues they prioritised (i.e. relationships, education, employment and pandemic decision-making), some key issues and evidence were missing from discussion, for instance, an alternative approach might have prompted more discussion of the commercial determinants of health or health services. Future studies, perhaps taking a deliberative approach more facilitative to engaging systematically with wide-ranging perspectives and evidence, might explore issues more comprehensively, and unpack popular discourses in more detail. Further, although creative engagement was prioritised within the project, detailed analysis of artworks and performance pieces was limited, with creative outputs generally explored in combination with textual data rather than through processes of visual analysis. It is possible that analysis focusing more predominantly on the creative outputs might have reached alternative conclusions. Visual and performance art from the project are presented more fully online (https://creativeinsights.sphsu.gla.ac.uk). Furthermore, the influence of the COVID-19 pandemic is writ large in the project design and data generated. This specific aspect of the UK context offered a useful lens for identification of structural influences on health in our research. However, continued engagement with young people in research on health determinants, as the experience of the pandemic becomes more distant, seems vital for deepening the understandings of young people's accounts of inequalities, including systemic and structural influences on health.

Despite limitations, our research provides some key insights on young people's understandings of influences on health and the generation of health inequalities. Our findings emphasise the nuanced and sophisticated accounts of young people, emphasising drivers and considerations of particular relevance to their life stage. We also draw attention to the importance of dominant discourses in shaping contemporary narratives. In the post-pandemic UK context, the prominence of meritocratic discourse functions to promote ideals of individual responsibility for health despite an increasingly hostile socioeconomic context. The young people in our study were variously engaged in reproducing these accounts of responsibility and resisting them, through both identification of constraints on individuals and communities and suggested critiques of power relations and decision-making. These findings are perhaps particularly salient as calls are issued to engage publics in discussions of the social determinants of health (Marmot et al., 2020) or reframe messaging around health inequalities for publics (L'Hôte et al., 2022). Indeed, population health researchers and policy makers concerned with addressing health inequalities can perhaps do more to ensure that these discussions incorporate reflection on dominant discourses and policy decision-making across key domains that influence health, including those most salient to young people's experience and transitions.

AUTHOR CONTRIBUTIONS

Gillian Fergie: Conceptualization (lead); data curation (equal); formal analysis (equal); funding acquisition (lead); investigation (lead); methodology (lead); project administration (lead); resources (lead); supervision (lead); writing—original draft (lead); writing—review & editing (lead). **Katherine Smith**: Conceptualization (equal); writing—review & editing (equal). **Caroline Vaczy**: Data curation (equal); formal analysis (equal); writing—original draft (supporting); writing—review & editing (supporting). **Mhairi Mackenzie**: Conceptualization (equal);

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writing—review & editing (equal). **Shona Hilton**: Conceptualization (equal); writing—review & editing (equal).

DATA AVAILABILITY STATEMENT

The data generated as part of the wider study are available to registered users with access to safeguarded data through the UK Data Service as Fergie, Gillian M. (2022). Creative Insights: Developing a Participatory Approach for Exploring Young People's Perspectives on Health Inequalities, 2019–2022. (Data Collection). Colchester, Essex: UK Data Service. 10.5255/UKDA-SN-855952.

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