FAMILY AFFLUENCE
FAMILY AFFLUENCE

Socioeconomic differences are found in many areas of health and health behaviours and the social relationships that support them. In general, young people with higher affluence tend to get along better with their families and peers, do better in school and report better health outcomes. The pattern is less clear in relation to some risk behaviours and in spending time with peers.

SOCIAL CONTEXT
Young people with higher affluence have better communication with parents, although the association is stronger for communication with fathers and among girls. Family affluence positively relates to perceived family support in over half the countries and regions and to peer support in about two thirds. It is also related to school performance, despite having no consistent association with liking school or school pressure.

HEALTH OUTCOMES
Inequalities related to family affluence exist across a range of health outcomes. Higher family affluence relates to better self-rated health and higher life satisfaction. It is also associated with frequency of multiple health complaints in around a third of countries and regions for boys and about half for girls. Low affluence relates to excess body mass and perceptions of being too fat, although this is not observed across all countries and regions. Medically attended injuries increase with higher family affluence, which might reflect differences in accessing health services or participation in sports in some countries and regions.

HEALTH BEHAVIOIRS
Higher affluence relates to more frequent physical activity, more regular toothbrushing, higher fruit intake and more frequent breakfast consumption in most countries and regions. Inequalities in soft-drink consumption vary, with higher affluence relating to higher consumption in some countries and regions but lower in others. Higher television-watching is associated with lower affluence, largely in western Europe, but the opposite relationship is observed in some eastern European countries.

RISK BEHAVIOIRS
No clear pattern of inequalities is found in risk behaviours. Low affluence relates to weekly smoking in most countries and regions, but not to age of smoking onset, drinking initiation or cannabis use. Young people from low-affluence families are more likely to have been bullied, but there is no consistent relationship for fighting, bullying others and cyberbullying.

DISCUSSION
Adolescent health and health behaviours share a complex association with family affluence. Longitudinal research in this area has found that the effects are bidirectional in nature. Obesity in adolescence, for example, predicts less education and lower incomes in adulthood (1); conversely, low adolescent SES increases the risk for adult obesity after differences in adult SES are taken into account (2,3). Research has also found that international differences in income inequality determine the size of health inequalities in adolescents (4). Health, SES and social mobility are intricately linked from an early age, which helps explain why health inequalities endure throughout the life-course.

The mechanisms that underlie these inequalities involve multiple causal pathways (5). First, family affluence affects adolescent health by limiting access to material resources that support health, such as good-quality schools, healthy food options and access to parks and playgrounds that facilitate physical activity (6).

Second, low family affluence levies the psychosocial effects of low socioeconomic rank and the stress and anxieties of living in relative poverty (7). This psychosocial path explains why the socioeconomic gradient in health extends through the full range of family affluence and why socioeconomic differences are observed in all HBSC countries and regions regardless of their
national wealth. Material and psychosocial pathways work in tandem: inequalities in food choices, for example, are determined by affordability of healthy food options and the stressors of relative deprivation, which disinhibit dietary restraint and drive preferences for high-fat, high-caloric foods (8–10).

Third, family affluence indirectly affects adolescent health though social stratification. Lower-affluence adolescents have less structured mealtimes and poorer communication with parents, perceive less social support from their families and peers, and do less well in school. Research has found that antisocial behaviour, school dropout and exposure to crime-ridden neighbourhoods are more common experiences for lower-affluence adolescents (11). Health inequalities are created and then reinforced by multiple social contexts.

Fourth, observed differences in health outcomes are also a consequence of socially patterned differences in early life experiences and the cumulative effects of psychological stress on the development of neuroregulatory centres of the brain that govern emotion, attention and social functioning (12).

CONCLUSION
The likelihood that adolescents are healthy, happy and doing well in school becomes significantly and progressively stronger as family affluence rises (11). Early socioeconomic exposures have lasting effects on lifelong health and well-being (13, 14). The HBSC study provides valuable information about the magnitude of these differences across multiple health behaviours and health outcomes.

REFERENCES