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The Healthy-Youth Paradox in Jamaica: Social Conditions, Functional Health and Chronic Morbidity Among Children and Young People in the 2023 Jamaica Survey of Living Conditions

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ABSTRACT

Background: Children and young people are commonly treated as comparatively healthy populations, yet chronic disease, functional limitations and unequal social conditions established early in life may shape later morbidity. Evidence from Jamaica remains fragmented, with few contemporary national studies directly comparing children aged 0–14 years with youth aged 15–24 years across social, geographical, healthcare and chronic-disease domains.

Objective: This study compared the sociodemographic characteristics, health status, healthcare utilisation, insurance coverage and self-reported chronic morbidity of Jamaican children and youth using the 2023 Jamaica Survey of Living Conditions.

Methods: A secondary cross-sectional analysis was conducted on 1,545 respondents aged 24 years or younger, comprising 926 children and 619 youth. Data were accessed through the SALISES Documentation Centre/Derek Gordon Databank, Mona Campus, The University of the West Indies. Frequencies, cross-tabulations, Pearson chi-square tests and contingency coefficients were used, with statistical significance set at $p<0.05$.

Results: Children and youth were similar by sex, parish, area of residence, health insurance, healthcare utilisation, injury and functional health. Significant differences occurred for educational level, household headship, general illness and asthma. Asthma was the most frequently reported chronic condition, affecting 6.0% of children and 9.9% of youth, although the association was weak. Most other chronic diseases were rare and statistically indistinguishable between cohorts.

Conclusion: Jamaican children and youth displayed structural and functional health similarity despite selected age-related differences. The findings identify asthma and reported illness as exceptions and underscore the need for life-course surveillance that bridges paediatric, adolescent and young-adult health rather than examining these populations separately.

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Introduction

Children, adolescents and young adults are often positioned within public-health discourse as comparatively healthy populations because their mortality and conventional chronic-disease burdens are substantially lower than those of middle-aged and older adults. This assumption is only partly justified because adolescence and early adulthood represent formative life-course stages during which biological, behavioural and socioeconomic exposures accumulate and influence subsequent disease trajectories. The World Health Organization (WHO) defines adolescence as ages 10–19 years and emphasises that this period involves rapid physical, cognitive and psychosocial development, while young adulthood extends the period during which important patterns of health behaviour and health-service engagement become established [1,2]. Globally, more than 1.5 million adolescents and young adults aged 10–24 years died in 2021, demonstrating that comparatively low mortality should not be confused with negligible health burden [2]. Furthermore, many health behaviours associated with non-communicable diseases (NCDs), including unhealthy diet, physical inactivity, tobacco use and harmful alcohol consumption, emerge or consolidate during adolescence and young adulthood [1-3]. The health of children and young people warrants examination not merely because of immediate morbidity but because early-life exposures constitute an important foundation for health across the life course.

The significance of this issue is evident in Latin America and the Caribbean, where young people constitute a substantial proportion of the population while simultaneously experiencing social inequality, uneven healthcare access and changing patterns

of NCD risk. The Pan American Health Organization (PAHO) estimates that young people comprise approximately 30% of the population of Latin America and the Caribbean and warns that their health needs are frequently overlooked because adolescence is presumed to be a healthy stage of life [3]. Regional health authorities have consequently expanded the NCD agenda beyond adulthood, explicitly recognising that asthma, type 1 diabetes, some cancers and other chronic conditions affect children, adolescents and young adults [4]. PAHO's adoption of a regional policy specifically addressing NCDs among children, adolescents and young adults reflects recognition that prevention cannot sensibly begin only after adult disease becomes clinically established [4,5]. This perspective is relevant to Caribbean societies undergoing nutritional, epidemiological and socioeconomic transitions in which infectious-disease control has been accompanied by increasing concern about chronic morbidity and its behavioural antecedents. Accordingly, contemporary surveillance must simultaneously examine current disease, functional health, healthcare access and the social context within which future adult morbidity develops.

Jamaica provides an especially important setting for such investigation because earlier research indicates that apparently good health among children and adolescents coexists with meaningful chronic morbidity. Bourne's analysis of Jamaican adolescents aged 10–19 years using the 2002 and 2007 Jamaica Survey of Living Conditions (JSLC) found that approximately 93% reported no illness or injury, but changes in hypertension, diabetes and unspecified health conditions challenged the assumption that adolescent health could be understood solely from low reported morbidity [6]. Earlier research on Jamaican children similarly documented changing patterns of disease and argued that the epidemiological profile of childhood was becoming more complex than conventional mortality indicators suggested [7]. Asthma represents one important example because Kahwa and colleagues found doctor-diagnosed asthma in 16.7% and current wheeze in 19.6% of Jamaican children aged 2–17 years in a national community-based survey [8]. Those figures are substantially higher than the prevalence produced by the current JSLC analysis, demonstrating how prevalence estimates can depend on case definitions, survey instruments, reference periods and whether symptoms, diagnoses or disease history are measured. These methodological differences make contemporary population-level comparison necessary rather than allowing older estimates to be treated as directly transferable to current Jamaican children and young people.

The attached 2023 JSLC analysis provides an opportunity to address this issue through a direct comparison of children aged 0–14 years and youth aged 15–24 years across multiple dimensions of health and social circumstances. The analytical file contains 1,545 respondents aged 24 years or younger, of whom 926 were children and 619 were youth, thereby allowing comparison across two adjacent life-course stages rather than studying either population in isolation. The comparison incorporates sex, socioeconomic position, geography, education, household headship, health insurance, general illness, functional health, healthcare utilisation, injury and an extensive set of chronic conditions. Such multidimensionality is important because the absence of recently reported illness does not necessarily imply the absence of a diagnosed chronic condition, and the presence of chronic disease does not invariably produce functional limitation. Jamaican evidence has also demonstrated disagreement between adolescents' self-reported health-related quality of life and parental proxy reports, reinforcing the importance of considering whose report is being measured and what construct the measure actually represents [9]. Consequently, the present study treats general illness, functional health and disease-specific morbidity as related but conceptually distinct dimensions rather than interchangeable measures of health.

Research Gap and Contribution of the Study

Despite an established literature on child and adolescent health in Jamaica, a clear empirical gap persists concerning direct comparisons between children and young people using contemporary national living-conditions data. Much of the existing Jamaican literature examines childhood, adolescence or particular diseases separately, while earlier comparative JSLC studies frequently use data that are now nearly two decades old [6,7]. Disease-specific studies, especially those concerning asthma, provide detailed clinical and epidemiological evidence but do not simultaneously examine socioeconomic status, functional health, insurance coverage, healthcare utilisation and broad geographical distribution [8]. Regional reports provide valuable Caribbean and Americas-wide perspectives but necessarily aggregate populations and cannot reveal whether the transition from childhood to youth is associated with specific differences within Jamaica [3-5]. Moreover, global adolescent-health frameworks increasingly call for comprehensive and age-disaggregated indicators, with WHO explicitly noting historical weaknesses in the measurement of adolescent health. The first research gap addressed by this study is the absence of a contemporary multidimensional comparison of Jamaican children and youth using the 2023 JSLC [10].

A second gap concerns what may be termed the healthy-youth measurement paradox, whereby very high proportions reporting no recent illness or functional difficulty can coexist with identifiable chronic disease and socioeconomic vulnerability. Conventional analyses may classify young populations as healthy because most respondents report neither illness nor disability, yet such classifications may conceal conditions that are episodic, medically controlled, previously diagnosed or insufficiently severe to restrict current functioning. The present dataset illustrates precisely why this distinction matters, because 96.6% of respondents reported no general illness and 96.0% of those with valid functional-health data reported no difficulty, while asthma alone was reported by 7.6% of the entire sample. The coexistence of these patterns means that chronic morbidity, recent illness and functioning should not be interpreted as equivalent outcomes. International adolescent-health frameworks increasingly emphasise multidimensional surveillance for this reason, but relatively little Jamaican work has empirically demonstrated these distinctions within the same contemporary dataset. This study contributes both descriptive evidence and a conceptual argument for separating reported illness, chronic disease and functional capability when assessing the health of younger populations [1,10].

3. Aim, Objectives and Research Questions

The primary aim of this study was to compare the socioeconomic, geographical and self-reported health characteristics of Jamaican children aged 0–14 years and youth aged 15–24 years using the 2023 Jamaica Survey of Living Conditions. The first objective was to determine whether the two age cohorts differed according to sex, socioeconomic group, area of residence, parish, educational attainment and household-head status. The second objective was to compare reported general illness, injury requiring medical attention, functional health, health-insurance coverage and healthcare utilisation between children and youth. The third objective was to examine age-cohort differences across reported asthma, diabetes, hypertension, arthritis, COPD, heart disease, sickle cell disease, depression, dementia, other mental disorders,

cancer, epilepsy, kidney disease and other diseases. The fourth objective was to distinguish statistical significance from the magnitude of association by evaluating contingency coefficients alongside Pearson chi-square statistics. The overarching research question was whether transition from childhood to youth in contemporary Jamaica is accompanied by broad deterioration in health or instead by selective differences occurring against a background of substantial social and functional similarity.

Conceptual Framework

The study is informed by a life-course social-determinants perspective in which health at any particular age represents the interaction of biological development, prior exposures, socioeconomic resources, physical environments, healthcare access and accumulated behaviour. Childhood and youth are especially important because they occupy different developmental stages while remaining sufficiently close in age to permit examination of when social roles and chronic morbidity begin to diverge. Education, household socioeconomic position, insurance and place of residence can influence exposure to environmental hazards, nutrition, preventive care, diagnostic opportunities and capacity to manage disease, but these pathways need not produce immediate functional impairment. Indeed, a chronic condition such as asthma may be present without producing current difficulty with everyday activities, when symptoms are intermittent or effectively managed. Similarly, socioeconomic disadvantage may increase long-term risk without generating detectable cross-sectional morbidity during childhood or early adulthood. The conceptual model rejects a deterministic assumption that poorer social conditions must necessarily correspond to worse contemporaneous self-reported health in every young population.

This framework also distinguishes disease, illness and functioning, because each represents a different dimension of health. Disease-specific questions capture reported diagnostic histories or recognised chronic conditions, whereas the general-illness item reflects a broader recent experience that may include temporary or acute health problems. Functional health captures the consequences of health for activity or capability and can remain favourable even in someone with an identified chronic condition. Healthcare utilisation represents realised contact with the health system rather than morbidity itself, while insurance describes one potential enabling resource for accessing healthcare. These distinctions are consistent with evidence from Jamaican adolescents with chronic illnesses showing that subjective assessments of quality of life can differ between adolescents and parental proxies and may not correspond mechanically to disease status.[9] The empirical analysis consequently evaluates whether childhood and youth differ consistently across these dimensions or whether the apparent direction of age inequality changes according to the health construct being measured.

Methods

Study Design and Data Source

This investigation employed a secondary cross-sectional analytical design using data from the 2023 Jamaica Survey of Living Conditions (JSLC). The JSLC is one of Jamaica's principal national household surveys and has been conducted since 1988 to provide evidence concerning socioeconomic conditions, welfare and the consequences of social and economic programmes [11]. The Planning Institute of Jamaica reports that the complete 2023 JSLC included 4,442 individuals from 1,719 households and that data collection occurred using Computer-Assisted Personal Interviews between July 2023 and March 2024 [12]. The broader 2023 report encompasses demographic characteristics, household consumption and poverty, health, education, housing and social protection and provides analyses at household and individual levels [12]. For the present secondary study, the analytical dataset was made available through the SALISES Documentation Centre and Derek Gordon Databank, Sir Arthur Lewis Institute of Social and Economic Studies (SALISES), The University of the West Indies, Mona Campus, Jamaica, West Indies, which identifies the JSLC among its archived data series. SALISES documentation identifies the Planning Institute of Jamaica as the depositor and also identifies the Statistical Institute of Jamaica and PIOJ among the institutions associated with the local archive and survey infrastructure [11].

The present analysis was restricted to respondents aged 24 years or younger and was not an analysis of the entire 2023 JSLC sample. The source output confirms that the filter AGEYRS ≤24 was applied, that the resulting working analytical file contained 1,545 cases, that no statistical weighting was applied in the displayed analyses and that user-defined missing values were treated as missing. These characteristics are important because they distinguish the analytical sample from the full national JSLC and mean that the statistics presented here should be interpreted as estimates from the filtered analytical cases rather than weighted national prevalence estimates. The children category comprised respondents aged 0–14 years, while the youth category comprised persons aged 15–24 years, yielding 926 children and 619 youth. The youth category corresponds to the upper age range commonly used by PAHO for youth, although the child category includes young adolescents aged 10–14 years who would also be classified as adolescents under the WHO definition. Consequently, the cohort classification employed here follows the categories constructed in the source analytical output rather than claiming that these categories map perfectly onto all international definitions [1,3].

Study Population and Analytical Cohorts

The final analytical population comprised 1,545 Jamaicans aged 0–24 years, with children representing 59.9% and youth 40.1% of respondents. The age categories were treated as mutually exclusive comparative cohorts for the purposes of cross-tabulation and inferential analysis. The sample contained 815 males and 730 females, representing 52.8% and 47.2%, respectively, and respondents were distributed across all 14 Jamaican parishes. St Catherine provided the largest number of respondents, accounting for 19.5% of the sample, followed by St Andrew at 18.3% and Clarendon at 11.4%. Broad residential location was classified into the Greater Kingston Metropolitan Area, other urban centres and rural areas. Because the analytical output was explicitly unweighted, no claim is made that these percentages reproduce the exact national population distribution of Jamaicans aged 0–24 years.

Sociodemographic Variables

Sociodemographic variables included age cohort, sex, parish, area of residence, socioeconomic group, educational level and household-head status. Socioeconomic position was classified as poor for respondents in consumption quintiles 1 and 2, middle for quintile 3 and wealthy for quintiles 4 and 5. Residential area consisted of the Greater Kingston Metropolitan Area, other urban centres and rural communities, permitting examination of broad spatial rather than neighbourhood-level differences. Educational level was grouped as primary and below, secondary and post-secondary, although the interpretation of education required substantial caution because only 484 respondents had valid educational-level information in the displayed analysis. Among those cases, the age composition of educational attainment necessarily reflected opportunities for progression through the

education system, making education partially age-dependent rather than a pure socioeconomic exposure. Household headship was coded dichotomously and likewise interpreted principally as a life-course role because children would not ordinarily be expected to serve as household heads.

Health, Healthcare and Functional Variables

Health-related variables included illness other than injury, injury requiring medical attention, functional health, health-insurance coverage and reported contact with a doctor, nurse or pharmacist. General illness was categorised as chronic illness, other illness, both chronic and other illness, or no illness, thereby capturing a different construct from the disease-specific variables analysed separately. Functional health was categorised as no difficulty, some difficulty, a lot of difficulty or inability to perform the activity at all. Health-insurance status was dichotomised as insured or uninsured, while healthcare contact was coded as yes or no among respondents for whom the question contained valid information. Only 56 respondents had valid healthcare-utilisation data, compared with 1,300 valid observations for functional health and 1,545 for health insurance and general illness. Consequently, healthcare-utilisation estimates were interpreted descriptively and with particular caution because they describe a highly restricted valid-case subset rather than the entire analytical sample.

Chronic-Disease Variables

Disease-specific variables included asthma, diabetes, hypertension, arthritis, chronic obstructive pulmonary disease (COPD), heart disease, sickle cell disease, depression, dementia, other mental disorder, cancer, epilepsy, kidney disease and an additional unspecified disease category. For descriptive presentation, affirmative histories were consolidated by combining respondents reporting a condition within the preceding 12 months with those reporting it more than 12 months previously. This approach produced an intuitive indicator of reported disease history but did not alter the original variables used in the inferential tests. Specifically, the Pearson chi-square analyses were calculated from the original multicategory disease variables, which could include "No", "Don't know" and "No response" categories in addition to the two affirmative categories. The reported disease percentages in Table 4 should not be described as the exact binary variables tested by the corresponding chi-square statistic.

Statistical Analysis

Descriptive statistics were expressed using frequencies and percentages, while bivariate associations between age cohort and categorical variables were evaluated using Pearson's chi-square test. Statistical significance was defined at the conventional two-sided α=.05 threshold, but p-values were not interpreted independently of effect magnitude or test assumptions. The source output reported nominal-by-nominal contingency coefficients, which were retained to indicate the strength of association and to distinguish statistically detectable differences from substantively large differences. Coefficients approaching zero were interpreted as negligible, while increasingly larger coefficients indicated progressively stronger relationships, although no rigid universal threshold was imposed because interpretation depends on table dimensions and context. Pearson statistics involving sparse categories were treated cautiously because low expected frequencies can undermine chi-square approximation, a problem especially important for rare chronic conditions among children and young people. Where the source output provided Fisher's exact testing for sparse 2×2 tables, it was considered supplementary evidence rather than replacing the primary reporting framework.

Missing Data, Sparse Cells and Inferential Caution

Missingness varied appreciably between variables and was handled by valid-case analysis in accordance with the SPSS output. Educational level had only 484 valid observations, meaning that 1,061 cases were unavailable for that analysis, while functional health had 1,300 valid observations and healthcare utilisation only 56. These differences prevent naïve comparison of raw counts across variables and require denominators to be considered alongside percentages. Rare chronic diseases generated small affirmative counts, and many corresponding contingency tables contained expected cell frequencies below five. Asthma, for example, produced a statistically significant Pearson test despite 40% of its cells having expected frequencies below five, while several rarer diseases produced even more serious assumption violations. Accordingly, failure to achieve statistical significance for rare diseases was not treated as evidence of epidemiological equivalence between children and youth.

Ethical and Data-Governance Considerations

This study constitutes a secondary analysis of an established survey dataset and involved no direct recruitment, clinical intervention or contact with respondents by the present investigator. The analysis was based on data made available through the SALISES Documentation Centre/Derek Gordon Databank at The University of the West Indies, Mona Campus, and the institutional provenance of the JSLC is documented by SALISES and PIOJ. No personally identifying information is reported in the attached analytical output, and findings are presented only in aggregate form [11,12]. The present analysis does not claim to have obtained an independent original fieldwork ethics approval because no new primary data collection was undertaken. Any manuscript submitted to a journal should nevertheless reproduce the specific data-use, ethical-clearance or access statement required by SALISES, PIOJ, STATIN and the target journal rather than inventing an ethics reference that is not contained in the available documentation. This distinction is important for methodological transparency and for separating the governance of the original JSLC from the responsibilities associated with the current secondary analysis.

Results

Sociodemographic Characteristics of Children and Youth

Table 1 demonstrates substantial sociodemographic similarity between children and youth in relation to sex and broad residential location. Males represented 53.8% of children and 51.2% of youth, and sex was not significantly associated with age cohort, $\chi^2(1)=0.982$, p-value=0.322, coefficient=0.025. Rural residence was the largest residential category for both cohorts, accounting for 42.3% of children and 39.4% of youth, whereas 29.0% and 29.9%, respectively, resided in the Greater Kingston Metropolitan Area. Area of residence was consequently not significantly associated with age cohort, $\chi^2(2)=1.397$, p-value=0.497, and the coefficient of 0.030 indicated an extremely weak relationship. The socioeconomic distribution was somewhat less uniform because 51.0% of children, compared with 47.0% of youth, were classified as poor, whereas 26.6% of children, compared with 32.3% of youth, were wealthy. Nevertheless, the overall socioeconomic association narrowly failed to reach conventional statistical significance, $\chi^2(2)=5.962$, p-value=0.051, coefficient=0.062, making this a suggestive but not confirmatory age-cohort difference.

The strongest associations in Table 1 concerned educational attainment and household headship, both of which are intrinsically structured by age. Among the 484 respondents with valid education data, 94.4% of the children represented in that valid subset were classified at primary or below, whereas 92.3% of youth were

classified as having post-secondary educational status in the source variable. The resulting association was large and highly significant, $\chi^2(2)=425.884$, $p<0.001$, coefficient=0.684, but it should not be interpreted simply as evidence of inequality because educational progression is itself dependent on chronological age. Household headship was similarly age-related because no child was identified as a household head, compared with 4.8% of youth, yielding $\chi^2(1)=45.768$, $p<0.001$ and coefficient=0.170. These results demonstrate the importance of distinguishing meaningful health-related disparities from expected developmental transitions in social roles. Accordingly, the biggest statistical differences between cohorts occurred in variables whose interpretation is inseparable from the life-course transition from childhood to early adulthood.

Table 1: Sociodemographic Characteristics of Children and Youth Aged 0–24 years, JSLC 2023

Characteristic	Children 0–14 years n (%)	Youth 15–24 years n (%)	Total n (%)	χ^2 (df)	p	Coefficient
Sex				0.982 (1)	.322	.025
Male	498 (53.8)	317 (51.2)	815 (52.8)			
Female	428 (46.2)	302 (48.8)	730 (47.2)			
Area of residence				1.397 (2)	.497	.030
Greater Kingston Metropolitan Area	269 (29.0)	185 (29.9)	454 (29.4)			
Other urban centres	265 (28.6)	190 (30.7)	455 (29.4)			
Rural	392 (42.3)	244 (39.4)	636 (41.2)			
Socioeconomic group				5.962 (2)	.051	.062
Poor, Quintiles 1–2	472 (51.0)	291 (47.0)	763 (49.4)			
Middle, Quintile 3	208 (22.5)	128 (20.7)	336 (21.7)			
Wealthy, Quintiles 4–5	246 (26.6)	200 (32.3)	446 (28.9)			
Educational level†				425.884 (2)	<.001	.684
Primary and below	67 (94.4)	4 (1.0)	71 (14.7)			
Secondary	4 (5.6)	28 (6.8)	32 (6.6)			
Post-secondary	0 (0.0)	381 (92.3)	381 (78.7)			
Head of household				45.768 (1)	<.001	.170
No	926 (100.0)	589 (95.2)	1,515 (98.1)			
Yes	0 (0.0)	30 (4.8)	30 (1.9)			

Note. Column percentages are within age cohort. †Educational-level analysis was based on 484 valid cases and requires considerable caution.

Geographical Distribution

The geographical distribution in Table 2 reinforces the comparability of the cohorts because children and youth were distributed across every Jamaican parish without a statistically significant overall age difference. St Catherine contributed 18.6% of children and 20.8% of youth, making it the largest parish category in both cohorts, followed by St Andrew at 17.7% and 19.2%, respectively. Clarendon accounted for 12.0% of children and 10.5% of youth, while St James contributed 8.3% and 8.7%, respectively. More visible descriptive differences appeared in Manchester, where youth represented 8.1% of their cohort compared with 5.4% among children, and Portland, where children accounted for 4.6% compared with 2.9% among youth. However, these parish-specific fluctuations did not collectively constitute a significant geographical age pattern, $\chi^2(13)=15.055$, p-value=0.304. The coefficient of .098 remained weak, and no expected cell count was below five, supporting the stability of this particular inferential result.

Table 2 is valuable because geographic compositional differences might otherwise confound comparisons in disease or healthcare utilisation. The absence of strong parish separation means that the child and youth cohorts were not simply drawn from radically different parts of Jamaica. At the same time, parish equivalence should not be interpreted as equivalence of neighbourhood environments because substantial socioeconomic and infrastructural heterogeneity exists within Jamaican parishes. International and regional adolescent-health research increasingly stresses the importance of social and environmental context in shaping healthy development, and broad parish classifications cannot capture exposure to housing quality, air pollution, food environments, violence or access to recreation. Consequently, the non-significant parish comparison strengthens the age-cohort comparison while simultaneously identifying a limitation of aggregate geography [1,3]. Future geocoded analysis could investigate whether neighbourhood-level exposures reveal inequalities obscured by parish-level aggregation.

Table 2: Parish Distribution of Children and Youth Aged 0–24 years

Parish	Children n (%)	Youth n (%)	Total n (%)
Kingston	33 (3.6)	21 (3.4)	54 (3.5)
St Andrew	164 (17.7)	119 (19.2)	283 (18.3)
St Thomas	25 (2.7)	14 (2.3)	39 (2.5)
Portland	43 (4.6)	18 (2.9)	61 (3.9)
St Mary	44 (4.8)	20 (3.2)	64 (4.1)
St Ann	38 (4.1)	16 (2.6)	54 (3.5)
Trelawny	35 (3.8)	27 (4.4)	62 (4.0)
St James	77 (8.3)	54 (8.7)	131 (8.5)
Hanover	42 (4.5)	23 (3.7)	65 (4.2)
Westmoreland	42 (4.5)	27 (4.4)	69 (4.5)
St Elizabeth	50 (5.4)	36 (5.8)	86 (5.6)
Manchester	50 (5.4)	50 (8.1)	100 (6.5)
Clarendon	111 (12.0)	65 (10.5)	176 (11.4)
St Catherine	172 (18.6)	129 (20.8)	301 (19.5)
Total	926 (100.0)	619 (100.0)	1,545 (100.0)

General Illness, Functional Health, Insurance and Healthcare Utilisation

The findings in Table 3 present an apparent healthy-youth paradox because an overwhelmingly favourable general health profile coexisted with a statistically detectable age difference in reported illness. Approximately 95.5% of children and 98.4% of youth reported no illness other than injury, whereas other illness affected 3.6% of children compared with 1.3% of youth. Chronic illness was reported by only 0.8% of children and 0.3% of youth, while the combination of chronic and other illness appeared in only two children. The overall association was statistically significant, $\chi^2(3)=10.070$, p-value=0.018, but the coefficient of 0.080 demonstrated that the magnitude of difference was weak. Furthermore, 37.5% of cells had expected frequencies below five, with a minimum expected count of 0.80, requiring additional caution in interpreting the Pearson statistic. Accordingly, statistical significance does not justify characterising children as broadly unhealthy relative to youth because more than 95% of each cohort reported no illness.

Other results in Table 3 provide strong contrary evidence to the proposition that the age cohorts differed generally in health. Precisely 96.0% of valid respondents in both age groups reported no functional difficulty, resulting in $\chi^2(3)=0.033$, p-value=0.998 and an almost null coefficient of .005. Insurance coverage was similarly identical to one decimal place, with only 13.9% of children and 13.9% of youth insured, $\chi^2(1)=0.000$, p-value=0.983. Among the 56 respondents with valid healthcare-utilisation information, 53.3% of children and 54.5% of youth reported visiting a doctor, nurse or pharmacist, producing a p-value of 0.942. Injury requiring medical attention was rare at 0.5% among children and 0.2% among youth and did not differ significantly between cohorts. Thus, Table 3 demonstrates why no single indicator should be permitted to define youth health, since a significant general-illness difference coexisted with virtually identical functioning, insurance and healthcare utilisation.

Table 3: General Health, Functional Health, Healthcare Utilisation and Insurance by Age Cohort

Indicator	Children n (%)	Youth n (%)	Total n (%)	χ^2 (df)	p	Coefficient
Illness other than injury				**10.070 (3)**	**.018**	**.080**
Chronic illness	7 (0.8)	2 (0.3)	9 (0.6)			
Other illness	33 (3.6)	8 (1.3)	41 (2.7)			
Both	2 (0.2)	0 (0.0)	2 (0.1)			
No illness	884 (95.5)	609 (98.4)	1,493 (96.6)			
Injury requiring medical attention				**1.373 (1)**	**.241**	**.030**
Yes	5 (0.5)	1 (0.2)	6 (0.4)			
No	921 (99.5)	618 (99.8)	1,539 (99.6)			
Visited doctor/nurse/ pharmacist†				**0.005 (1)**	**.942**	**.010**
Yes	24 (53.3)	6 (54.5)	30 (53.6)			
No	21 (46.7)	5 (45.5)	26 (46.4)			
Functional health‡				**0.033 (3)**	**.998**	**.005**
No difficulty	654 (96.0)	594 (96.0)	1,248 (96.0)			
Some difficulty	20 (2.9)	18 (2.9)	38 (2.9)			

A lot of difficulty	5 (0.7)	5 (0.8)	10 (0.8)			
Cannot do at all	2 (0.3)	2 (0.3)	4 (0.3)			
Health insurance				**0.000 (1)**	**.983**	**.001**
Uninsured	797 (86.1)	533 (86.1)	1,330 (86.1)			
Insured	129 (13.9)	86 (13.9)	215 (13.9)			

Note. †Healthcare utilisation was available for only 56 respondents. ‡Functional-health analysis contained 1,300 valid observations.

Chronic Disease Burden

Asthma was the dominant chronic condition in Table 4, producing both the highest reported prevalence and the only statistically significant disease-specific association with age cohort. After combining the two affirmative history categories for descriptive purposes, asthma was reported by 56 children, representing 6.0%, and 61 youth, representing 9.9%, giving a combined prevalence of 7.6%. The original multicategory asthma variable produced $\chi^2(4)=10.729$, p-value=0.030 and a coefficient of 0.083, indicating a statistically detectable but weak association. The higher descriptive percentage among youth suggests that asthma remains relevant beyond childhood and may persist or become more readily recognised as young people age. However, the asthma test itself involved sparse cells, with 40% having expected counts below five and a minimum expected count of 0.40. Consequently, asthma emerges as an important epidemiological signal rather than definitive evidence that age itself causes increasing disease between childhood and youth.

All other conditions displayed in Table 4 were uncommon, and none achieved conventional statistical significance. Diabetes and hypertension were each reported by four respondents, arthritis by two, sickle cell disease by six, depression by two, another mental disorder by 12, epilepsy by six and kidney disease by two. Other mental disorders were descriptively more frequent among youth at 1.3% than children at 0.4%, but the corresponding test remained non-significant, p-value=0.146. Kidney disease was reported only among two youth and yielded a p-value of115, while heart disease appeared in three children but no youth and yielded a p-value of 0.156. These very small numbers generate low statistical power and sparse expected frequencies, meaning that absence of significance cannot establish equal disease risk. Table 4 supports a conclusion of low reported prevalence for most chronic conditions while requiring substantial restraint regarding comparisons of rare conditions.

Table 4: Reported Chronic Disease Histories among Jamaican Children and Youth Aged 0–24 years

Condition	Children n (%)†	Youth n (%)†	Total n (%)†	Pearson χ^2 (df)‡	p	Coefficient
Asthma	56 (6.0)	61 (9.9)	117 (7.6)	10.729 (4)	.030	.083
Diabetes	2 (0.2)	2 (0.3)	4 (0.3)	1.663 (3)	.645	.033
Hypertension	2 (0.2)	2 (0.3)	4 (0.3)	0.833 (3)	.842	.023
Arthritis	1 (0.1)	1 (0.2)	2 (0.1)	0.751 (2)	.687	.022
COPD	0 (0.0)	0 (0.0)	0 (0.0)	0.057 (1)	.812	.006
Heart disease	3 (0.3)	0 (0.0)	3 (0.2)	2.009 (1)	.156	.036
Sickle cell disease	2 (0.2)	4 (0.6)	6 (0.4)	1.775 (1)	.183	.034
Depression	1 (0.1)	1 (0.2)	2 (0.1)	2.165 (2)	.339	.037
Dementia	1 (0.1)	0 (0.0)	1 (0.1)	0.669 (1)	.413	.021
Other mental disorder	4 (0.4)	8 (1.3)	12 (0.8)	3.842 (2)	.146	.050
Cancer	1 (0.1)	0 (0.0)	1 (0.1)	0.669 (1)	.413	.021
Other/unspecified disease	1 (0.1)	0 (0.0)	1 (0.1)	0.669 (1)	.413	.021
Epilepsy	5 (0.5)	1 (0.2)	6 (0.4)	2.067 (2)	.356	.037
Kidney disease	0 (0.0)	2 (0.3)	2 (0.1)	4.329 (2)	.115	.053

Note. †Descriptive prevalence combines “Yes, in the last 12 months” and “Yes, more than 12 months previously”. ‡Pearson tests use the original multicategory response variable, including “No”, “Don't know” or “No response” where present, and are not tests of the collapsed affirmative percentages alone.

Synthesis of Age-Cohort Differences

Table 5 demonstrates that statistically significant differences were concentrated in a small subset of the characteristics examined rather than forming a general pattern of health deterioration between childhood and youth. Educational level produced by far the strongest relationship, coefficient=0.684, followed by household headship at 0.170, but both are heavily structured by developmental age. General illness produced a significant but weak association at coefficient=0.080, while asthma likewise produced a weak association at .083. Conversely, sex, parish, residential area, injury, healthcare utilisation, functional health and insurance produced no statistically significant cohort differences. Socioeconomic group fell immediately outside the conventional threshold at p-value =0.051, illustrating why dichotomising evidence into “significant” and “non-significant” categories can obscure potentially relevant gradients. The overall pattern in Table 5 is better characterised as selective age differentiation within broad structural and functional similarity than as a simple health advantage of one cohort over the other.

The effect-size pattern in Table 5 is equally important because statistically significant findings were not necessarily substantively large. The asthma and general-illness coefficients were both below 0.10, indicating that age cohort explained comparatively little of the observed categorical variation even where $p<0.05$. In contrast, education demonstrated a very large statistical relationship because children and youth necessarily occupy different positions in educational progression. Health insurance produced a coefficient of only 0.001 and functional health 0.005, revealing almost complete similarity between the two groups for those indicators. This combination illustrates a core methodological lesson of the study: age-cohort comparison should incorporate substantive effect magnitude, denominator structure and developmental plausibility rather than treating the p-value as a sufficient interpretation. The findings consequently address the study's original gap by demonstrating precisely which dimensions of contemporary Jamaican child-youth health differ and which remain remarkably similar.

Table 5: Summary of Principal Age-Cohort Associations

Variable	χ^2 (df)	p	Coefficient	Interpretation
Sex	0.982 (1)	.322	.025	Non-significant; negligible
Parish	15.055 (13)	.304	.098	Non-significant; weak
Area of residence	1.397 (2)	.497	.030	Non-significant; negligible
Socioeconomic group	5.962 (2)	.051	.062	Borderline; weak
Educational level	425.884 (2)	<.001	.684	Significant; strong
Head of household	45.768 (1)	<.001	.170	Significant; modest
General illness	10.070 (3)	.018	.080	Significant; weak
Injury	1.373 (1)	.241	.030	Non-significant; negligible
Healthcare utilisation	0.005 (1)	.942	.010	Non-significant; negligible
Functional health	0.033 (3)	.998	.005	Non-significant; negligible
Health insurance	0.000 (1)	.983	.001	Non-significant; essentially none
Asthma	10.729 (4)	.030	.083	Significant; weak

Discussion

Principal Findings

The central finding of this study is that Jamaican children and youth displayed considerably more health similarity than health divergence, despite occupying distinct developmental stages. Children and youth were statistically indistinguishable by sex composition, parish, broad residential area, functional health, insurance status, healthcare utilisation and injury, and virtually all chronic conditions except asthma. General illness differed significantly, but the effect size was small, and more than 95% of each cohort reported no illness. Asthma constituted the clearest disease-specific exception because reported history increased from 6.0% among children to 9.9% among youth, and the original multicategory variable was statistically associated with age cohort. Educational attainment and household headship showed significant differences, but these primarily reflect normal life-course progression rather than evidence that one cohort occupies universally better social circumstances. Collectively, these findings challenge a binary interpretation in which youth must be categorised as either healthier or less healthy than children and instead reveal a domain-specific transition.

Comparison with Earlier Jamaican Evidence

The present finding that most children and youth reported favourable general and functional health strongly supports earlier Jamaican evidence depicting adolescence as a comparatively healthy stage. Bourne reported that approximately 93 of every 100 Jamaican adolescents aged 10–19 years had experienced no illness or injury during the reference period in the 2007 JSLC, a result broadly consonant with the 96.6% reporting no illness in the present combined 0–24-year sample [6]. The similarity is notable despite different survey years and cohort definitions and suggests persistence of generally favourable self-reported health among younger Jamaicans. However, the earlier study also reported growth in some chronic conditions between 2002 and 2007 and warned against allowing high average health to obscure smaller populations living with chronic disease. That caution is reinforced by the current findings because asthma affected 117 respondents even though 96% of valid respondents reported no functional difficulty [6]. Thus, the 2023 evidence supports the broad "healthy youth" observation while contradicting any stronger inference that favourable general health means absence of clinically or epidemiologically relevant morbidity.

Evidence concerning Jamaican children provides a similar mixture of support and contradiction. Earlier JSLC-based research reported major changes in childhood disease patterns between 2002 and 2007 and argued that chronic conditions were becoming an increasingly important component of child health [7]. That study reported considerably greater asthma-related morbidity than the present analysis and even identified diabetes among children, whereas diabetes was reported by only two children in the current dataset [7]. These discrepancies should not automatically be interpreted as evidence that disease has dramatically disappeared because the studies differed in period, variable construction, survey context and denominators. The current 6.0% descriptive asthma history among children is also substantially lower than the 16.7% doctor-diagnosed asthma and 19.6% current wheeze found by Kahwa and colleagues in their dedicated national asthma survey of Jamaican children aged 2–17 years. Dedicated respiratory surveys can capture symptoms and diagnostic histories more comprehensively than a broad living-conditions instrument, making lower JSLC estimates epidemiologically plausible [8]. The contrast illustrates the importance of measurement method and strengthens the argument that general-purpose surveys and disease-specific epidemiological surveillance should be regarded as complementary rather than interchangeable.

Asthma as the Dominant Chronic Condition

Asthma's prominence in this study is consistent with decades of

Jamaican and Caribbean research identifying respiratory disease as a substantial paediatric and adolescent health concern. A Jamaican study of exercise-induced asthma among schoolchildren in Kingston, St Andrew and St Catherine reported a prevalence of 20.8%, although the clinical construct and testing procedure were very different from those employed in the JSLC. Kahwa and colleagues subsequently demonstrated high prevalence of wheeze and doctor-diagnosed asthma nationally and identified associations with parental asthma, allergic disease, mould exposure and household pets [13]. Research from Trinidad and Tobago has similarly documented asthma as an important adolescent disease, while broader Caribbean reviews have described relatively high prevalence of asthma and allergic disease across English-speaking Caribbean populations [8]. These studies support the present finding that asthma stands apart from diabetes, hypertension, arthritis and most other chronic conditions in younger populations. At the same time, their generally higher prevalence estimates caution strongly against interpreting the 7.6% JSLC estimate as the definitive biological prevalence of asthma among Jamaicans aged 0–24 years [14,15].

The significantly higher descriptive asthma burden among youth compared with children warrants particular consideration, although it should not be interpreted causally. One explanation could be cumulative diagnostic opportunity because older respondents have had more years during which asthma might have been identified, thereby increasing the probability of ever reporting the condition. Another possibility is persistence of childhood respiratory disease into adolescence and early adulthood rather than newly emerging disease. Differences in self-report and proxy-report processes may also matter because responses for younger children are more likely to depend on household adults, whereas older youth may have greater knowledge of their own diagnostic histories. Jamaican research on adolescent chronic illness has demonstrated discrepancies between adolescent and parent-proxy assessments of health-related quality of life, illustrating that reporting source can influence measurement. The present cross-sectional dataset cannot distinguish among these mechanisms, making longitudinal or age-specific clinical research necessary [9].

Caribbean Comparison

The broader Caribbean evidence supports the conclusion that apparently healthy younger populations can carry important chronic-disease burdens that become visible only when disease-specific measures are employed. Caribbean asthma research has repeatedly identified respiratory morbidity among school-aged children and adolescents, and historical evidence suggests that allergic sensitisation and environmental exposures are important components of this burden [14,15]. PAHO now explicitly recognises asthma, type 1 diabetes and certain cancers among the NCDs affecting people younger than 24 years, despite traditional NCD programmes being oriented largely towards adults This regional policy shift is compatible with the current study's argument that prevention and surveillance must precede the adult manifestation of chronic disease .[4,5]. However, the very low prevalence of diabetes, hypertension and many other conditions in the current Jamaican sample contrasts with the much greater cardiometabolic burden observed among adult Caribbean populations. Rather than representing contradictory epidemiology, this contrast is consistent with life-course accumulation, whereby many NCDs emerge clinically only after prolonged exposure to behavioural, social and metabolic risk.

The Caribbean comparison also underscores why disease prevalence alone provides an incomplete basis for policy. PAHO emphasises that many behaviours associated with later NCDs are acquired during adolescence and youth even when clinically apparent disease remains uncommon [3]. Consequently, a youth population with very low hypertension or diabetes prevalence cannot necessarily be regarded as protected from future cardiometabolic burden if obesity, poor diet, sedentary behaviour, tobacco exposure or social disadvantage are developing simultaneously. The present JSLC output does not provide sufficient information in the supplied analysis to test all of those behavioural pathways, and this absence represents an important boundary of inference. The study's socioeconomic results are nevertheless relevant because almost half of respondents were classified in the poor socioeconomic group, and poverty can influence opportunities for healthy food, recreation, healthcare and educational advancement. The lack of a significant child-youth socioeconomic difference should not be confused with absence of socioeconomic vulnerability in the overall young population. Regional prevention should consequently address both existing disease and the conditions under which later disease develops.

Global Comparison

Globally, the findings support WHO's characterisation of adolescence as a period that is generally healthy in conventional mortality terms but marked by preventable illness, injury and the establishment of later health risks. WHO reports that young adolescents aged 10–14 years have among the lowest mortality risks of any age group, which is compatible with the overwhelmingly favourable functional-health profile observed in the JSLC [1,2]. Yet WHO simultaneously identifies injuries, violence, self-harm, maternal conditions and mental-health problems as important causes of morbidity and mortality among adolescents and young adults [2]. The current Jamaican sample reported extremely low levels of injury requiring medical attention and low reported depression, which appears more favourable than the prominence of these conditions in global adolescent-health discourse [2]. However, the narrow JSLC variables cannot be assumed to measure the full spectrum of mental distress, self-harm, violence exposure or minor injury considered by specialised global health surveillance. Thus, apparent contradiction between Jamaican survey estimates and global priorities may result partly from differences in what is measured rather than true absence of these health problems.

WHO's recent Global Action for Measurement of Adolescent Health is relevant to the methodological implications of this study. The initiative notes that comprehensive adolescent-health measurement has historically been inadequate and proposes a standardised framework of indicators intended to support national, regional and global monitoring. The present analysis demonstrates why such multidimensional measurement is needed because different indicators produced markedly different impressions of the same population [10]. General illness indicated a statistically significant age difference, functional health showed virtually perfect similarity, asthma revealed a specific chronic-disease difference, and insurance identified low coverage but no age disparity. None of these measures alone adequately represent the health of Jamaicans aged 0–24 years. The study supports global movement away from single-indicator conceptions of adolescent health and towards integrated surveillance incorporating morbidity, functioning, health services, social conditions and risk exposures.

The Healthy-Youth Measurement Paradox

The findings permit the study to conceptualise a healthy-youth measurement paradox rather than simply reproducing the common assertion that young people are healthy. The paradox refers to the coexistence of extremely favourable general and functional indicators with identifiable disease-specific morbidity and substantial socioeconomic vulnerability. In the present sample, 96.6% reported no general illness and 96.0% of valid respondents reported no functional difficulty, yet 7.6% reported an asthma history and approximately half of respondents occupied the poor socioeconomic grouping. This combination is not internally contradictory because the measures capture different time frames, constructs and consequences of health. An individual can have a diagnosed chronic disease that is asymptomatic at the time of survey, controlled through treatment, episodic in expression or insufficiently severe to impair normal functioning. Consequently, the health of young people should be represented as multidimensional rather than reduced to a binary classification of sick versus healthy.

This conceptualisation also helps explain why chronic-disease surveillance beginning in middle age can underestimate the developmental origins of adult morbidity. Children and youth may accumulate exposures well before diabetes, hypertension or cardiovascular disease become clinically observable, meaning that low current prevalence can coexist with substantial future risk. PAHO's decision to extend NCD prevention explicitly to children, adolescents and young adults embodies precisely this life-course logic. The present results add Jamaican empirical evidence by showing that the period before age 25 is dominated by favourable functioning but not by complete absence of chronic disease or socioeconomic disadvantage [4,5]. Asthma provides the clearest current manifestation, while the socioeconomic distribution raises questions about longer-term pathways that cannot be answered by the cross-sectional data. The proposed paradox should be treated as an interpretive framework arising from this study rather than as an established clinical syndrome or previously validated theory.

Policy Implications

The most immediate policy implication is that Jamaica should resist treating children and young people as a homogeneous low-need population merely because reported illness and functional limitation are uncommon. Asthma prevention, diagnosis, treatment adherence and environmental management warrant particular attention because respiratory disease was substantially more prevalent than every other chronic condition examined. Earlier Jamaican asthma research identified mould, allergies, parental asthma and household animal exposure among relevant risk factors, indicating that management extends beyond clinical prescribing to housing and environmental conditions. School and community health programmes provide logical platforms for identifying uncontrolled symptoms because children and youth spend substantial portions of their daily lives within educational environments [8]. Jamaica's participation in adolescent health-data initiatives, including school-based health surveillance, demonstrates that infrastructure for more youth-centred monitoring is feasible. Integrating respiratory-health assessment with broader adolescent-health surveillance could improve continuity between paediatric, school-health and young-adult services [16].

A second policy implication concerns the very low health-insurance coverage recorded in both groups, with only 13.9% classified as insured. Equal insurance coverage between children and youth should not be interpreted as policy success because statistical equality can coexist with uniformly low coverage. Whether this represents a meaningful barrier depends on Jamaica's mix of publicly financed and privately financed healthcare and cannot be inferred from insurance status alone. Nevertheless, insurance and other measures of financial protection are relevant to specialist access, continuity of treatment, diagnostic pathways and the management of chronic illness. Policy evaluation should distinguish equity between age groups from adequacy of healthcare resources available to both groups. Future analyses should test whether insurance interacts with socioeconomic group, rurality and chronic illness rather than examining only its bivariate association with age.

Implications for Future Research

Future Jamaican research should move beyond bivariate comparisons by estimating multivariable models in which age cohort, sex, socioeconomic position, geography and insurance are evaluated simultaneously. Such analyses could determine whether the descriptive child-youth difference in asthma persists after adjustment for social and residential characteristics and whether the near-significant socioeconomic association at p-value=0.051 becomes relevant within disease-specific models. Age should also be examined as a continuous variable or in narrower developmental categories because aggregating everyone aged 15–24 years may conceal differences between adolescents and young adults. Children aged 0–14 years are themselves heterogeneous, ranging from infancy to early adolescence, and the health meaning of a chronic diagnosis differs considerably across that span. Analyses separating early childhood, middle childhood, adolescence and young adulthood would provide stronger life-course resolution. Where sample size permits, interaction terms could also assess whether age-related patterns differ by sex, socioeconomic group or urban-rural residence.

Longitudinal and clinically validated research is also necessary to separate diagnosed morbidity from undiagnosed disease and to determine whether chronic conditions reported during childhood persist into adulthood. The large discrepancy between the current JSLC asthma estimate and earlier dedicated Jamaican asthma surveys illustrates the importance of instrument-specific ascertainment. Future studies should combine symptom questions, physician diagnoses, medication history, biomarkers or objective clinical measurements wherever feasible [8]. Mental health warrants particular attention because the very small number reporting depression in this broad household survey should not be interpreted as evidence that clinically meaningful psychological distress is similarly rare. WHO notes that many adult mental-health disorders begin before adulthood and may remain undetected or untreated, highlighting the limitations of relying exclusively on diagnosed-condition questions. Greater alignment of Jamaican monitoring with internationally recommended adolescent-health indicators would improve both national policy relevance and international comparability [2].

Strengths and Limitations

A major strength of this study is the use of a contemporary national living-conditions dataset that permits social and health indicators to be examined within a common analytical framework. The 1,545-person analytical sample includes children and youth from all 14 Jamaican parishes and from metropolitan, other urban and rural settings, providing substantial geographical diversity. The analysis also extends beyond a single disease by incorporating general illness, injury, functional health, insurance, service utilisation and numerous chronic conditions. Reporting contingency coefficients alongside chi-square statistics reduces the risk of equating statistical significance with substantive importance and makes clear that both significant health associations were

weak. Another methodological strength is the explicit distinction between collapsed affirmative disease percentages and the original multicategory variables used in Pearson testing. This transparency is important in secondary analysis because misleading simplification of SPSS outputs can otherwise produce incorrect interpretations of what was statistically tested.

Several limitations constrain inference and should be explicit in any Scopus submission. First, the cross-sectional design prevents causal conclusions about whether transition from childhood to youth produces changes in morbidity, and current age cannot reconstruct individual disease trajectories. Second, the displayed analysis was unweighted, so the percentages should not automatically be characterised as weighted national prevalence estimates despite the national origin of the JSLC. Third, substantial missingness affected education, functional health and especially healthcare utilisation, making the effective denominator variable-specific and severely limiting interpretation of the 56-person utilisation subset. Fourth, self-reported or household-reported disease is vulnerable to diagnostic access, recall error and proxy-reporting differences among younger children. Fifth, rare diseases generated extensive sparse-cell problems, so non-significant chi-square tests frequently had limited statistical power and should not be interpreted as equivalence. Sixth, the broad 0–14 and 15–24 categories combine developmentally heterogeneous ages, while bivariate analyses leave possible confounding by sex, socioeconomic circumstances and other factors unresolved.

Conclusion

This study fills an important gap in contemporary Jamaican health research by directly comparing children aged 0–14 years and youth aged 15–24 years across socioeconomic, geographic, healthcare, functional and chronic-disease dimensions using the 2023 Jamaica Survey of Living Conditions. The principal finding is not broad health deterioration between childhood and youth but substantial similarity across most of the indicators examined. Children and youth were statistically similar by sex, parish, residential area, health insurance, healthcare utilisation, injury and functional health, while most chronic diseases were rare and showed no statistically detectable age-cohort association. General illness differed significantly but weakly, and asthma emerged as the only disease-specific variable showing a significant age relationship, with reported histories increasing from 6.0% among children to 9.9% among youth. Education and household headship differed more strongly, but these patterns largely represent expected developmental transitions rather than direct evidence of health inequality. These findings address the identified research gap by demonstrating that the movement from childhood into youth in Jamaica is characterised by selective rather than universal differentiation.

The wider significance of the study lies in challenging an overly simple healthy-youth assumption and replacing it with a multidimensional understanding of early-life health. Very high levels of reported functional capacity and absence of recent illness can coexist with chronic disease, socioeconomic vulnerability and health risks whose consequences may become evident only later in adulthood. Jamaican findings both support international evidence that younger populations generally experience favourable functioning and contradict any interpretation that such favourable averages eliminate the need for NCD surveillance. [1-5] Asthma requires immediate attention as the dominant reported chronic condition, while the rarity of other NCDs creates an opportunity for prevention before adult cardiometabolic disease becomes established. More refined age stratification, objective disease measurement, multivariable modelling and longitudinal follow-up are needed to determine how childhood social conditions translate into later Jamaican morbidity. A life-course health strategy that connects paediatric, adolescent and young-adult surveillance would consequently provide a stronger evidence base for protecting both the present health and future adult health of Jamaica's younger population.

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