Never better — or getting worse?

Australia21

The health and wellbeing of young Australians

Richard Eckersley 2008

About the author

Richard Eckersley is a founding director of Australia21 Ltd, a visiting fellow at the National Centre for Epidemiology and Population Health, ANU, and author of 'Well & Good' (Text, 2005).
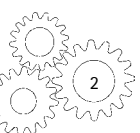
About Australia21

Australia 21 is a non for profit company whose core business is multidisciplinary research and development on issues of strategic importance to Australia in the 21st century.

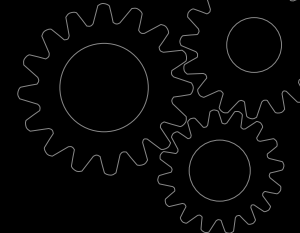The company's charter commits it to:

- Promoting interdisciplinary and inter-institutional discussion to germinate new research on topics of significance to Australia's future;
- Building networks between researchers, community and business leaders and policy makers
- Improving community understanding of the factors that will contribute to a better future for our children.
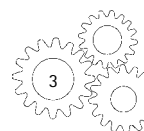
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SUMMARY

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The health and wellbeing of young people, an important indicator of Australia's future population health, is declining. This development is of immense social significance. It has implications not only for how we deal with specific current concerns such as child abuse and neglect, obesity, media sexualisation of children, and binge drinking, but for national priorities and public policy more broadly.

With the possible exception of increasing wealth, improving health is the most widely used measure of human progress. Wealth has only ever been a means to the end of a better life; health is a core component of that end. If health is not improving, it is hard to sustain the belief that, as a society we are making progress.

The orthodox view of young people's health and wellbeing is of a continuing improvement in line with historic trends. It rests mainly on two lines of evidence: declining death rates and high levels of self-reported health and happiness. Both measures are flawed. Mortality might once have been a good summary measure of overall health, but this is no longer true. In Australia, death now strikes very few young people: about 40 in every 100,000 each year. And trends in the major causes of death (especially the biggest killer, road accidents) do not necessarily reflect underlying changes in physical and mental health.

High levels of self-reported health and happiness cannot be taken at face value. Self-reported health is not an accurate measure of health status: many people with serious health problems will still say their health is excellent or very good. Likewise, happiness measures do not reflect all aspects of wellbeing.

The orthodox view underestimates the growing importance to overall health and wellbeing of non-fatal, chronic illness especially, in the case of young people, mental disorders. Research suggests 20-30% of young people (that is, 20-30,000 per 100,000) are suffering significant psychological distress at any one time, with less severe stress-related symptoms such as frequent headaches, stomach-aches and insomnia affecting as many as 50%. Mental disorders are the largest contributor to the burden of disease in young Australians, measured as both death and disability, accounting for almost half the burden; this is far more than the second biggest contributor, injuries. The weight of evidence suggests that the prevalence of mental disorders has increased over successive generations of youth, as have some physical illnesses, notably diabetes, linked to rising levels of obesity. Violent crime is continuing to increase.
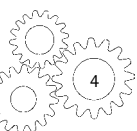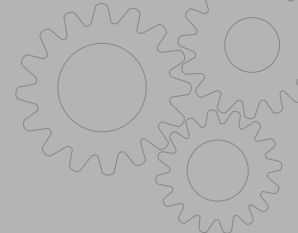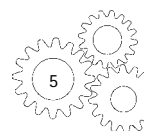
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The Australian Commission for the Future drew attention to concerns about young people's health and wellbeing in a seminal report published twenty years ago. Comparing the situation then and now, there have been important successes, especially in turning around rising youth suicide and drug-related deaths. However, it appears that two decades of concerted policy intervention and substantial increases in health spending, and a long economic boom have not improved more fundamental features of young people's resilience and wellbeing.

The more tangible factors contributing to the decline in mental health include family conflict and breakdown, education and work pressures, media and technological impacts, dietary changes and environmental pollution. However, the causes also include cultural intangibles, such as excessive materialism and individualism. While young people are materially better off, and have more opportunities for education, leisure and travel than ever before, social and cultural changes have made it harder for them to develop a strong sense of identity, purpose, belonging and security: in short, to feel life is deeply meaningful and worthwhile.

Closing the gap between the scale of policy responses and the magnitude of the challenge to optimise young people's wellbeing will require more fundamental actions. These actions need to go well beyond specific health interventions. Examples include:

- Conceptualising health as more than a matter of healthcare services, including shifting emphasis from the dominant, disease-focused, biomedical model of health to a preventative, social model. This should include increasing the proportion of the health budget allocated to prevention and public health from less than 2% in 2005 to, say, 5% by 2020. The tradition bias in medicine (including public health) against mental health also needs to be addressed.
- Reorienting education to give it a clearer focus on increasing young people's understanding of themselves and the world to promote human growth, development and wellbeing in the broadest sense. This should include making more use of innovative approaches like role-based inquiry, narrative, and experience- and issue-based learning.
- Setting stricter standards for the corporate sector, especially the media and consumer industries, to uphold the UN Convention on the Rights of the Child, which include the right 'to protection from harmful influences, abuse and exploitation'. Concerns here go beyond junk food ads, 'alcopops' and the media sexualisation of children, to include the wholesale 'commodification' of childhood: the commercial manipulation and indoctrination of young people into an unhealthy, unsustainable, hyper-consumer lifestyle.
- At the most fundamental, cultural level, changing the stories or narratives by which Australians define themselves, their lives and their goals. These changes should include making better health (in the broadest sense), not greater wealth the nation's defining goal. This, in turn, would shift the emphasis of economic activity away from private consumption for short-term, personal gratification towards social investment in building a more equitable, healthy and sustainable way of life.

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In September1988 the Australian Commission for the Future published my report, *Casualties of change: The predicament of youth in Australia*, a wide-ranging analysis of the social and psychological problems faced by young Australians, expressed most clearly in rising rates of suicide, drug abuse and crime (Eckersley 1988). It was, so far as I know, the first time anyone had looked at broad, generational shifts in young people's wellbeing and the report attracted a great deal of professional, political and public attention.

I concluded that as a society, we appeared not to recognise the seriousness of the problems being experienced by young people. 'To the extent that we do recognise the problems, we are applying remedies that will not work because they do not address the cause of the problems, causes that are deeply rooted in the fundamental changes occurring in Australian society.'

Today, 20 years later, and despite sustained economic growth, a range of policy intervention and substantially higher spending on health, I believe this is still true. To give one example: then, I said research suggested young people were not only drinking at an earlier age than previously, but also that 'binge drinking' – with the frequent aim being 'to get drunk and get drunk quickly' – was becoming more common. We are still grappling with the same problem.

This report is, in part, an examination of what has happened to the health of young Australians, with a focus on those in their teens and twenties, since I wrote the first report. But it also ranges far more widely over the patterns and trends in health and wellbeing, taking advantage of the much greater quantity and quality of evidence now available. There have been gains in wellbeing over the past two decades, notably the reversals in the trends in youth suicide and drug-related deaths, which, with road accidents are the leading causes of deaths in young people. However, the overall picture, when we look at new data on the total 'burden of disease' is disappointing and disturbing. I believe the picture poses a profound challenge to the conventional, or official, view that things are getting better, and so to the way in which we, as a society are addressing social problems.

As well as representing a 'retrospective' on young people's health and wellbeing since *Casualties of change* was published, this report further develops some issues raised in two earlier reports on young people by Australia 21, in collaboration with the Australian Youth Research Centre at the University of Melbourne (Eckersley et al 2006, Eckersley et al 2007).

Challenging the orthodoxy

The orthodox view of young people's health and wellbeing in Australia is of continuing improvement in line with historical trends. The Australian Institute of Health and Welfare, for example, states in its 2008 report on Australia's health (AIHW 2008a:280), that, 'Most young Australians are in good health, as indicated by self-reported health status, and relatively low and declining morbidity and mortality'. (The Institute does acknowledge 'a number of health concerns', and I also want to acknowledge that I draw heavily on its data in my analysis; its reports are extremely useful). This view is echoed in other official material. For example, a Victorian government report on how young Victorians are faring (DEECD-DPCD, 2008) says: 'Most young Australians enjoy very good health and there have been enormous improvements in young people's health over the past 20 years.'

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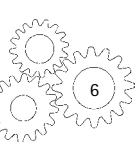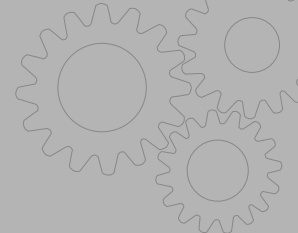
A corollary is that, with overall health improving, attention needs to be focused on social inequalities in health, which remain marked and have even increased in some instances. As the Institute's 2007 report on the health and wellbeing of young Australians (AIHW 2007:x) states: 'While most young people in Australia are doing well, there are areas where further gains in health and wellbeing could be made, particularly among young indigenous Australians, young people in regional and remote areas and young people suffering socioeconomic disadvantage.'

I want to argue against the orthodox position, while acknowledging the complexity of the picture of young people's health and wellbeing. In summary, I believe the conventional view overestimates the importance of declining death rates and underestimates that of adverse trends in a range of non-fatal, chronic health problems, especially mental disorders. The problems have their sources in quite fundamental features of modern societies, which go well beyond socio-economic inequalities and disadvantage.

> *The conventional view underestimates the importance of non-fatal, chronic health problems, especially mental disorders.*

Contexts and definitions

This report presents an overview of the patterns and trends in young Australians' health and wellbeing; shows that some of the apparent contradictions can be explained, although 'irreconcilable differences' remain; discusses the social determinants of these patterns and trends; and, finally, considers what this means for how we seek to improve young people's health and wellbeing. The picture of the health of young Australians is also broadly true of youth in other developed nations (and, in some respects, increasingly the developing world), so I draw on evidence from other countries besides Australia.

I define health very broadly to include all aspects of wellbeing, not just clinically significant disease, disorder and disability. I use the terms 'health' and 'wellbeing' somewhat interchangeably and sometimes together to emphasise their many dimensions: illness and wellness, physical and psychological, objective and subjective. Health is closely related, in this view to quality of life, defined as the degree to which people enjoy (or societies provide) the living conditions (social, economic, cultural and environmental) that are conducive to total health and wellbeing (physical, mental, social and spiritual).

Paradox, contradiction and ambiguity mark the debate and discussion about young people today. They can be portrayed as having the time of their lives, or struggling with life in their times. Concerns about their health and wellbeing are dismissed as 'moral panics' that have recurred throughout history. Young people should not be seen as 'a problem that needs fixing'. Nor are they 'cultural sponges', passive 'victims' of their environment. They are not a homogeneous group, but are highly individual. We shouldn't judge their lives by obsolete standards based on past linear transitions from education to work to marriage to parenthood. All these things are, or can be, true. Their relevance depends on the scale of the analysis. None undermines the value of the large-scale, 'big picture', analysis I present here of generational changes in health and wellbeing and their social determinants. It is at this level that we can best judge the 'net effects' of the profound social changes occurring in the modern world.

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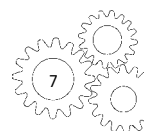
A central feature of my work is to look for coherence in the overall picture of health and wellbeing rather than precision in the detail. Drawing on a large body of research in a range of disciplines allows us at least partially, to side-step the many 'ifs and buts' that apply to specific research findings. It also enables us to move beyond limited disciplinary boundaries and perspectives. Different disciplines develop different models, or conceptual frameworks for studying the world. These generate different research questions, produce different results and lead to different interpretations of reality. However, when the various streams of evidence, both direct and indirect, are taken together they produce a coherent and compelling (if still provisional) picture of declining resilience and wellbeing among young people.

The health of young people is not only important in its own right…it is crucial to assessing the overall state and future of Australian society.

The complexity of interactions between social causes and health effects makes it extremely difficult, perhaps impossible, to prove the influence on wellbeing of specific factors, especially complex, pervasive factors such as the media. Consider how long it took to establish that cigarette smoking causes lung cancer and heart disease, a straightforward matter of an individual behaviour involving a toxic substance. For all its growing technical virtuosity, science still deals crudely with the complexities and intricacies of life. We cannot wait for conclusive proof before acting. Finally, let me stress the context of my argument is not a neutral or ambivalent one about young people's health; it is the context of the unequivocal, official view that it is getting much better.

The health of young people is not only important in its own right, or for their sake; it is crucial in assessing the overall state and future of Australian society. The young reflect best the tenor and tempo of the times by virtue of growing up in them. Because of their stages of biological and social development, they are most vulnerable to social risks and failings. Many of the attitudes and behaviours — even the illnesses — that largely determine adult health have their origins in childhood, adolescence and early adulthood. The health of young people shapes the future health of the whole population and, in a broader social sense, the health of society.

With the possible exception of increasing wealth, improving health is the most widely used measure of human progress. Wealth has only ever been a means to the end of a better life; health is a core component of that end. If health is not improving, it is hard to sustain the belief that as a society, we are making progress. As a recent report by UNICEF, the United Nations Children's Fund, (UNICEF 2007:39) on the wellbeing of children and adolescents in rich countries notes, all families today are aware that 'childhood is being shaped by forces whose mainspring is not necessarily the best interests of the child'. At the same time, people are 'becoming even more aware that many of the corrosive social problems affecting the quality of life have their genesis in the changing ecology of childhood'.
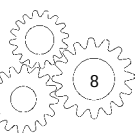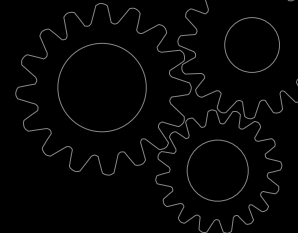
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Historically, the health of young Australians reflects the overall trends in population health in the developed world (McMichael 2001:185-249). The toll of infectious diseases has fallen as a result of improved hygiene, nutrition and living and working conditions, and medical advances such as antibiotics and vaccines (it is only about fifty years ago that polio deaths were reported in the press like the road toll). Chronic, non-communicable diseases have become more common. This is not to say that infectious diseases have become insignificant: for example, sexually transmitted diseases are on the rise among young people (AIHW 2007:58-59).

The dramatic rise in life expectancy, which globally has more than doubled in the last one hundred years, is one of humanity's greatest achievements (Eckersley 2005). Mortality rates continue to decline and life expectancy to rise, including among children and youth. Death rates for young people aged 12-24 have halved, and life expectancy at birth has increased by about five years in the past 20 years (AIHW 2007:x). Mortality and life expectancy (the number of years people can, on average expect to live at prevailing mortality rates) are the standard measure of health. As the Australian Institute of Health and Welfare says in another of its reports (AIHW 2006:xiii): 'Children under 15 years are generally much healthier than in previous generations, with a fall in their death rates of over 90% over the past 100 years and a halving over the past two decades'.

Today the major causes of death among young Australians are, in order: road accidents, suicide, accidental poisoning (including drug overdoses) and cancer (AIHW 2007:64-66). Building on the long-term decline in infectious-disease mortality, we have seen a fall in deaths from road accidents and other injuries over the past thirty years. In about the past decade we have also seen a decline in deaths from suicide and drugs, which had previously increased rapidly (at least among young males). However, the decline in the road toll is a result of better roads, safer cars, seat belts and random breath tests, and improved intensive medical care and says little about general living conditions. The reversals in suicide and drug-related deaths, while welcome do not necessarily reflect an improvement in underlying health (as discussed later).

Scale anomalies

Mortality might well have been a valid indicator of overall health historically; when infectious diseases dominated, people who became ill mostly either recovered or died. But this is now questionable. Mortality and life expectancy do not reflect adequately the growing importance to health and wellbeing of non-fatal, chronic health problems. Nor is this shift in importance simply a result of the success in reducing mortality, or more (or better) diagnoses of chronic conditions. Modern medicine has contributed to the 'measurement error' in keeping more people alive, but without, in many cases, preventing or curing disease and disability. However, there is increasing evidence that chronic problems are becoming more common for other reasons to do with changing lifestyles and social conditions, as we shall see. Just as we often wrongly equate quality of life with standard of living, we confuse how well people live with how long they live.

There are growing 'scale anomalies' in generalising about health trends from mortality rates. On the one hand, death now strikes only about 40 out of every 100,000 young Australians (0.04%) each year, so declining mortality affects few people (AIHW 2007:64); on the other, 20-30% of young people (20-30,000 per 100,000) are experiencing significant psychological distress at any one time, with less severe stress-related problems (including psychosomatic symptoms such as frequent headaches, stomach pains and sleeplessness) affecting as many as 50% (Eckersley 2005:147-169). These figures also challenge other evidence often cited to support the orthodox view that most young people are doing well, namely that 80-90% say they are healthy, happy and satisfied with their lives.

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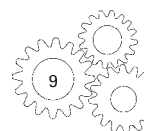
Mental health

Among Australians aged 15-24 mental disorders now account for 49% of the burden of disease, measured as both death and disability (and 61% of the non-fatal burden) (AIHW 2007:19-21). This is by far the biggest contribution and well ahead of the next most important contributor, injuries, at 18% (see Figure 1). Young people appear to be suffering mental health problems at an earlier age than before, experiencing them at higher rates than older age groups, and retaining their increased risk beyond youth into older age.

(a) Includes acute respiratory diseases, maternal conditions, nutritional deficiencies, endocrine and metabolic disorders, other neoplasms, skin diseases and ill-defined conditions.
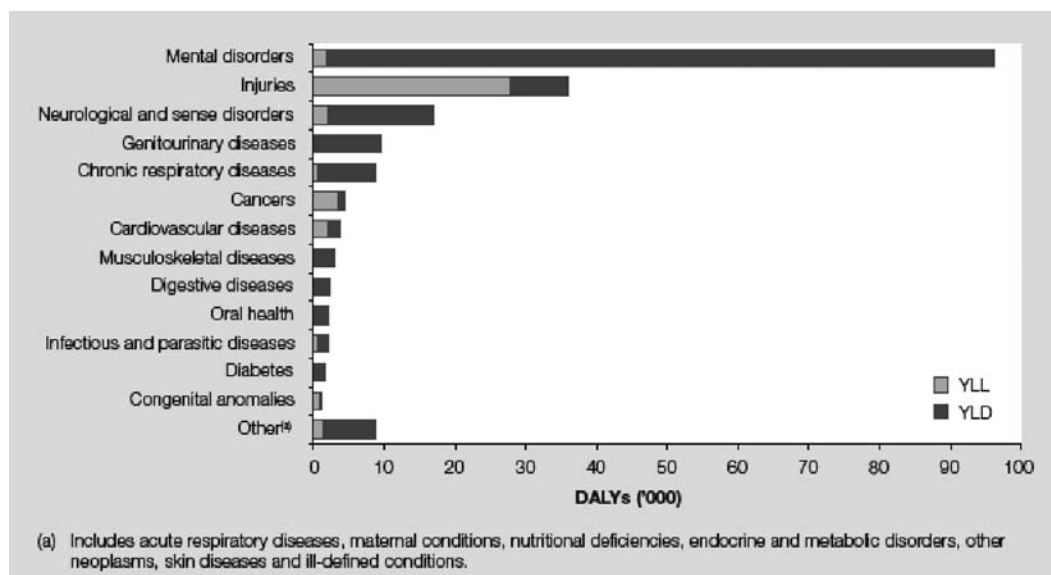
Figure 1. Burden of disease by major disease groups for Australians aged 15-24, 2003. DALYs, disability-adjusted life years, represent lost years of healthy life; YLL, years of life lost, measures premature death due to disease or injury; YLD measures years of healthy life lost due to disease, disability or injury (AIHW 2007:20).

A 1997 national survey (ABS 1998) of adult Australians' mental health and wellbeing found that those aged 18-24 had the highest prevalence of mental disorders during the twelve months prior to the survey – 27% (see Figure 2). A related survey (Sawyer et al 2000) of children and adolescents (aged 4-17) found 14% were experiencing mental health problems at the time of the survey. About 10% of young people have a long-term mental or behavioural problem, and 16% report high or very high levels of psychological distress (AIHW 2008a:281).

A survey (Bernard et al 2007) of more than 10,000 Australian students from prep school (age 4-6) to year 12 (age 17-18) found that about 40% of students could be described as displaying lower levels of social and emotional wellbeing. Between a fifth and a half of students said they: were lonely (18%); had recently felt hopeless and depressed for a week and had stopped regular activities (20%); were very stressed (31%); had difficulty controlling how depressed they got (32%); lost their temper a lot (35%); worried too much (42%); and had difficulty calming down when upset (48%).

The student's wellbeing tended to increase in primary school and decrease in high school. There was, at most, only a weak positive relationship between socio-economic status and overall wellbeing. Students tended to score themselves lower on wellbeing than did their teachers, suggesting teachers may be unaware of the extent of the emotional difficulties students are experiencing.
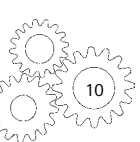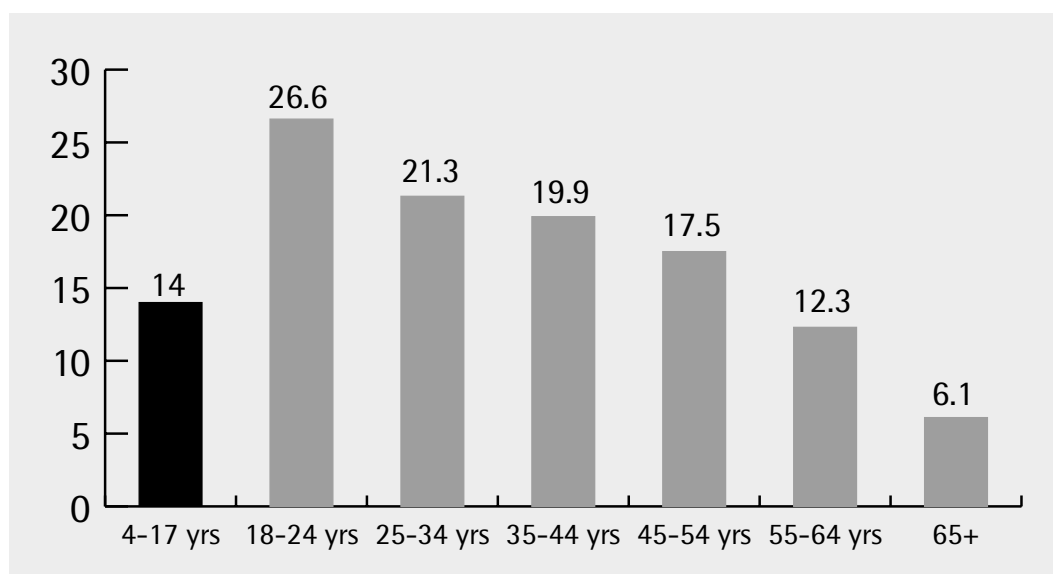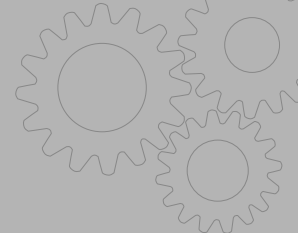
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Figure 2: Prevalence(%) of mental health problems among Australian, by age (based on data from ABS 1998, Sawyer et al 2000).

Several surveys by the Australian Childhood Foundation (Tucci et al 2006, 2007, 2008) of children 10-14 or 10-17 produce a similar picture of high levels of stress, worry and anxiety. For substantial minorities, increasing to majorities for some questions, their sense of confidence in themselves, their community and their place in the world is under threat (Tucci et al 2007). Concerns range from how they look, not doing well enough, being bullied and not fitting in, being hurt by an adult, and feeling unsafe in public places and using public transport and the internet, through to climate change, water shortages, pollution and world affairs. Based on one survey (Tucci et al 2007), the foundation established three categories of children: those who felt well-connected and supported – 52%; a 'worried' group – 42%; and a 'disconnected and insular' group (the most vulnerable) – 8%.

While such findings imply a worsening situation, long-term trends in mental health are very difficult to establish conclusively because of the lack of good, comparative data. The issue remains contentious; not all studies show an increase. An Australian review, prepared for an earlier Australia 21 youth project (Eckersley et al 2006), concluded that, on the basis of available data, it was not possible to determine whether there had been a long-term change in the mental health and wellbeing of young Australians (Aird et al 2004). However, the weight of international evidence indicates the prevalence of psychological problems among young people has risen in developed nations in recent decades, with the latest US research suggesting a 5-8-fold increase over the past 70 years (see Box 1). The trends are despite the increased treatment of mental disorders. The evidence is mixed on whether prevalence is still rising (see Box 2).

Scientific cautions about the trends include that they reflect: older people forgetting past episodes of mental illness (resulting in understated rates in the past); reduced stigmatisation (so a greater willingness to admit to mental illness); and increased diagnosis and the growing 'medicalisation' of moods and emotions (especially with the development of new therapeutic drugs). While these factors may be involved, the best research takes them into account. Furthermore, as stated earlier, we need to look at all the evidence, direct and indirect, in its totality, in trying to understand a very complex situation.

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BOX 1. Recent overseas research on patterns and trends in young people's mental health
A major US study (Kessler, Chiu et al 2005, Kessler, Berglund et al 2005) has shown almost a half
of Americans will experience a clinical mental disorder during their lives, while over a quarter
will suffer a disorder in any one year; three-quarters of lifetime cases first experienced a disorder
in adolescence and early adulthood. The risk increases for successive generations: those aged 18
to 29 have an estimated lifetime risk four times that of those aged 60 and over. The researchers
say the prevalence and risk estimates are conservative, the lifetime risk in younger cohorts
underestimated, and the increased risk in these cohorts is 'at least partly due to substantive rather
than methodological factors'. Comparisons with an earlier survey showed that the prevalence of
mental disorders in Americans aged 18-54 did not change significantly in the decade, 1990-92 and
2001-03 (12-month prevalence, 29.4% and 30.5%, respectively), but the rate of treatment increased
(from 12.2% to 20.1% of the 18-54 population) (Kessler, Demler et al 2005). The prevalence might
have risen but for increased treatment, or increased treatment had no effect on prevalence.

A US study (Lloyd-Richardson et al 2007) found 47% of adolescents engaged in some form of
non-suicidal self-injury within the past year, 28% at a moderate or severe level, and averaging
13 incidents of self-harm – biting, cutting, burning, or hitting themselves. The most common
reasons included: to feel something, even if it was pain; to get a reaction from someone; to
get control of a situation; and to stop bad feelings. The researchers acknowledge some minor
self-injury may represent a 'normative expression' of teen culture. However, the reasons behind
it were much the same as for the more serious forms. There were no significant differences
between socio-economic groups.

A meta-analysis (Costello et al 2006) of 26 studies of children and youth born between 1965 and
1996 concluded that when concurrent assessment rather than retrospective recall was used, 'there
is no evidence for an increased prevalence of child or adolescent depression over the past 30
years'. However, the failure to detect any trend could be because the analysis included a relatively
small number of studies from different countries, which yielded very different prevalence rates.

A UK study (Collishaw et al 2004) of health surveys carried out in 1974, 1986 and 1999 found
a rise in some mental health problems among both boys and girls aged 15-16. Overall, the
prevalence of conduct problems increased from 7% to 15%, and that of emotional problems from
10% to 17% (hyperactive problems did not show a significant rise). The preliminary results from
a more recent analysis (Collishaw, Pickles et al 2007) of English health survey data from 1986
and 2006 also shows that today's adolescents experience considerably higher rates of emotional
problems. The differences between the 1986 and 2006 generations become more marked with
increasing severity of symptoms, and also appear to vary by symptom.

Sweden, the model social democracy that performs well in international comparisons of young
people's wellbeing, has not been immune to the adverse trends in mental health and wellbeing.
Data suggest mental health has declined, at least since the late 1980s (Hjern 2006, Stefansson
2006). In one study, the proportion of boys who said they were often or always felt unhappy
doubled to 9% between 1988 and 2002; for girls the proportion rose from 23% to 32%. In
2001-2, 20-30% of boys aged 11-15, and 30-40% of girls, said they experienced every week
psychosomatic symptoms such as abdominal pains, headaches and disturbed sleep; the proportions
have increased continuously since the mid-1980s.

In a new study drawing on results of a widely used psychological test, Twenge et al (under review)
found a steady decline in the mental health of American college students between 1930 and 2007
and adolescents between 1951 and 2002. Five to eight times as many college students now score
above common cut-off levels for psychopathology.

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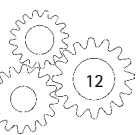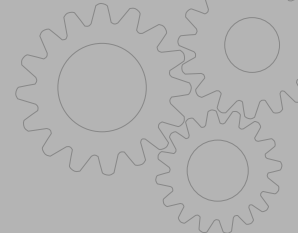
The findings on mental health cast doubt on any wider health significance of the fall in youth suicide. The reasons for the fall are not clear, but the evidence suggests the explanation may be that more young people are seeking and getting help, not that fewer need help. Psychological distress increased, particularly among young men, during the period that the male youth suicide rate fell (AIHW 2007:23-24, Jorm and Butterworth 2006). Hospitalisations of young people for intentional self-harm and emotional and behavioural problems increased over this period, with hospitalisations for self-harm rising by 51% for young women, and 27% for young men, between 1996 and 2006 (AIHW 2003:98, AIHW 2007:26, AIHW 2008b).

The World Health Organization (WHO 2001:36) has stated that child and adolescent mental and behavioural disorders are very costly to society in both human and financial terms. 'The aggregate disease burden of these disorders ... would be complex to calculate because many of these disorders can be precursors to much more disabling disorders during later life' (see Box 3).

BOX 2. Children's temperament and behaviour: better or worse?
A study (Smart and Sanson 2008) comparing survey results for children aged 2-3 and 6-7 from the 1980s and 2000s illustrates some of the confusing elements of research findings. It suggests that children then and now are similar in temperament and behaviour. According to parent reports, today's children are doing better on some aspects; teacher reports indicate they are doing worse on some measures (both report less anxiety today). Parents reported more conduct problems than teachers in the past, but fewer today (an unusual trend). As the researchers note, it might be that parents are now more tolerant of poor behaviour; or perhaps teachers are more aware of these issues today. Anecdotal evidence from experienced teachers suggests today's children tend to behave more poorly at school than children of the 1980s.

The results might, therefore, indicate a social shift that will show up later in teenagers and young adults; or it might be that problem behaviour in young children has become more normal for parents. Also, these are very young children, with limited exposure to the psychosocial influences considered in the report. Only small minorities (1%-13%) of the 1980s children revealed emotional and behavioural problems; but by 2002, when aged 19-20, 50% were assessed as having problems in these areas (Smart and Sanson 2005).

Crime and drugs

Young people make up most of the perpetrators of crime and, with violent crime, a disproportionate share of its victims. With the exception of the homicide rate, which has been fairly stable since the 1970s, reported rates of crime are now mostly higher than the (rising) rates recorded in the 1970s and 1980s, many times higher in the case of assault and sexual assault (although apparent changes in some classifications make direct comparisons difficult) (Eckersley 1988). Reported rates of property crime and robbery peaked in about 2001 and have since fallen (AIC 2008a, 2008b). However, assault rates increased 33% between 1996 and 2006. This increase was mainly due to a rise in more serious, aggravated assault which increased by 46% between 1999 and 2006. Sexual assault also increased. The increases in assault and sexual assault involving (as victims) children aged under 15 were almost double those for older people.

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Box 3. The health of the Australian population

The arguments presented in this report also apply to the Australian population as a whole, but with some important qualifications. Again, the orthodox view is very positive, with the Australian Institute of Health and Welfare stating (AIHW 2008a:6): 'Australia's level of health continues to improve overall. Moreover, in most aspects of health Australia matches or leads other comparable countries'.

Mental disorders are the third largest contributor to the total burden of disease, after cancer and cardiovascular disease, and the largest contributor to the non-fatal component of the disease burden. The proportion of all Australians reporting 'mental and behavioural problems' as long-term conditions increased from 5.9% in 1995 to 11% in 2004-5 (AIHW 2008a:220).(By comparison, the proportion with diabetes increased from 2.4% to 3.6% over this period).

This picture is offset by declining death rates for leading health problems, including the degenerative diseases of cancer, heart disease and strokes (AIHW 2008a), which have relatively little impact on young people's health. However, there is often a lag of decades between exposure and ill-health in these instances, between living conditions and lifestyle behaviours and the illnesses they cause (for example, smoking and lung cancer). To some extent, current mortality rates reflect a way of life that has long past (whether for better or worse).
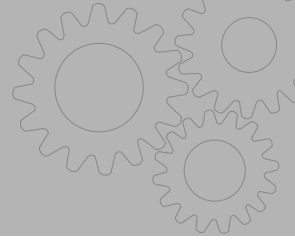
On the basis of current trends, Australians' life expectancy is projected to increase 0.24% a year to 2023; years of 'healthy life', which takes disability into account, will increase by 0.22% a year (Begg et al 2007:7, 115). These projections take account of the impacts of the rise in obesity (which has reduced the improvement in heart disease deaths, for example), but do not factor in any rise in the burden of mental illness.

Furthermore, recent international research suggests the disease burden of mental illness has been underestimated. People attribute higher disability to mental disorders than to the commonly occurring physical disorders (Ormel et al 2008). The higher disability associated with mental illness applies to people's 'social and personal role functioning'; with 'productive role functioning', the disability of mental and physical disorders is comparable. A study that compared the severity of 15 illnesses found severe depression ranked third behind quadriplegia and being in the final year of a terminal illness (Schwarzinger et al 2003).

Another analysis argues that the burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connection between mental illness and other health conditions (Prince et al 2007). Mental disorders increase the risk of both communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk of mental illness. As the authors comment, developed countries prioritise non-communicable diseases that cause early death (such as cancer and heart disease) above those that cause years lived with disability (such as mental disorders).

Another consideration is the extent to which medical advances are contributing to improved health. For example, blood pressure and cholesterol drugs and heart surgery have had a considerable impact on heart disease mortality. So if we want to measure the healthiness of current ways of living (the focus of this report), there might be a case for parcelling out the effects of medical treatments.

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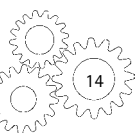
It is not clear to what extent these increases are real or a result of greater awareness and reporting (especially with the under-15 assaults). However, it seems improbable that a sustained rise in reported violent crime over several decades would be wholly a statistical artefact. Supporting the view that the rise is at least partly real, hospitalisations due to assault among those aged 12-24 increased by 27% between 1996 and 2006 (AIHW 2008b). The proportion of young people in care and protection is also continuing to rise (AIHW 2007:xii).

As with suicide rates and mental health, the fall in drug-related deaths does not necessarily indicate an overall improvement in drug and alcohol abuse. Heroin use, the major cause of these deaths, peaked in the late 1990s, and has since fallen (a possible contributor to the fall in robberies). So too has total illicit drug use, including the most widely used, marijuana (although ecstasy and cocaine use is rising) (AIHW 2008a:142-145).

In the study that found 40% of students revealed poor emotional and social wellbeing, 89% of the students said they were happy.

However, recent reports indicate a rise in other drug-related problems, including drinking alcohol at levels that pose short-term and long-term risks to health (although recent trends vary depending on the measurement, and under-age drinking may have dropped) (ABS 2006, DEECD-DPCD 2008, Roche et al 2007). Drug-induced psychosis, especially from amphetamine use, has increased (Degenhardt et al 2007). Overall, 37% of young Australians (aged 14-29) today binge drink at least once a month, and 23% have used an illicit drug in the previous 12 months (AIHW 2008a:284). The decline in smoking among young people is good news and will pay health dividends later in life (AIHW 2008a:132-135).

Health, self-reported health and happiness

In the study (Bernard et al 2007) that found 40% of students revealed poor emotional and social wellbeing, 89% of the students said they were happy. The results illustrate the contrasting pictures that emerge from different measures – and the danger in taking self-reported health and happiness measures at face value, as the orthodox view does (see also Eckersley 2005:153-154). Similarly, another study (Smart and Sanson 2005) found that over 80% of young people were satisfied with their lives – including lifestyle, work or study, relationships with parents and friends, accomplishments and self-perceptions. However, 50% were experiencing one or more problems associated with depression, anxiety, anti-social behaviour and alcohol use. In other words, most of those with problems were satisfied with life.

The explanations for the apparent contradictions are complex, and include that evaluating one's happiness involves illusions, rationalisation and mitigation, and that some 'unhealthy' behaviours (such as illicit drug use or binge drinking) can be considered as part of enjoying life and coping with stress. The different pictures also reveal the difference between the public mask and the private person, especially, in the case of young people, the vulnerability, anxiety and insecurity that are often hidden behind an outward show of self-confidence, worldliness and 'cool' (Eckersley 2005:100-104, Hamilton 2008). Even seriously depressed people can lead outwardly normal, even successful, lives (Stavropoulos 2008).

The same issue arises with self-reported health (which strongly correlates with happiness and life satisfaction). In 2004-05, 70% of young Australians aged 15-24 assessed themselves to be in excellent or very good health, while a further 24% rated their health as good; only 7% reported their health to be fair or poor (AIHW 2007:12). Yet among Australians who reported mood disorders as a long-term health condition, 30% rated their health as excellent or very good, 31% rated it as good, and only 39% rated it as fair or poor (the proportions were the same for those who reported five or more long-term conditions) (AIHW 2006:27). While self-reported health is correlated to actual health, it is not an accurate measure of health status.

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Physical health

Adverse patterns and trends also characterise some chronic physical illnesses and risk factors, notably those linked to obesity, physical activity and nutrition. Almost a third (30%) of males and 22% of females aged 15-24 are overweight or obese, which places them at risk of a wide range of health problems, including diabetes, heart disease, some cancers and mental illness (AIHW 2007:71-73). A NSW study (Booth et al 2006) of students aged 7-16 found that the prevalence of overweight and obesity had risen from 11% in 1985 to 25% in 2004; significant minorities (up to 20%) of 15-16-year olds already had risk factors for diabetes, heart disease and liver disease, with overweight and obese students much more likely to be at risk.

Less than a half of males and a third of females aged 15-24 meet national guidelines for physical activity (although the proportions have risen since 1985) (AIHW 2007:73-75). Activity levels decline with increasing age in this group; a quarter of males and a third of females are sedentary, doing little or no exercise. Most young people do not eat the recommended daily amounts of fruit and vegetables (AIHW 2007:76-78).

Significant minorities of 15-16-year olds already had risk factors for diabetes, heart disease and liver disease.

Based on hospitalisation rates for young people, asthma and epilepsy are declining, cancer and cystic fibrosis are stable, but diabetes, cerebral palsy and Crohn's disease are increasing (AIHW 2007). Generally speaking, allergies (other than asthma) are on the rise (Poulos et al 2007). In a South Australian study (Dollman and Lewis 2007) the perceived importance of many health-related attitudes towards diet, sleep, exercise, visiting the doctor and dentist, etc, declined among 10-15-year-olds between 1985 and 2004, with implications for future health (the exception was the perceived importance of not smoking, which increased).

Other evidence

Other research provides more indirect evidence of young Australians' situation. One survey (Tucci et al 2005) reported 'a growing sense among parents that childhood is at risk because the daily environment in which children live is perceived to be increasingly less safe, stable and predictable'. It found that 80% or more of parents believed children were growing up too fast; worried about their children's futures; and felt children were targeted too much by marketers. These worries are part of wider concerns about social priorities, quality of life and global futures (Eckersley 2005).

Over 80% of young Australians are personally optimistic about their own lives, and this proportion has not changed over the past 20 years (like happiness and life satisfaction, it tends to be a stable measure at the population level) (Eckersley et al 2007). However, a growing proportion appears to believe quality of life in Australia is declining (despite a long economic boom that has seen strong economic growth, declining unemployment and rising incomes) (Eckersley et al 2007). The gap between their expected and preferred futures for Australia has widened, and concerns about the future of the world have increased (see Table 1). In one survey (Tucci et al 2006), almost two thirds of children aged 10-17 either did not believe (18%), or were unsure (44%), that their generation would be better off than their parents; 27% were concerned the world would end before they got old.

Two thirds of children aged 10–17 either did not believe or were unsure that their generation would be better off than their parents.
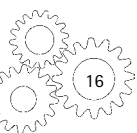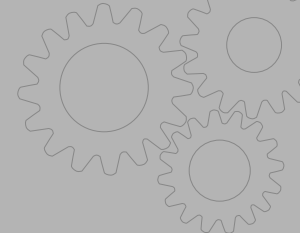
These perceptions can be considered an aspect of a sense of wellbeing, and they may well impact on personal health. For example, psychological research shows that viewing the world as comprehensible, manageable and meaningful is associated with wellbeing. Biomedical research shows that people become more stressed and more vulnerable to stress-related illness if they interpret the stress as evidence that circumstances are worsening, feel they have little control over its causes, and don't know how long it will last.

Table 1: Declining optimism about national and global futures among young Australians, aged 15-24 (1995) and 18-24 (2005) (Eckersley et al 2007)

Year Question		1995 %	2005 %
Future quality of life in Australia:			
	Better	35	24
	Worse	34	49
Positive scenarios of Australia's future. 1. 'Growth': focus on individual wealth, economic growth, the 'good life':			
	Expect	63	77
	Prefer	16	11
2. 'Green': focus on community, family, equality, environmental sustainability:			
	Expect	35	23
	Prefer	81	89
World in 21st Century:			
'new age of peace and prosperity'		41	16
'bad time of crisis and trouble'		55	65

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Health problems (especially emotional and behavioural disorders) among young people are usually explained in terms of personal experiences and situations and their associated risk factors (such as parental conflict, abuse and neglect, bullying, academic failure, being poor or unemployed) and protective factors (such as good parenting, enjoying school, academic achievement, having friends and socialising) (Eckersley 2005, Bernard et al 2007, Patel et al 2007). The broader, macrosocial determinants of the patterns and trends in population health are less clear and less discussed, with the focus being on socio-economic disadvantage and inequality (Eckersley 2005, 2006a, 2007a).

Rapidly changing social contexts promulgate new and sometimes unexpected health threats.

An introductory commentary (Resnick and Bowes 2007) on a series of papers on adolescent health in the medical journal, *Lancet*, in 2007 states the papers incorporate three fundamental principles: rapidly changing social contexts promulgate new and sometimes unexpected health threats; health and ill-health are understood best as a result of the complex interplay between biological, psychological and sociological factors; and the sociological factors have global reach in their effect on young people.

A wide range of such factors has been implicated in the patterns and trends in young people's health and wellbeing (Eckersley 2005, 2007b, in press):

- Changes in the worlds of family, work and education, such as family conflict and breakdown, poverty and unemployment, job stresses and insecurity, and education pressures (the most commonly cited factors).
- Cultural changes — for example, excessive materialism and individualism (discussed later), and the emergence of a youth culture that isolates young people from adults and increases peer and media influence.
- Increased media use and changing media content, linked to violence, consumerism, loss of community and social cohesion, vicarious life experiences, invidious social comparisons, and pessimism about global conditions and futures.
- The decline of religion, which 'packages' many sources of wellbeing, including social support, spiritual or existential meaning, a coherent belief system and a clear moral code (paradoxically, however, at a population or national level, some research suggests religion is a health burden).
- Changes in diet, which have been implicated in many chronic health problems. For example, a large increase in the ratio of omega 6 to omega 3 fatty acids has been linked to cardiovascular disease and mood disorders.
- Comorbidity, especially between drug use and mental illness, but also between mental and physical problems such as obesity and depression, and depression and heart disease.
- Environmental degradation, including widespread toxic chemical pollution, which affects neurological development and immune function.

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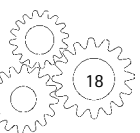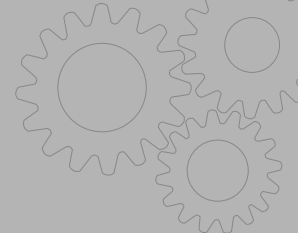
Environmental changes loom large as a future risk to health, including mental health, especially global warming and its consequences. A major WHO report (Corvalan et al 2005) warns that the dual trends of the growing exploitation of ecosystems and their generally declining condition are unsustainable. There is an increasing risk of 'non-linear changes' in ecosystems, including accelerating, abrupt and potentially irreversible changes, which could have 'a catastrophic effect on human health'. The UN Human Development Report (HDR 2008:7) warns of climate change: 'Today, we are witnessing at first hand what could be the onset of major human development reversal in our lifetime.'

Of course, there have also been social improvements, including greater gender, religious, ethnic and racial equality and tolerance; and environmental improvements, such as cleaner urban air and water in the developed world (notably reduced lead pollution). I am focusing in this section on explanations for the apparent decline in health, especially mental health.

> *The UN Human Development Report warns that we are witnessing what could be the onset of major human development reversal.*

Complexity of effects

There are several important points to make about these explanatory factors. Their trends over time provide indirect corroboration of evidence that psychological and social problems have risen among youth. For example, if family breakdown, work-family pressures, heavy media use, materialistic values, or dietary deficiencies are implicated in these problems and have increased over time, these trends would predict decreased wellbeing.

The factors interact with other biological and social factors to produce individual, age and generational differences. These include: genes 'for' depression, anxiety and addiction (that is, the presence of these genes confers increased risk), but whose expression is influenced by environmental factor such as adverse life events; changes in personality and other psychological traits, including increased extraversion, anxiety (neuroticism), self-esteem, narcissism, and decreased sense of control, which are themselves responses to social changes (notably rising individualism and declining social connectedness); and aspects of fetal, child and adolescent development, which increase vulnerability to risk (Eckersley 2005).

The health effects are not usually independent, direct and immediate; rather the causal pathways are complex, being often interdependent, indirect and delayed. A UK study (Nairn et al) of children aged 9-13 indicates one pathway by which media exposure affects children's wellbeing is by making them more materialistic; materialistic children have a poorer opinion of themselves and their parents; these children argue more with their parents. Increasing individualism can both contribute to rising inequality and amplify its effects by weakening social bonds and group identity (Eckersley 2006a). The associations between different risk factors, and between these factors and health problems, can vary over time, as demonstrated in a recent analysis of the association between adolescent conduct problems and family type, income and family size (Collishaw, Goodman et al 2007).

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Some of the factors that explain social patterns of health may not be implicated in the trends over time. For example, studies typically show social and economic gradients in mental health problems (that is, higher prevalence in lower-income and single-parent and blended families). However, the UK research on time trends (Collishaw et al 2004, Collishaw, Pickles et al 2007), cited in Box 1, shows the rise in problems occurred across all family types and social classes, as does the Swedish research (Stefansson 2006) with socio-economic status. In other words, socio-economic factors such poverty, unemployment and family breakdown, on which I focused in the 1988 report, are important explanations for the health differences within populations, but they do not appear to explain the changes in the health of populations over time.

Studies of rich and poor youth reveal more similarities than differences in their adjustment and socialisation.

Other recent studies reinforce the need to look beyond socio-economic disadvantage in seeking to understand and explain what is happening to young people's wellbeing. As already noted, some show little, if any, socio-economic differences (Bernard et al 2007, Lloyd-Richardson et al 2007); some have even found higher rates of problems in higher-status groups. Several US studies have shown that children in rich families (a little researched group) may be more likely than children in general to suffer substance-use problems, anxiety and depression (Luthar 2003, Luthar and Latendresse 2005). Two possible explanations are given: excessive pressures to achieve and isolation from parents, both physical and emotional. The researchers say that comparative studies of rich and poor youth reveal 'more similarities than differences in their adjustment patterns and socialization processes' (Luthar and Latendresse 2005). An Australian survey (Beyondblue and Beaton 2007) of different professions found professionals had higher levels of depression than the general population, with law doing worst among the professions and young people (aged 20-29) doing worst among age groups.

Finally, the factors span different levels or layers of causation, with broad social conditions often being 'refracted' through personal life events and individual behaviours. The more fundamental levels include the defining features of modern Western culture (perhaps especially Western youth culture), materialism and individualism, which shape (and are also shaped by) many of the other factors. These cultural characteristics were considered in an earlier Australia 21 report (Eckersley et al 2006). The next section repeats some of this material in developing the discussion of culture and worldviews.

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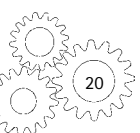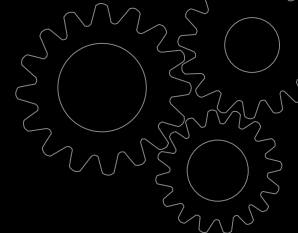
Materialism (giving importance or priority to money and possessions), research suggests, breeds not happiness but dissatisfaction, depression, anxiety, anger, isolation and alienation (Kasser 2002, Eckersley 2005, 2006a, 2007a). People for whom 'extrinsic goals' such as fame, fortune and glamour are a priority in life tend to experience more anxiety and depression and lower overall wellbeing – and to be less trusting and caring in their relationships – than people oriented towards 'intrinsic goals' of close relationships, personal growth and self-understanding, and contributing to the community.
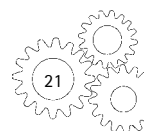
As materialism reaches increasingly beyond the acquisition of things to the enhancement of the person, the cultural goal (promoted through the media and marketing) becomes not only to make people dissatisfied with what they have, but also with who they are. Consumer culture both fosters and exploits the restless, insatiable expectation that there must be more to life. In short, the more materialistic people are, the poorer their quality of life. 'It is important we appreciate how much of their identity girls are losing to celebrity culture, peer pressure and consumerism', Hamilton (2008:254) says in her study of girls. 'These forces are now shaping almost every aspect of girls' lives'.

Individualism (the relaxation of social ties and regulation and the belief that people are independent of each other) is supposed to be about freeing people to live the lives they want (Eckersley 2005, 2006a, 2007a). Historically, it has been a progressive force, loosening the chains of religious dogma, class oppression and gender and ethnic discrimination, and so associated with the liberation of human potential. However, individualism is a two-edged sword: as sociologists have noted, the freedom people now have is both exhilarating and disturbing, and with new opportunities for personal experience and growth also comes the anxiety of social dislocation and isolation.

> *With new opportunities for personal experience and growth also comes the anxiety of social dislocation and isolation.*

The costs of individualism relate to a loss of social support and personal control, both of which are important to wellbeing. These costs include: a heightened sense of risk, uncertainty and insecurity; a lack of clear frames of reference; a rise in personal expectations, coupled with a perception that the onus of success lies with the individual, despite the continuing importance of social disadvantage and privilege; a surfeit or excess of freedom and choice, which is experienced as a threat or tyranny; increased self-esteem, but of a narcissistic or contingent form that requires constant external validation and affirmation; and the confusion of autonomy with independence (or, to put it somewhat differently, redefining 'thinking *for* ourselves' as 'thinking *of* ourselves').

There is direct evidence of the role of defining cultural qualities in health. One study (Eckersley and Dear 2002) found strong correlations between individualism and youth suicide rates in developed nations. Another (Kalogeraki 2007) found that cultural traditions relating to individualism and collectivism had both direct and indirect (by influencing risk-factor prevalence) effects on teenage drug taking, and recommends that 'public policy makers should direct their efforts towards inducing a "cultural shift" that could eliminate the most negative effects of cultural trends such as excessive individualism'. The importance of culture is also implied in research that shows, for example, rates of mental disorder in young people of English origin in the UK are four times greater than the rates in young people of Indian origin (Patel et al 2007). (This is not only a large effect relative to other social factors, it runs counter to the usual epidemiological view of ethnic minority status as a source of disadvantage.).

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Concerns about the culture of modern societies are also apparent in public perceptions of quality of life (Eckersley 2005). Studies in Western nations over the past decade, both qualitative and quantitative, reveal levels of anger and moral anxiety about changes in society that were not apparent thirty years ago. They show that many people are concerned about the materialism, greed and selfishness they believe drive society today, underlie social ills, and threaten their children's future. They yearn for a better balance in their lives, believing that when it comes to things like individual freedom and material abundance, people 'don't seem to know where to stop' or now 'have too much of a good thing'.

For example, a study of 'middle Australia' found that a half of those surveyed felt quality of life was falling, with the most common reasons given being, in order: too much greed and consumerism; the breakdown in community and social life; too much pressure on families, parents and marriages; falling living standards; and employers demanding too much (Pusey 2003). Most people believed family life was changing for the worse, citing the breakdown of traditional values; too much consumerism and pressure to get more money and buy things; a breakdown of communication between family members; and greater isolation of families from extended family networks and the community.
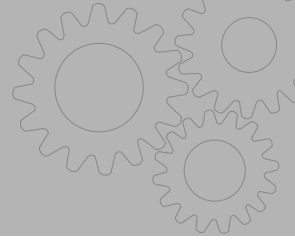
Studies reveal levels of anger and anxiety about social changes that were not apparent thirty years ago.

A close link exists between Western culture and the ideology of capitalism; each feeds off the other. A comprehensive analysis (Kasser et al 2007) of the psychological consequences of corporate capitalism concludes that its aims (self-interest, financial success, competition) 'conflict with and undermine pursuits long thought by psychologists to be essential to individual and collective wellbeing'. These include helping the world to be a better place; having committed, intimate relationships; and feeling worthy and autonomous.

Stavropoulos (2008:8-11), writing from the combined (and unusual) perspectives of political science and psychotherapy, says that depression reveals 'the strain and effect of living with the disjuncture between the individualist "ideals" of liberalism and the relational reality of our lives'. The depressed often berate themselves for failing to live up to these 'ideals', she says. Focusing on the individual experience alone artificially detaches people from the wider sociopolitical context, which never ceases to influence emotional wellbeing. 'Recognizing the politics of depression is a prerequisite of its healing.'

Thus one of the most important and growing costs of the modern way of life is 'cultural fraud': the promotion of images and ideals of 'the good life' that serve the economy but do not meet psychological needs, nor reflect social realities. To the extent that these images and ideals hold sway over people, they encourage goals and aspirations that are in themselves unhealthy. To the extent that people resist them because they are contrary to their own ethical and social ideals (and, indeed, health promotion messages), these images and ideals are a powerful source of dissonance that is also harmful to health and wellbeing.
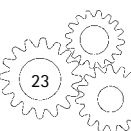
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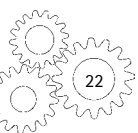
Material progress or sustainable development?

Most, if not all, of the explanatory factors are associated with a particular form or model of national development, material progress, which focuses on economic growth and material welfare, even at the expense of other aspects of life (Eckersley 2005, 2006b). Together with other

Material progress comes with an array of cultural and moral prerequisites and consequences that affects profoundly how people think of the world and themselves.

evidence, the factors point to a state of 'overdevelopment', where social changes that were once beneficial to health have now become harmful. The various lines of evidence represent an intricate and complex web of cause and effect. They show that material progress does not simply and straightforwardly make people richer, so giving them the freedom to live as they wish. Rather, it comes with an array of cultural and moral prerequisites and consequences that affects profoundly how people think of the world and themselves, and so the choices they make. The costs to health and wellbeing can no longer be regarded as unfortunate side-effects of a model of progress whose major effects remain largely beneficial; they are a direct and fundamental consequence of how Western societies and cultures have defined and pursued progress.

Consequently, material progress is coming under growing challenge from a new model, sustainable development, which does not accord economic growth overriding priority. Instead, it seeks a better balance and integration of social, environmental and economic goals and objectives to produce a high, equitable and enduring quality of life. Sustainable development is not about 'dedevelopment', but 'redevelopment'. It does not only affect policy options and decisions; there is growing evidence that a cultural transformation is taking place, a profound shift in values and attitudes. However, the trend is not set, the situation remains unstable, and its effects may be yet to flow through to health and wellbeing.

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CONCLUSION

I have argued that, notwithstanding all the complexity and uncertainties, the totality of the evidence suggests that fundamental social, cultural, economic and environmental changes in Australia and other Western societies are impacting adversely on young people's health and wellbeing. These changes have made it harder for young people to feel accepted, loved and secure; to know who they are, where they belong, what they want from life, and what is expected of them: in short, to feel life is deeply meaningful and worthwhile.

We might well ask why we should bother with such a broad analysis of whether or not young people's overall health and wellbeing is rising or falling. Why not simply discuss health on a disease-by-disease, case-by-case basis, given this is how we tend to treat health (that is, which problems are growing in prevalence, which declining; which individuals are most at risk, which least)? One reason is straightforward: societies are already making such judgements; it is this orthodoxy I am challenging.

But embedded in this simple question, or context, are also other important considerations, including of public policy. Examples include:

Research: The broad perspective is important as a framing or conceptual device. However elusive a definitive answer might be, the question generates questions that otherwise would not be asked. It encourages more transdisciplinary dialogue and synthesis, creating new perspectives and insights into many, more specific, issues about health. It compensates, in part, for the weaknesses and limitations that arise from the increasingly specialised and often reductionist nature of scientific research. In all these ways, it increases the usefulness of science's to society. Yet this sort of research remains at the margins of mainstream science; it deserves more support.

Health: Whether young people's health is located within a social world that is improving or deteriorating will determine what approaches we should take to health. If quality of life is improving for the majority, attention can legitimately be focused on the minority at risk; if not, then health promotion must include broader and deeper social changes. Health expenditure is rising and in 2005-06 accounted for 9% of GDP ($87 billion, and 45% more per person, in real terms, than a decade ago); less that 2% of health expenditure is for prevention and health promotion (AIHW 2008a:xiv). This trend is unsustainable and some reallocation of resources is essential (for example, increasing prevention and health promotion spending to, say, 5% by 2020). The tradition bias in medicine, including public health, against mental health also needs to be eliminated, and more resources allocated to mental health care.

Education: Children who are not well, physically and mentally, are more likely to be poor students, difficult to teach, and less likely to achieve their full potential in life. The challenge for education is in its ability to address this situation. This includes, but goes beyond, education to enhance individual resilience and wellbeing. It must embrace a wider, social perspective that draws its legitimacy and inspiration from the fundamental goal of education: to give young people a better understanding of themselves and their world so that they can, in turn, lead richer, healthier lives and contribute to creating a better world. More use should also be made of innovative teaching approaches such as role-based inquiry, narrative, and experience- and issue-based learning, to build stronger links between the curriculum and young people's lives and passions.

Business: Our quality of life depends on the regulation by government of the social and physical environment to protect our physical safety and health. We also regulate business activities to ensure national economic benefits and financial propriety. We need to extend this regulation to guard against moral hazard and psychological harm. Those who decry 'nanny states' and 'social engineering' should acknowledge the benefits (for example, clean air and water and safer working conditions and consumer goods). They also need to recognise that the 'media-marketing

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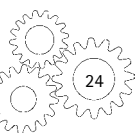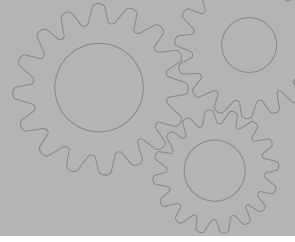
complex' is now engaged in social engineering on a massive, global scale, and this is, I have argued, resulting in an increasing burden of illness and illbeing, especially among the young. This surely breaches the United Nations Convention on the Rights of the Child, which include the right 'to protection from harmful influences, abuse and exploitation' (UNICEF 2008). Concerns here go beyond junk food ads and the media sexualisation of children to include the wholesale 'commodification' of childhood: the commercial manipulation and indoctrination of children and youth into living an unhealthy, unsustainable, hyper-consumer lifestyle.

Corporate practices breach children's right to protection from harmful influences, abuse and exploitation.

Society: We manage our societies with the aim of making progress, of improving quality of life; we need to consider, and weigh, the patterns and trends in health and wellbeing in judging if this is the case. Social conditions, not medical and other health care, are the primary determinants of population health, so health research should play a bigger role in the political debate about future directions and priorities. If young people's wellbeing is improving, then this challenges a major theme in contemporary social criticism. If it is declining, then this substantially weakens the case for continuing on our present path of social development, a central tenet of which is that health is continuing to improve. The evidence presented here clearly favours a shift from the model of material progress to that of sustainable development. This, in turn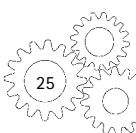, would mean moving the emphasis of economic activity away from private consumption for short-term, personal gratification towards social investment in building a more equitable, healthy and sustainable way of life.

The politics of health is seen largely as the politics of healthcare services. This focus reflects the dominance of a biomedical model of health that focuses on the treatment of individual cases of disease at the expense of the social model of disease prevention and health promotion presented in this report. If past successes in health promotion, such as that of tobacco control, have taught us anything, it is that our efforts must go beyond exhorting individuals to change their ways. They have to include fiscal and legislative changes that make healthy behaviour the cheapest and easiest option (Semenza 2007). These efforts have often been strenuously opposed by vested interests, notably in the corporate sector.

The politics of health should be the politics of everything, the defining goal of government. The central purpose of our present social system is to create wealth; we need to make that purpose to create health, in its broadest sense. Making this change requires more than a change in policies. It means redesigning the conceptual framework, or worldview, within which policy decisions are made, rethinking 'the defining idea' of how we make life better. It means changing the stories or narratives by which we define ourselves, our lives and our goals.

Contrary to the prevailing orthodoxy, the core obstacle to improving quality of life is not a poverty of the means to the end of the 'good life' as we currently define and pursue it; it is a poverty of the end itself. To address this 'poverty of ends', we need to take into account all aspects of being human and human wellbeing: not just material needs, but also social, cultural and spiritual needs. Achieving this goal will mean recognising the political 'reality gap' that exists between (policy) relevance and (response) effectiveness. Policy reformers regard those who advocate transformational change as unrealistic because social change happens incrementally; transformers say reformers are being unrealistic because what they do is not fixing the problems.

Both sides are right. This is the challenge we face: to match the scale of our response to the magnitude of the challenge. Meanwhile, for all the extra efforts we are making and the gains we have made, the gap between what we are doing and what we now know we need to do continues to widen.

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NOTES

This report draws on the following papers:

Eckersley, R. 2007. The health and wellbeing of young Australians: present patterns and future challenges. *International Journal of Adolescent Medicine and Health*, vol. 19. no.3:217-227.

Eckersley, R. (in press). The health and well-being of young Australians: Patterns, trends, explanations and responses. In DL Bennett, SJ Towns, Elliott, EL, Merrick J. *Challenges in adolescent health: An Australian perspective*. Victoria, BC: Int Acad Press.
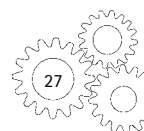
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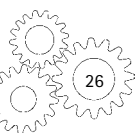
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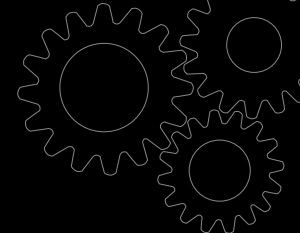
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