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The health and wellbeing of young Australians: Patterns, trends, explanations and responses

Richard Eckersley

***Abstract*:** The orthodox view of the health and wellbeing of young Australians has been one of continuing improvement. This picture underestimates the importance of adverse trends in a range of chronic physical and mental health problems. These have their sources in quite fundamental features of western societies, and optimizing young people's health will mean making correspondingly fundamental social, economic and cultural changes. Better health (not greater wealth) should be the defining goal of government, and this means seeing health as much more than a matter of healthcare services. Medicine and other health professions need better to recognize this if they are to continue to be part of the solution to improving health and wellbeing, and not become part of the problem.

INTRODUCTION

The 'big picture' of the health and wellbeing of young Australians is marked by paradox, contradiction and ambiguity. Young people are portrayed as having the time of their lives, or struggling with life in their times. The wide range of views reflects fragmented and narrow disciplinary perspectives, often based on limited evidence; an incomplete understanding of a complex picture; and historical, ideological, generational and other sources of bias and prejudice.

The orthodox view of young people's health and wellbeing is of continuing improvement, in line with historical trends. The Australian Institute of Health and Welfare (1), for example, states that young people generally enjoy a level of health that is good and has improved in recent times. 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 (2) 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, both physical and mental. The problems have their sources in quite fundamental features of modern societies, which go well beyond socio-economic inequalities and disadvantage.

I present an overview of the patterns and trends in young Australians' health and wellbeing; show that some of the apparent contradictions can be explained, although 'irreconcilable differences' remain; discuss the social determinants of these patterns and trends; and, finally, consider 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).

The health of young people is not only important in its own right, or for their sake; it is crucial to 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.

As a recent report by UNICEF (3) 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'.

PATTERNS AND TRENDS IN YOUNG PEOPLE'S WELLBEING

Historically, the health of young Australians reflects the overall trends in population health in the developed world (4). 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 (2).

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 (5). 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 (see Figure 1) (2).

[Insert Figure 1 about here.]

Today, the major causes of death among young Australians are, in order: road accidents, suicide, accidental poisoning (including drug overdoses) and cancer (2). 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 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).

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. Thus the Australian Institute of Health and Welfare (6) says in another of its reports: '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'.

While mortality might have been a valid indicator of overall health historically, 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, therefore, growing 'scale anomalies' in generalizing 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 (2); on the other, 20-30% of young people 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% (5). These figures also challenge other often-cited evidence to support the orthodox view that most young people are doing well, namely that 80-90% say they are healthy, happy and satisfied (this is discussed further in the next section) (2,5).

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) (2). This is by far the biggest contribution and well ahead of the next most important contributor, injuries, at 18% (see Figure 2). 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 1997 national survey (7) 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 3). A separate 1998 survey (8) of children and adolescents (aged 4-17) found 14% were experiencing mental health problems at the time of the survey.

[Insert Figures 2,3 about here.]

A survey (9) 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%).

These findings imply that, while mortality rates may continue to fall among young people, the picture is rather different for trends in chronic conditions. Children and adolescents have the highest rates of increase in the prevalence of chronic disease (2). In the case of mental health, long-term trends are very difficult to establish conclusively because of the lack of good, comparative data, and the issue remains contentious; not all studies show an increase. However, a growing body of evidence indicates the prevalence of mental illness is rising (see Box 1). Furthermore, when the different lines of evidence, both direct and indirect, are taken together, they produce a coherent and compelling (if still provisional) picture of declining psychological resilience and wellbeing.

[Insert Box 1 about here.]

A similar picture is found for 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 (2). A recent study (17) of students aged 7-16 found that the prevalence of overweight and obesity had risen from 11% in 1985 to 25% in 2004. It showed 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) (2); 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 (2).

The proportion of young people with a disability increased from 6% to 9% between 1981 and 2003 (although part of this rise may be a measurement artefact) (2). Generally speaking, allergies are also on the rise (although trends vary for specific allergic conditions) (18). In a South Australian study (19), 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 research provides more indirect evidence of young Australians' situation. One survey (20) 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 (5).

IRRECONCILABLE DIFFERENCES?

Some of the apparent ambiguities and contradictions in health trends can be explained. 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 in the past decade, while welcome, do not necessarily reflect an improvement in underlying health. Psychological distress has increased, particularly among young men, during the period that the male youth suicide rate fell (2,21). Hospitalizations of young people for intentional self-harm and emotional and behavioural problems increased over this period, especially self-harm among young women (2).

The reasons for the fall in youth suicide are not clear, but this evidence suggests the explanation may be that more young people are seeking and getting help, not that fewer young people need help. Nor does the fall in drug-related deaths indicate an overall improvement in drug and alcohol abuse. Heroin use, the major cause of deaths, has dropped, but recent reports indicate a rise in other drug-related problems, including risky drinking (22) and drug-induced psychosis, especially from amphetamine use (23). The decline in smoking among young people is good news, and will pay health dividends later in life (6).

Recent studies illustrate well the contrasting picture that emerges from different measures. In the study cited above (9) showing about 40% of students had low social and emotional wellbeing, 89% of students said they were happy. Another survey (24) found that over 80% of young people were satisfied with their lives, but that 50% were experiencing one or more psychological or behavioural problems. In other words, most of those with problems were satisfied with life. Both sets of findings need to be qualified to give a more balanced, and reconcilable, view of their wellbeing (see Box 2).

[Insert Box 2 about here.]

Another common point of confusion concerns the question of whether young people are optimistic or pessimistic, which is important to wellbeing. This depends on whether we are measuring their attitude to their personal future, or to the future of Australia or the world. 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) (25).

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) (25). 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). These attitudes may well impact on personal health and wellbeing (25). 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, among other things, they interpret the stress as evidence that circumstances are worsening.

[Insert Table 1 about here.]

Nevertheless, differences in perspectives on young people's health remain. In a recent project (26), my colleagues and I sought a better understanding of the points of convergence and divergence in the commentaries and evidence relating to young people's wellbeing. It proved far from straightforward. Disciplines see things differently; they draw on different conceptual frameworks and approaches, which yield different evidence and interpretations. Participants in the project could not agree on several key issues, including: whether trends in wellbeing can be generalised over generations; the extent to which different measures and findings can be explained and reconciled; the relative importance of social influences and individual capacities in determining wellbeing; and the relative influences of biological and social factors in young people's development.

EXPLANATIONS FOR PATTERNS AND TRENDS IN WELLBEING

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 socializing) (5,9,27). 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 (5,28,29).

An introductory commentary (30) 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:

- 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) (5,27,31,32).
- 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 influence (5,28,29,31).
- 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 (5).
- 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, research suggests religion is a health burden) (33).
- Changes in diet, which have been implicated in many chronic health problems (4). 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 (34).
- Comorbidity, especially between drug use and mental illness (23,35), but also between mental and physical problems such as the links between obesity and depression (36), and depression and heart disease (28,37).
- Environmental degradation, including widespread toxic chemical pollution, which affects neurological development and immune function (38,39).

Environmental changes loom large as a future risk to health, including mental health, especially global warming and its consequences. A major WHO report (39) 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'.

There are several important points to make about these explanatory factors. Their trends over time provide indirect corroboration of evidence that psychosocial 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 (5); 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) (5,40); and aspects of fetal, child and adolescent development, which increase vulnerability to risk (5).

The health effects are not usually independent, direct and immediate; rather the causal pathways are complex, being often interdependent, indirect and delayed. For example, a UK study (41) 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 lower 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 (28). The associations between different risk factors, and between these factors and health problems, can vary over time, as demonstrated in a recent analysis of family type, income, family size and conduct problems (42).

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 (12,13) on time trends mentioned above shows the rise in problems occurred across all family types and social classes, as does the Swedish research (15) with socio-economic status. This suggests changes in these areas are not the main reasons for the trends.

While not supported by the broader socio-economic analyses, 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 (43,44). 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' (44). A recent Australian survey (45) 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 the more distal and diffuse influences being 'refracted' through the more proximal and specific. The more fundamental include the defining features of modern Western culture (perhaps especially Western youth culture): materialism and individualism. These shape (and are also shaped by) many of the other factors. Given this, it is worth saying more about these two qualities.

MODERN WESTERN CULTURE AND PROGRESS

Materialism (giving importance or priority to money and possessions), research suggests, breeds not happiness but dissatisfaction, depression, anxiety, anger, isolation and alienation (5,28,46). 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.

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 (5,28,29). 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.

The costs of individualism relate to a loss of social support and personal control, both of which are important to wellbeing. These 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 separateness.

Mistaking autonomy for independence (or, to put it somewhat differently, redefining 'thinking *for* ourselves' as 'thinking *of* ourselves') encourages a perception by individuals that they are separate from others and the environment in which they live, and so from the very things that affect their lives. The more narrowly and separately the self is defined, the greater the likelihood that the personal influences and social forces acting on individuals are experienced as external and alien. The creation of a 'separate self' could be a major dynamic in modern life, impacting on everything from citizenship and social trust, cohesion and engagement, to the intimacy of friendships and the quality of family life.

There is direct evidence of the role of defining cultural qualities in health, including strong correlations between individualism and youth suicide rates in developed nations (47). Their importance 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 rates in young people of Indian origin (27). (This is not only a large effect relative to other social factors, it runs counter to the usual epidemiological view of ethnicity and race as a source of disadvantage.)

Concerns about the culture of modern societies are also apparent in public perceptions of quality of life (5). 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'.

A close link exists between Western culture and the ideology of capitalism; each feeds off the other. A comprehensive analysis (48) 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.

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.

Such deep cultural changes help to explain why young people's wellbeing seems to have declined in recent decades despite the benefits that should have flowed from other social changes, including greater gender, religious, ethnic and racial equality and tolerance.

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 (5,49). Together with other 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 what they do.

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 societies and cultures define and pursue 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.

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 meaningful and worthwhile.

We might well ask why we should bother with such a broad analysis of whether or not life is getting better. 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)? There are several reasons.

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.

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 social reforms. Health expenditure is rising and in 2004 accounted for an average 9% of GDP in rich countries (9.2% in Australia), up from 5% in 1970 (50); prevention and public health programs receive only about 3% of this expenditure. This trend is unsustainable and some reallocation of resources is essential. The broad analysis will help to plan for future healthcare needs and to manage their costs.

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. If young people's wellbeing is not declining, then this challenges a major theme in contemporary social criticism. If it is, 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. (This is not necessarily to warn of an impending social crisis or catastrophe. To use an appropriate analogy, we are not talking about an acute, fatal disease, but a chronic, worsening disability.)

Historically, health professions, notably medicine, have been part of a broad, progressive movement that has increased life expectancy and quality of life. Today, they appear to be, at best, countering the growing harm to health of adverse social trends. At worst, they are becoming part of the problem because of an emphasis on a biomedical model 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 chapter.

This situation suits governments because it limits the political significance of health. The politics of health is seen largely as the politics of healthcare services; it 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. Making this change requires more than a change in policies. It means redesigning the conceptual framework, or worldview, within which policy decisions are made; it means rethinking 'the defining idea' of how we make life better.

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REFERENCES

1. AIHW. Australia's health 2004. AIHW Cat. No. AUS 44. Canberra: Australian Institute of Health and Welfare, 2004.
2. AIHW. Young Australians: Their health and wellbeing 2007. AIHW Cat no. PHE-87. Canberra: Australian Institute of Health and Welfare, 2007.
3. UNICEF. Child poverty in perspective: An overview of child well-being in rich countries. Innocenti Report Card 7. Florence: UNICEF Innocenti Research Centre, 2007.
4. McMichael AJ. Human frontiers, environments and disease: past patterns, uncertain futures. Cambridge: Cambridge University Press, 2001.
5. Eckersley R. Well & good: morality, meaning and happiness. 2nd ed. Melbourne: Text Publishing, 2005.
6. AIHW. Australia's health 2006. AIHW Cat. No. AUS73. Canberra: Australian Institute of Health and Welfare, 2007.
7. ABS. Mental wealth and wellbeing: profile of adults, Australia 1997 [Catalogue No. 4326.0], Canberra: Australian Bureau of Statistics, 1998
8. Sawyer MG, Arney FM, Baghurst PA, Clark JJ, Graetz BW, Kosky RJ, Nurcombe B, Patton GC, Prior MR, Raphael B, Rey J, Whaites LC, Zubrick SR. The mental health of young people in Australia. Canberra: Australian Government Publishing Service, 2000.
9. ASG. The state of student social and emotional health. Melbourne: Australian Scholarships Group, 2007. www.asg.com.au/socialemotional
10. Kessler RC, Berglund P, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication', Arch Gen Psychiat 2005;62:593-602.
11. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiat 2005;62:617-27.
12. Collishaw S, Maughan B, Goodman R, Pickles A. Time trends in adolescent mental health. J Child Psychol Psyc 2004;45:1350-62.
13. Collishaw S, Pickles A, Natarajan L, Maughan B. 20-year Trends in Depression and Anxiety in England. Poster paper presented at the International Society for Research in Child and Adolescent Psychiatry Conference, London, 21 June 2007.
14. Hjern A. Chapter 7: Children's and young people's health. Scand J Public Healt 2006;34(3):165-83.
15. Stefansson C-G. Chapter 5.5: Major public health problems – mental ill-health. Scand J Public Healt 2006;34(3):87-103.
16. Costello EJ, Erkanli A, Angold A. Is there an epidemic of child or adolescent depression? J Child Psychol Psyc 2006;47:1263-71.
17. Booth M, Okely AD, Denney-Wilson E, Hardy L, Tang B, Dobbins T. NSW schools physical activity and nutrition survey (SPANS) 2004: summary report. Sydney: NSW Department of Health, 2006.
18. Poulos LM, Water A-M, Correll PK, Loblay RH, Marks GB. Trends in hospitalizations for anaphylaxis, angioedema, and urticaria in Australia, 1993-1994 to 2004-2005. J Allergy Clin Immonol 2007;120:878-84.

19. Dollman J, Lewis F. Trends in health attitudes and self-perceptions among school-age South Australians between 1985 and 2004. Aust NZ J Pub Health 2007;31(5):407-13.
20. Tucci J, Mitchell J, Goddard C. The changing face of parenting. Melbourne: Australian Childhood Foundation, 2005.
21. Jorm AF, Butterworth P. Changes in psychological distress in Australia over an 8-year period: evidence of worsening in young men. ANZ J Psychiatry 2006;40:47-50.
22. ABS. Alcohol consumption in Australia: a snapshot, 2004-05. Canberra: Australian Bureau of Statistics, 2006.
23. Degenhardt L, Roxborough A, McKetin R. Hospital separations for cannabis- and methamphetamine-related psychotic episodes in Australia. MJA 2007;186(7):342-5.
24. Smart D, Sanson, A. What is life like for young Australians today, and how well are they faring? Family Matters 2005;70:46-53.
25. Eckersley R, Cahill H, Wierenga A, Wyn, J. Generations in dialogue about the future: the hopes and fears of young Australians. Canberra: Australia 21 Ltd. Melbourne: Australian Youth Research Centre, 2007. www.australia21.org.au .
26. Eckersley R, Wierenga A, Wyn J. Flashpoints and signposts: pathways to success and wellbeing for Australia's young people. Canberra: Australia 21 Ltd. Melbourne: Australian Youth Research Centre and VicHealth, 2006. www.australia21.org.au .
27. Patel V, Flisher AJ, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. Lancet 2007;369:1302-13.
28. Eckersley R. Is modern Western culture a health hazard? Int J Epidemiol 2006;35:252-8.
29. Eckersley R. Culture. In Galea, S. (ed). Macrosocial Determinants of Population Health. New York: Springer, 2007:193-209.
30. Resnick MD, Bowes G. Comment: Us and them: worldwide health issues for adolescents. Lancet 2007:369:1058-60.
31. Rutter M, Smith DJ. (eds.). Psychosocial disorders in young people: time trends and their causes. Chichester: John Wiley and Sons for Academia Europaea, 1995.
32. Strazdins L, Shipley M, Broom DH. What does family-friendly really mean? Wellbeing, time, and the quality of parents' jobs. Australian Bulletin of Labour 2007;33(2).
33. Eckersley RM. Culture, spirituality, religion and health: looking at the big picture. Med J Australia 2007;186(10):S54-S56.
34. Parker G, Gibson NA, Brotchie H, Heruc G, Rees A-M, Hadzi-Pavlovic, D. Omega-3 fatty acids and mood disorder. Am J Psychiatry 2006;163:969-78.
35. Loxley W, Toumbourou JW, Stockwell T et al. The prevention of substance use, risk and harm in Australia: a review of the evidence. Monograph. Ministerial Council on Drug Strategy 2004.
36. Anderson SE, Cohen P, Naumova EN, Jacques PF, Must A. Adolescent obesity and risk for subsequent major depressive disorder and anxiety disorder: prospective evidence. Psychosom Med 2007;69(8);740-7.

37. Goldbacher EM, Matthews KA. Are psychological characteristics related to risk of the metabolic syndrome? A review of the literature. Ann Behav Med 2007;34(3):240-52.
38. Grandjean P, Landrigan PJ. Developmental neurotoxicity of industrial chemicals. Lancet 2006;368:2167-78.
39. Corvalan C, Hales S, McMichael A et al. Ecosystems and human wellbeing: health synthesis. A report of Millennium Ecosystem Assessment. Geneva: World Health Organization, 2005. www.who.int/globalchange.
40. Twenge JM. Generation me: why today's young Americans are more confident, assertive, entitled – and more miserable than ever before. NY: Free Press, 2006.
41. Nairn A, Ormond J, Bottomley P. Watching, wanting and wellbeing: exploring the links. British National Consumer Council, no date.
42. Collishaw S, Goodman R, Pickles A, Maughan B. Modelling the contribution of changes in family life to time trends in adolescent conduct problems. Soc Sci Med 2007;65(12):2576-87.
43. Luthar SS. The culture of affluence: psychological costs of material wealth, Child Dev 2003;74:1581-93.
44. Luthar SS, Latendresse SJ. Children of the affluent: challenges to wellbeing, Curr Dir Psychol Sci 2005;14(1):49-53.
45. Beyondblue, Beaton Consulting. Research summary: Opening our eyes to depression among Australian professionals. Annual professions survey, April 2007.
46. Kasser T. The High Price of Materialism. Cambridge, MA: MIT Press, 2002.
47. Eckersley R, Dear K. Cultural correlates of youth suicide. Soc Sci Med 2002;55:1891-904.
48. Kasser T, Cohn S, Kanner AD, Ryan RM. Some costs of American corporate capitalism: A psychological exploration of values and goal conflicts. Psychol Inq 2007;18(1):1-22.
49. Eckersley RM. Progress, sustainability and human wellbeing: is a new worldview emerging? Int J Innovation and Sustainable Development 2006;1(4):304-17.
50. OECD. Health at a glance: OECD indicators 2005. Paris: OECD Publishing, 2005.

FIGURES, BOXES AND TABLES

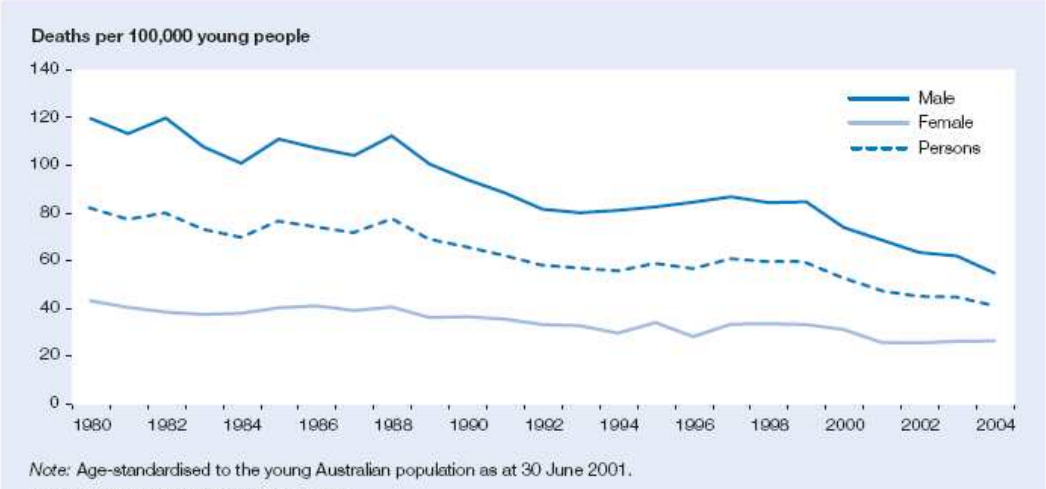

Figure 1. Death rates for Australians aged 12-24, 1980-2004 (2). Reprinted with permission from the Australian Institute of Health and Welfare.

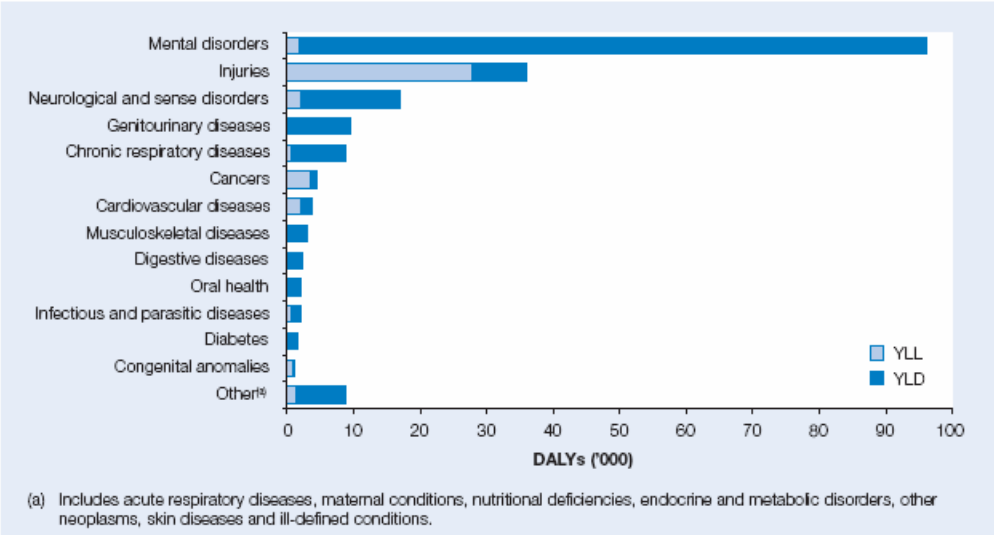

Figure 2. Burden of disease by major disease groups for Australians aged 15-24, 2003. DALYs, disability-adjusted life years, represent lost years of healthy life; YLL, years of life lost, measures premature death due to disease or injury; YLD measures years of healthy life lost due to disease, disability or injury (2). Reprinted with permission from the Australian Institute of Health and Welfare.

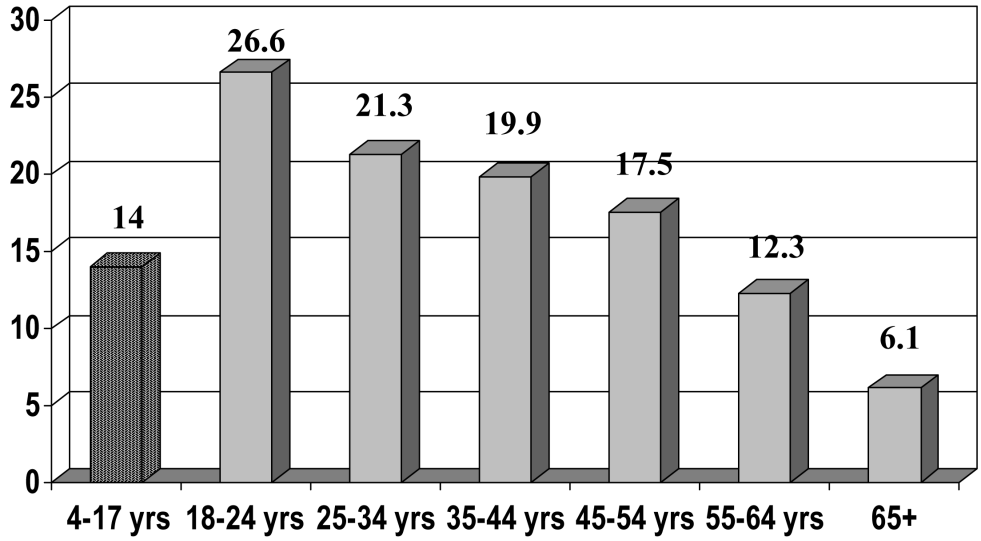

Figure 3: Prevalence(%) of mental health problems among Australian, by age (based on data from 7,8).

Box 1. Recent overseas research on trends in young people's mental health

A major US study (10,11) 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 at least partly real rather than a methodological artifact.

A UK study (12) 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 (13) 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 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 (14,15). 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 one or more psychosomatic symptoms such as abdominal pains, headaches and disturbed sleep; the proportions have increased continuously since the mid-1980s.

A recent meta-analysis (16) 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.

Box 2.Young Australians: most satisfied but half have a 'problem'

The Australian Temperament Study has followed a large, representative group of Victorian children from infancy to age 19-20 in 2002. A recent analysis (24) 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.

Both sets of findings need qualifying. The most troubled people often drop out of such studies, and people also tend to give what they think are the 'right' answers. Responses to questions about happiness and life satisfaction are also biased by the nature of these qualities, especially that happiness and satisfaction reflect the use of various cognitive devices to maintain these states, whatever people's circumstances (5). These include holding illusory self-beliefs, rationalization, adaptation and mitigating negative experiences. To some extent, people take their situation as a given, and assess their subjective wellbeing within that context.

On the other hand, 'antisocial behaviour' in this study included any illicit drug use in the past month, and problem alcohol use was defined as binge drinking (7 or more drinks for males and 5 or more for females) on five or more occasions in the past month. While these categories may be reasonable from a health perspective, many young people would not see this drug and alcohol use as a problem and could even consider it as part of enjoying life. Alcohol and drug use can be seen as an adaptive response to life's pressures; it is also part of 'the good life' our culture promotes.

Table 1: Declining optimism about national and global futures among young Australians, aged 15-24 (1995) and 18-24 (2005) (25)

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