

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, pp. 217-227.

## **The health and wellbeing of young Australians: present patterns and future challenges**

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**Abstract:** The orthodox view of the health and wellbeing of young Australians is 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 health will mean making correspondingly fundamental social and cultural changes. To achieve this transformation, the politics of health must be seen as much more than the politics 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 better health, and not become part of the problem.

**Keywords:** health, medicine, politics, psychosocial, social determinants, wellbeing, young people

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## **INTRODUCTION**

The broad picture of the health and wellbeing of young Australians is not unambiguous or unequivocal. Positions and opinions range from the very optimistic to the deeply pessimistic. 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 a limited evidence base (and sometimes no empirical evidence at all); an incomplete understanding of a complex picture; and ideological, generational and other sources of bias and prejudice.

The orthodox, or official, view is of continuing improvement in health. Lomborg (1) summarises this position at the global level in this way: ‘...children born today – in both the industrialized world and developing countries – will live longer and be healthier, they will get more food, a better education, a higher standard of living, more leisure time and far more possibilities...’ In Australia, the official position, as articulated by the Australian Institute of Health and Welfare (2), is that young people ‘generally enjoy a level of health that is good and has improved in recent times, as indicated by levels of mortality, morbidity and disability’.

Variations on this position include that, with health improving, attention needs to be focused on social inequalities in health, which remain marked and have increased in some instances (3). Another is found in some recent social commentaries on youth that propose a new generational improvement in wellbeing. Thus Huntley (4) says that in contrast to

Generation X, today's youth, Generation Y, are 'a happy, well-behaved and optimistic bunch....This is a healthy demographic, reporting low levels of psychological distress'.

In this paper, I want to argue against the orthodox position, while acknowledging the ambiguity and complexity of young people's health and wellbeing. I will present an overview to illustrate the diverse and sometimes contradictory evidence on the patterns and trends; show that some of these 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.

Before presenting my case, I want to make a few important points. 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. I define health very broadly to include all aspects of wellbeing, so I use these terms somewhat interchangeably and sometimes together to emphasise the many dimensions of health: illness and wellness, physical and psychological, objective and subjective. Health and wellbeing are measured variously as mortality and morbidity (physical and mental), happiness and life satisfaction. 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).

For historical reasons, the official view emphasises material conditions and physical health, especially longevity; the contribution of mental illness to the burden of disease has only recently begun to be acknowledged (5). Quality of life is not the same as standard of living, and how well we live is not just a matter of how long we live, especially in rich nations such as Australia. (As a GP told me recently, 'Before we just tried to keep people alive; now people are staying alive, but they're not very happy.').

The paper emphasises psychosocial problems, such as depression, anxiety, drug abuse, delinquency and suicide. These problems involve interactions between social conditions and individual psychology and behaviour, so reflect better than general mortality and morbidity data the effects of today's social conditions on quality of life. They also have implications for physical health, with growing evidence of links between psychological and physical wellbeing (5).

## **OVERVIEW**

Historically, the health of young Australians reflects the overall trends in population health in the developed world. The toll of infectious diseases has fallen as a result of medical advances such as antibiotics and vaccines, and improved hygiene, nutrition and living and working conditions (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 (6). [This is not to say that infectious diseases have become

insignificant: for example, sexually transmitted diseases are on the rise among young people (7).]

Today, the major causes of death among young people are, in order: road accidents, suicide, cancer and accidental poisoning (including drug overdoses) (7). Measured by mortality, young people's health continues to improve (7). Building on the long-term decline in infectious disease deaths, 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 been increasing rapidly (at least among young males). Surveys of young people consistently show that over 80 per cent say that they are healthy, happy and satisfied with their lives (7,8).

However, other health indicators show many young people are not faring well. The adverse trends in young people's health range across both physical and mental problems, and from relatively minor but common complaints to rare but serious problems. A fifth to a third of young people are experiencing significant psychological stress and distress at any one time, with some estimates of the prevalence of a more general malaise (frequent headaches, indigestion and sleeplessness) reaching 50% (8).

Young people are experiencing mental health problems at higher rates than older age groups, and retaining their increased risk beyond youth into older age (8). A 1997 national survey 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) (9). A 1998 survey of children and adolescents (aged 4-17) found 14% were experiencing mental problems at the time of the survey (10). Psychological distress among youth appears to have increased since then (7,11).

*[Insert Figures 1 & 2 about here.]*

These findings are consistent with overseas studies, which also suggest that psychosocial problems have become more common in young people in recent decades (8,13,14), although the evidence is sometimes contradictory and the issue remains contentious (14,15). The latest US research shows 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 (16,17). The lifetime risk increases for successively younger generations: those aged 18 to 29 have a fourfold higher risk than those aged 60 and over.

Almost a third of young males and a quarter of young females (aged 12-24) are overweight or obese, and these proportions are rising (7). The changes place young people at risk of a wide range of health problems later in life, including diabetes, heart disease and some cancers; there may also be effects on mental health, including through the stigmatisation of the obese. A recent study of students aged 7 to 16 found that the prevalence of overweight and obesity had risen from 11% in 1985 to 25% in 2004 (18). 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.

Other research provides more indirect evidence of young Australians' situation. One survey 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' (19). 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 (8,20,21). That young people share this lack of confidence about social conditions is an aspect of quality of life, one which impacts on personal wellbeing (8,21).

### **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 says little about general living conditions. The reversals in suicide and drug-related deaths within the past decade do not necessarily reflect an improvement in underlying health.

Hospitalisations of young people for intentional self-harm and emotional and behavioural problems increased during the period that the youth suicide rate fell (7). Psychological distress has also increased over this period (7), particularly among young men (11). This evidence suggests the explanation for the fall in suicide is 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 methamphetamine use and risky drinking (22,23,24).

A recent study illustrates well the contrasting picture that emerges from different measures (25). It 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 their lives. Both sets of findings need to be qualified to give a more balanced, and reconcilable, view of their wellbeing (see box).

*[Insert box about here.]*

Another common point of confusion concerns the question of whether young people are optimistic or pessimistic, which is important to wellbeing (20,21). This depends on whether we are measuring their attitude to their personal future, or to the future of society 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). 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). 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).

*[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. The cultures of scientific disciplines are so ingrained that they appear to be the natural and right way to look at the world. 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**

A wide range of factors have been implicated in the patterns and trends in young people's health: structural changes such as increasing inequality, work strains, education pressures, family breakdown, mobility, and urbanisation (5,6,8,13); cultural changes – for example, excessive materialism and individualism (5,8,13); increasing media use and changing media content, linked to violence, consumerism, and social fragmentation and isolation (8,27); 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 (28); changes in diet, for example, a large increase in the ratio of omega 6 to omega 3 fatty acids, which has been linked to cardiovascular disease and mood disorders (29); comorbidity, especially between drug use and mental illness (22,23); and environmental changes, such as the effect of chemical pollution on endocrine function, disrupting disease resistance and reproduction (30).

The last - environmental changes - looms large as a future health risk, especially global warming and its consequences. A major 2005 report (30) 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. First, they interact with other 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 shaped by environmental factor such as adverse life events (8); changes in personality and other psychological traits, including increased anxiety (neuroticism) and decreased sense of control, which are themselves a

response to social changes (8,31); and aspects of foetal, child and adolescent development, which increase vulnerability to risk (8,26).

Secondly, the health effects are not usually independent, direct and immediate; rather the causal pathways are complex, being often interdependent, indirect and delayed. These pathways involve intense interactions between the objective and subjective worlds. For example, many of the factors are linked to increasing individualism - the relaxation of social ties and regulation and the belief that people are independent of each other - which is a defining feature of modern societies (5,8). The literature here is itself ambivalent, noting that the freedom people now have is both exhilarating and disturbing, that with freedom come both new opportunities for personal experience and growth and the anxiety of social dislocation.

The costs of individualism relate to a loss of both social support and personal control, which are important to health (5,8). 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 contingent or narcissistic form that requires constant external validation and affirmation; and the confusion of autonomy with independence.

Thirdly, the trends in some of the explanatory factors provide indirect corroboration of evidence that psychosocial problems have risen among youth. For example, if family breakdown, heavy media use, low personal control, or low dietary omega 3 fatty acids are implicated in these disorders, and have increased over time, these would predict decreased wellbeing.

Finally, some of the factors that explain social patterns of health may not be implicated in the trends over time. For example, studies typically show a socio-economic gradient in mental health problems (that is, higher prevalence in lower-income and single-parent and blended families) (8, 10). However, a UK study (14) of 15-16-year-olds found some problems had risen between 1974 and 1999 among both boys and girls and across all family types and social classes, suggesting that 'relatively broad societal changes (for example, in the media, youth culture or social cohesion) are affecting adolescent mental health'.

Acknowledging these pervasive and diverse social impacts helps us to understand why young people's wellbeing appears to have declined in recent decades despite the psychosocial benefits that should have flowed from other social changes, including greater gender, religious, ethnic and racial equality and tolerance (themselves a result of increasing individualism).

Most, if not all, of the explanatory factors are associated with a particular form of national development, material progress, which focuses on economic growth and material welfare (8,32). Along with other lines of evidence, including trends in alternative

measures of progress, they point to a state of 'overdevelopment', where social changes that were once beneficial to health have now become harmful. As a result, material progress is coming under growing challenge from a new model, sustainable development, which does not accord economic growth overriding priority, but, instead, 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 changes in Australia (and other Western societies) are impacting adversely on young people's health and wellbeing.

Readers might well ask why we should bother with a broad analysis of young people's health, with the question of whether it is improving or deteriorating. Why not simply discuss health on a disease-by-disease, case-by-case basis, given this is how we tend to treat it (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, it generates questions that otherwise would not be asked; it creates 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 degrading will determine what approaches we should take to health. If quality of life is improving for the majority, our 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 OECD countries (9.2% in Australia), up from 5% in 1970 (33). Prevention and public health programs receive only about 3% of this expenditure (33); about 25%, perhaps more, of health expenditure during an individual's lifetime is spent in the last couple of years of life (34). This trend is unsustainable and some reallocation of resources is essential. The broad analysis will help us to plan for future healthcare needs and to manage their costs.
- *Society:* Finally, 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 (8,32). If young people's wellbeing is not deteriorating, 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.

Historically, health professions, notably medicine, have been part of a broad, progressive movement that has increased life expectancy and quality of life. Today, they are, at best,

countering the growing harm to health of adverse social trends. At worst, they are becoming part of the problem because of an overemphasis on an individual, biomedical, disease-centred approach to health (its benefits notwithstanding), and their political advocacy for this perspective at the expense of a more social, preventative model.

This situation suits governments because it limits the political significance of health. From the point of view presented in this paper, the politics of health is much more than the politics of healthcare services; it should be the politics of everything, the defining goal of government. Systems are defined by the purpose they are designed to serve; change the purpose and the system changes. The central purpose of our present social system is to create wealth; we need to make that purpose to create health.

## REFERENCES

1. Lomborg B. *The skeptical environmentalist: measuring the real state of the world*. Cambridge: Cambridge University Press, 2001.
2. AIHW. *Australia's health 2004*. [AIHW Cat. No. AUS 44]. Canberra: Australian Institute of Health and Welfare, 2004.
3. Richardson, S, Prior, M. *No time to lose: the wellbeing of Australia's children*. Melbourne: Melbourne University Press, 2005.
4. Huntley R. *The world according to Y: inside the new adult generation*. Sydney: Allen & Unwin, 2006.
5. Eckersley R. Is modern Western culture a health hazard? *Int J Epidemiol* 2006; 35: 252-8.
6. McMichael AJ. *Human frontiers, environments and disease: past patterns, uncertain futures*. Cambridge: Cambridge University Press, 2001.
7. AIHW. *Australia's young people: their health and wellbeing 2003* [AIHW Catalogue no. PHE-50], Canberra: Australian Institute of Health and Welfare, 2003.
8. Eckersley R. *Well & good: morality, meaning and happiness*. 2<sup>nd</sup> ed. Melbourne: Text Publishing, 2005.
9. ABS. *Mental wealth and wellbeing: profile of adults, Australia 1997* [Catalogue No. 4326.0], Canberra: Australian Bureau of Statistics, 1998
10. 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.
11. 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.
12. Steenkamp, M, Harrison, J. *Suicide and hospitalised self-harm in Australia*. [AIHW cat. no. INJCAT 30.] Canberra: Australian Institute of Health and Welfare, November, 2000.
13. Rutter M, Smith DJ. (eds.). *Psychosocial disorders in young people: time trends and their causes*. Chichester: John Wiley and Sons for Academia Europaea, 1995.

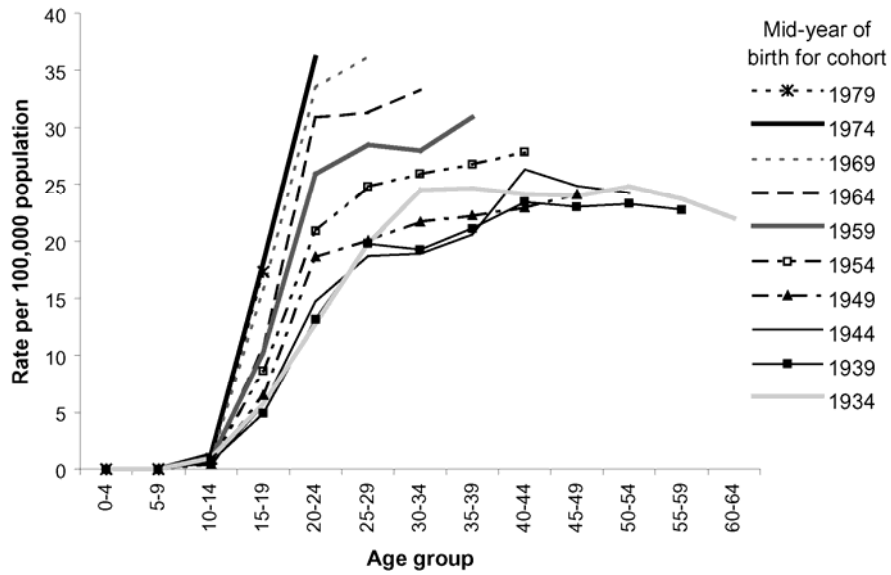


14. Collishaw S, Maughan B, Goodman R, Pickles A. Time trends in adolescent mental health. *J Child Psychol Psyc* 2004; 45: 1350-62.
15. Costello, EJ, Erkanli, A, Angold, A. Is there an epidemic of child or adolescent depression? *J Child Psychol Psyc* 2006; 47: 1263-71.
16. Kessler RC, Berglund P, Demler 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.
17. 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.
18. 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.
19. Tucci J, Mitchell J, Goddard C. The changing face of parenting. Melbourne: Australian Childhood Foundation, 2005.
20. Eckersley R. Dreams and expectations: young people's expected and preferred futures and their significance for education. *Futures* 1999; 31: 73-90.
21. 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](http://www.australia21.org.au) .
22. 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.
23. Australian National Council on Drugs. Methamphetamines: position paper. Canberra: ANCD, 2007 [www.ancd.org.au](http://www.ancd.org.au) .
24. ABS. Alcohol consumption in Australia: a snapshot, 2004-05. Canberra: Australian Bureau of Statistics, 2006.
25. Smart D, Sanson, A. What is life like for young Australians today, and how well are they faring? *Family Matters* 2005; 70, Autumn: 46-53.
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](http://www.australia21.org.au) .
27. Millwood Hargrave A, Livingston S, Harm and offence in media content: a review of the evidence. Bristol: Intellect, 2006.
28. Eckersley RM. Culture, spirituality, religion and health: looking at the big picture. *Med J Australia* 2007; 186 (10): S54-S56.
29. 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.
30. 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](http://www.who.int/globalchange).
31. Twenge JM. Generation me: why today's young Americans are more confident, assertive, entitled – and more miserable than ever before. NY: Free Press, 2006.
32. Eckersley RM. Progress, sustainability and human wellbeing: is a new worldview emerging? *Int J Innovation and Sustainable Development* 2006; 1 (4): 304-17.

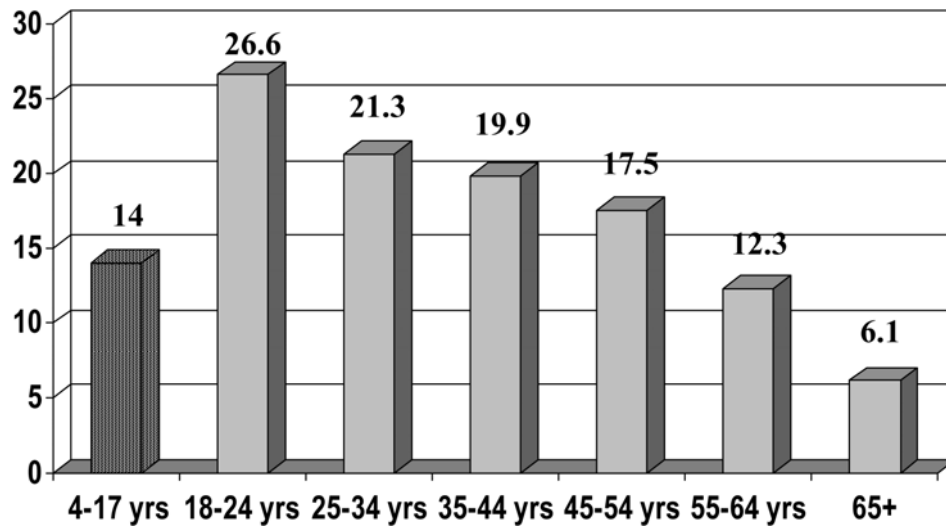
33. OECD 2005. Health at a glance: OECD indicators 2005. Paris: OECD Publishing.
34. Van Weel C, Michels J 1997. Dying, not old age, to blame for costs of health care. *Lancet* 350: 1159-60.

## Figures and tables

*Figure 1: Male suicide by age and birth cohort, Australia (12).*



**Figure 2:** Prevalence(%) of mental health problems among Australian, by age (9,10).



***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 (25) 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 (8). 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 seem 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 (21)\*.

<i>Year</i> <i>Question</i>	<i>1995</i> <i>%</i>	<i>2005</i> <i>%</i>
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

\* Differences between years are indicative only, and are not necessarily statistically significant.