Opportunities and challenges for promoting health in a changing world

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Introduction

A recent review of priorities for the Western Australian Health Promotion Foundation’s (Healthway) strategic plan provided us with an opportunity to consider the global context within which health promotion practitioners and policy makers are now operating and implications for policy and practice in Australia. We concluded that since our earlier review of priorities in 1998, “nothing has changed, but everything has changed”. With some minor modification, risk factors and major causes of death and disability have, by and large, remained much the same over the five-year period. However, promoting health at the beginning of the 21st century is not the same as promoting health five years ago and health promotion practitioners and policy makers seeking to reach high-risk target groups ignore the global context at their peril.

This is not meant to be a comprehensive review, but rather an overview to stimulate debate and discussion. The article starts with a brief consideration of high-priority risk factors, but the main focus is on global events and trends that might affect health promotion policy and practice (referred to hereafter as ‘health promotion’). We attempt to identify some practical implications that may need to be considered by practitioners and policy makers in the future.

Priority risk factors

With the exception of the addition of asthma, since 1998 there has been little change in Australia in priority diseases and conditions or behavioural risk factors. However, greater efforts are required in tobacco control, preventing and reducing obesity and overweight through physical activity and good nutrition, and mental health.

So what?

There needs to be greater emphasis on building effective partnerships to tackle social determinants of health, as well as leadership development to facilitate participation by disadvantage groups and advocacy for policy and legislative change. Moreover, the field needs to keep abreast with technological changes that will present challenges and opportunities for communicating with target groups.
**Tobacco control.** Although recognised as a ‘blue chip’ public health investment, there is disquiet about the level of tobacco control funding in Australia. While considerable progress has been made in tobacco over the past 20 years, continued effort is needed. Comprehensive, long-term, government-funded interventions targeting individuals and population groups and policy and legislative change are still essential to prevent tobacco use initiation; reduce tobacco use; and reduce exposure to environmental tobacco smoke. In addition, a higher level of funding to tobacco advocacy groups is required to enable pressure to be maintained on political leaders for continued legislative reform.

**Obesity and overweight.** The global epidemic of overweight and obesity is raising concerns about the likely unprecedented future health, social and economic costs unless the epidemic can be curbed. In Australia, about one-half of adult women and almost two-thirds of adult men are overweight or obese and there are growing levels of obesity in children and older adults. It is generally agreed that the dramatic change in weight status seen globally over the past two to three decades is due to an energy imbalance caused by changes in the environment: that is, the creation of ‘obesogenic environments’ that promote excessive food consumption (e.g. increased reliance on foods away from home, food advertising, marketing, promotion and pricing of food) and discourage physical activity. The alarming trends – particularly in childhood obesity – have prompted calls for strategies that mirror public health’s efforts in tobacco control. These include the need for the formation of advocacy groups with the specific aims of curbing food marketing to children through the media and schools, preventing manufacturers, restaurants and fast-food outlets using increased portion sizes as a marketing tool; as well as overcoming real and perceived barriers to children walking and cycling to school.

**Mental health.** The World Health Organization (WHO) estimates that by 2020 in developed countries, unipolar depression will be the third-leading cause of disability-adjusted life years and self-inflicted injuries the 10th-leading cause. These trends are likely to have major effects on the health budget. In Australia in 1996, mental disorders were the leading cause of years of healthy life lost due to disability and the third-leading cause of the overall burden of disease. It is estimated that nearly 18% of Australians had experienced mental health disorder symptoms in any year. Recently, the National Heart Foundation recognised depression, social isolation and lack of social support as independent risk factors for coronary heart disease. Moreover, Marmot and colleagues identified lack of control, social isolation and lack of social support as social determinants of health that help explain health inequalities.

Prevention efforts are ideally placed in childhood because experiences in childhood lay the foundation for mental health later in life. In addition, promoting good mental health also has synergies with promoting physical activity because participation in physical activity positively influences mild depression. Encouraging greater participation in society (e.g. through sport and the arts) also can beneficially influence mental health by providing opportunities for meaningful participation, increasing self-mastery, enhancing social support and decreasing social isolation. Mental health promotion at local and State levels is often hampered because no lead agency perceives the topic as its priority area. Given WHO’s prediction of an increase in mental health problems, leadership at the local and State level is critical for implementing effective prevention programs.

**Priority target groups**

**Disadvantaged populations.** There is an urgent need to go beyond the rhetoric and for decisive action to be taken to reduce inequalities in health. Regardless of how socio-economic status is measured (by income, education, the socio-economic status of place of residence, occupation), those in lower socio-economic groups – particularly Indigenous Australians – have poorer health than other Australians. The life expectancy of Indigenous Australians is 20 years less than other Australians, and Indigenous Australians experience unacceptably higher levels of morbidity and mortality. The health status of Indigenous Australians is a national tragedy and urgent action is required.

A 1999 review on social inequalities in health by Turrell and colleagues concluded that “… if health promotion (sic) is to be effective in reducing health inequalities in health status between SES groups, it will have to move beyond behavioural measures to structural changes – that is, to intersectoral measures concerning housing, education, employment, etc”. While people from disadvantaged backgrounds express a desire for health information and change, they are often unable to act on information because of practical constraints such as time, money and access. Thus, they concluded that at the population level, individual-level interventions aimed at strengthening individuals and families are limited in terms of their ability to narrow health differentials. Programs that include environmental change aimed at reducing structural barriers are essential. Community development strategies were also identified as a high priority as they focus on strengthening local communities by building community ties and networks. Given that perceived control is a key concept in understanding socio-economic differences in health, empowering disadvantaged groups by providing opportunities to drive their own interventions may be doubly beneficial.

Clearly, the health sector cannot tackle these problems alone. More than ever before, health organisations need partnerships with sectors outside of health with the aim of working with
local communities to assist them to develop programs they perceive will improve the health of local residents. This may include programs apparently unrelated to health. Turrell and colleagues concluded that “… community development initiatives that do not specifically target a health issue can nonetheless result in improved health through the enhancement of quality of life”.

**Children and young people.** Experience in early life has been identified as a critical social determinant of health, thus emphasising the need for programs targeting children, adolescents and mothers.

For adolescents, ‘health promoting schools’ – especially in disadvantaged areas – offer a practical strategy through which health inequalities can be redressed and high-risk populations can be targeted. For example, noting the failure of efforts to curb the supply of drugs, Catford has argued that greater effort is required using a health-promotion approach focused on increasing sense of connectedness and resilience in young people. A sense of connectedness and resilience has been found to protect young people from developing anti-social behaviours, including drug use. In addition, creating caring school environments where cognitive skills are taught to children at risk is a means of decreasing depression in young people. Thus, Catford has suggested that health-promoting schools are one of the best buys to reach adolescents.

**The global context for health promotion at the beginning of the 21st century**

While risk factors and target groups remain relatively unchanged, the context within which health promotion is operating now is very different. The section that follows considers some of the global factors that are impinging on health promotion locally and some of the implications for policy and practice.

**We live in uncertain times.** Global events such as the terrorist attacks in New York on 11 September 2001 and the terrorist bombings in Bali in 2002, as well as heightened awareness of terrorist acts, the outbreaks of severe acute respiratory syndrome (SARS) and avian flu in 2003 and 2004, and the war with Iraq in 2003, all combine to increase anxiety in the community. Governments worldwide are upgrading public health systems as a precaution against bioterrorist attack. In the US, some States are shifting resources from other public health activities to fund biodefence. Added to this is uncertainty generated by corporate collapses and corporate downsizing, which contribute to job insecurity.

Hugh Mackay has suggested that one of the positive outcomes of uncertainty is a tendency for people to ‘re-tribalise’ and take comfort in each other. However, a negative outcome of re-tribalisation is the tendency for some people to discriminate against those not included in the tribe: i.e. the potential for a rise in racism. Racism and prejudice against Indigenous Australians contributes additional detrimental effects to their health and well-being. In recent years, Muslim immigrants have experienced unprecedented racism. Moreover, during 2002/03, the Australian Government’s handling of border control and refugees in the face of growing international criticism points to its confidence in the community mood to justify its hardline stance.

Stress, job insecurity, social exclusion and racism are all social determinants of health than cannot be ignored by our field. What role can health promotion play in helping to counter fear and build community strength? Efforts to build community are clearly important. In recent years, there have been a number of articles promoting sport and the arts as vehicles through which social inclusion and social support can be achieved, particularly when targeting young people. Active participation in sport and the arts can provide opportunities to foster trust and relationship formation – elements of social capital and means of addressing social determinants of health. Moreover, sport and the arts can be used to promote diversity and tolerance through greater involvement of multi-cultural groups, and – for example – working with sport to develop policies that encourage social inclusion and minimise racism (e.g. such as being undertaken by VicHealth).

However, simply introducing sport, physical activity, arts or community programs is not enough: the atmosphere created by leaders and the provision of adequate infrastructure support to overcome structural impediments to participation are critical success factors. Thus, leadership development is required for those working with young and disadvantaged populations, as well as efforts to reduce costs associated with participation.

**We live in a violent society.** Violence places a burden on the health and well-being of the population. The WHO recently recognised violence as a public health issue requiring a public health response to address its root causes. Each year, nearly two million people worldwide die as a result of violence and many more are injured and suffer a range of physical, sexual and mental health problems. Globally, billions of dollars are spent on violence-related health care, law enforcement and lost productivity. The causes of violence are complex, involving an interplay between biological, social, cultural, economic and political factors that influence individuals, groups, families, communities and society. Predisposing factors that contribute to violence include alcohol and drug abuse, social isolation, and stressful events or circumstances including poverty. In addition, social inequalities resulting in an unequal access to resources is a major factor contributing to violence. There is evidence that low social capital is associated with violence, crime and deprivation and in turn, with mortality rates.

The WHO has recommended a number of public health
interventions aimed at addressing the root causes of violence, many of which relate to social determinants of health, including: prenatal and perinatal health care for mothers; social development programs for children and adolescents; good parenting practice training; media campaigns designed to change social norms; as well as improvements to urban infrastructure.43 Our field can play a role by devising programs aimed at social determinants of health including programs targeting children, young people and parents.

The world seems to be getting smaller. Never before in human history has the world been so connected. In a globalised world, information is readily available and can be distributed worldwide with the touch of a computer key. Despite the well-justified fear of a ‘technological divide’ between socio-economic groups, access to health information is unprecedented. There is a growing literature on the impact of globalisation on population health:

- Increasing numbers of people travel throughout their State, nationally and internationally, which aids the transmission of infectious diseases as evidenced by the 2003 outbreak of the SARS virus.
- There is growing concern that globalisation has the potential to increase inequalities between the rich and the poor.49
- Large multinationals are encouraging labour market reform, resulting in corporate downsizing, greater dependence on part-time and temporary jobs without benefits, and weakening unions – all of which create a growing sense of economic and employment insecurity, which are social determinants of health.23
- A central feature of globalisation is the creation of opportunities for trade, globalised marketing and the creation of norms by global corporations. For example, it is estimated that the US food industry spends more than $US30 billion annually worldwide on advertising and promotion.50
- There is increasing concern that globalisation is fuelling an epidemic of diet-related diseases worldwide through the promotion of energy-dense foodstuffs and diets.
- World Trade Organization agreements designed to facilitate trade between countries have the potential to limit the ability of countries to legislate against health-compromising marketing practices at the expense of interfering with trade.48

Concern about the impact of globalisation on health has prompted the WHO to develop a global strategy to draw industry’s attention to its responsibility to promote healthy diets and physical activity.50 Global issues that need to be addressed include limitations on the amounts of fat, salt and sugar in foods; simple and more comprehensive labelling; and the regulation of food marketing to children. On a practical level, our field can play a role in the establishment of coalitions aimed at lobbying for reform of industry marketing practices that are detrimental to health, for example, greater regulation of marketing of food to children.

We live in an ageing society. In developed countries worldwide, it is predicted that by 2020 the population aged 65 years and over will have increased by 71%.44 In Australia in 2001, 12% of the population was aged 65 years and over. This is estimated to rise to 16% by 2016 and by 2051, more than six million Australians will be aged over 65 (25%). A number of reviews have considered the impact of an ageing population on health costs and have suggested that the changing demographic composition of Australia will have a considerable but manageable effect on the projected cost of health services.51 Increased expenditure associated with an ageing population is predicted to be offset by a decline in resources required for youth programs and education.52 Nevertheless, some suggest that it is not so much the cost of an ageing population that threatens a blowout in health expenditure, but rather the cost of increasing quality of health technology and delivery.52

In recent years, disability rates in older age have declined, largely as a consequence of positive behaviour choices in early life. Many health problems in older life can be postponed or delayed by adopting healthier habits in early life,53-55 thus strategies implemented now will have a major impact on the health of future older cohorts. Primary prevention behaviours (such as physical exercise, healthy diet, moderation of alcohol use, not smoking and use of cancer screening) help prevent frailty and delay the onset of disability.53-54

Encouraging older people to remain active as they age is also a priority55 and is now a key strategy in some countries.56 To this end, the WHO has initiated a Global Movement for Active Ageing with a specific focus on physical activity.53,54 However, strategies that promote mobility and independence, as well as reduce social exclusion and increase social support,56 are required to ensure individuals can achieve personal goals and can contribute to society.57

Individual and environmental interventions that prevent falls, encourage regular exercise and encourage better use of pharmaceutical medicines have the potential to prevent the loss of function and improve quality of life in older people.55 Thus, the main focus of health promotion interventions in older people is to maintain and improve function (e.g. maintain or increase physical activity) and to maintain and increase quality of life (e.g. reduce social isolation by encouraging meaningful participation and access to public transport). Our field has a major part to play in facilitating such active participation (e.g. lobbying for access to public transport).

We live in a rapidly changing technological world. Access to television, radio, computers, e-mail, the internet, and pay TV...
has revolutionised access to information, the way we use information, the way we work and the way we entertain ourselves. As noted by the OECD, technology is transforming virtually every familiar aspect of daily living, and its impact on society will be every bit as radical as that of the Industrial Revolution more than a century ago.

These changes are thought to have decreased our face-to-face interactions with each other and contributed to declining social capital. They have also resulted in a significant increase in the level of sedentariness in the community. For example, on average, children watch 2½ hours of commercial television per day and are exposed to approximately 25,000 commercials per year. In addition, they are exposed to advertising on pay TV and in banner ads when they use the internet. While children are watching television or using the computer, they are not participating in physically active pursuits and this may be contributing to the increase in overweight and obesity.

Another byproduct of the rapidly changing technological world is that efforts to promote health using the mass media will have many more channels of communication through which to target specific target groups. With the growth in pay TV, pay radio (e.g. the introduction of satellite radio stations with no advertising in the US), and the growth in MP3 technology that allows music to be downloaded from the Web and used on digital music players such as iPods, it may become increasingly difficult to market health messages using mass media. Although an increase in media channels may assist in targeting specific segments, the cost of reaching a wide range of people through the mass media may stretch health promotion budgets. Moreover, if there is an increase in channels that do not include advertising, the potential to market to some subgroups may be limited.

While changes in technology present problems, there are also opportunities for public health interventions, including: (1) the scope to reach a mass audience; (2) the potential cost-effectiveness of internet-based interventions; (3) the opportunities to support individually tailored prevention programs; (4) the capacity for the internet to support automated applications that guarantee program fidelity; (5) the options for convenient delivery of intervention booster sessions; (6) the anonymity of the internet that appeals to some users; and (7) the potential for programs to be easily refined and targeted. Nevertheless, there are many challenges to overcome and the full potential of the changing technologies is yet to be fully realised. There also are inequities in access to technologies such as the internet that will need to be overcome to ensure that the ‘technological divide’ does not increase health inequalities between high and low socio-economic groups. This includes those over 55 years, who are less likely to access the internet despite their relative wealth. There must be greater effort to remove barriers associated with disadvantaged groups accessing information technologies, including skills training. Our field needs to remain abreast of new technologies, particularly in terms of reaching young people. Greater effort needs to be made to explore the potential of changing technology through health promotion projects and health promotion research. Moreover, we need to define what role our field should play in partnering with others to ensure access to technology, e.g. in disadvantaged areas and for older adults.

We live in a time-pressured world. Improvements in technology and accompanying productivity have created a time-pressured, faster and more stressful pace of life. These changes in time pressures affect a range of health risk factors including stress, diet, physical activity and access to social support derived from family and friends. Time constraints hinder community participation, civic engagement and volunteerism – all important elements of social capital. In terms of obesity and overweight, Hill suggests that the quest for improved productivity and efficiency has increased the demand for getting a ‘better deal’ and may be contributing to the rise in ‘super sizing’ of product lines as a way of competing for the fast-food dollar. Moreover, increasing demands on time have reduced traditional food preparation, increased the demand for pre-packaged foods, and increased the need for people to get to places quicker rather than walk. While it may not be possible to change the pace at which we live, we need to take time pressures into account when designing programs and, particularly, in terms of creating supportive environments.

We continue to unravel the mystery of life. The full potential of the sequencing of the human genome will not be realised for some time. While only about 2% of deaths in the US may be attributed to purely genetic disease, McGinnis estimates that about 60% of deaths have some genetic component; for example, diabetes, cardiovascular disease and cancer. Genomics-based drugs are expected to enter efficacy trials over the next few years and new interventions with specificity for individual vulnerabilities to environmental and behavioural factors will become available. There is some evidence, for example, that the propensity towards being spontaneously active could be influenced by genotype. Future interventions will aim to alter genetic determinants of disease and disability. Despite the potential of the human genome, behavioural choices represent the single most important factor influencing our health and the choices we make are affected by the choices available. Thus, social determinants will remain strongly associated with health and will continue to require intervention. As suggested by McGinnis, whether a gene is expressed can be determined by environmental exposures or behavioural patterns, but the nature and consequences of the choices available are affected by our social circumstances. Similarly, the type of health care we need may be determined by our genes, but the type of
health service we receive may be determined by our social circumstances. Health promoters and policy makers will still have a key role to play in changing behaviours and the environment in the future to minimise the impact of a genetic predisposition and to reduce the impact of non-genetically related risk factors.

Research and clinical advances in genetics present both opportunities and challenges for health promotion. Opportunities include the potential to target information and interventions for those identified as more susceptible to ‘lifestyle’ diseases, and to partner with clinicians in promoting earlier intervention or behavioural change prior to disease onset. But there are also a number of challenges. These include concerns that an awareness of genetic predisposition may foster a sense of fatalism and erode self-responsibility for health behaviours and that predictive genetics can lead to adverse psychosocial consequences, anxiety and mental health problems for affected individuals and their families. Public understanding and responses to genetic information and advances have implications for both health promotion practice and research, as does our evolving knowledge of the interactions between genetics, environments and individual behaviour.

We need leadership. Globally, there are calls for leaders with the potential to inform, motivate and work in complex environments and across sectors. Others have suggested that while we have trained numerous health promotion practitioners to be technically competent, there are questions about whether we have trained leaders who can lead the field into its next phase of development.

Funding bodies and employers in our field are becoming aware of this need. For example, VicHealth and Healthway both fund leadership development programs. However, in addition to health sector leaders, we need leaders in other sectors who are sympathetic to health-related issues. For example, leaders who can work with Indigenous and culturally and linguistically diverse communities to initiate community development programs are required, as well as sport, arts and other leaders who can increase active participation among those living in disadvantaged areas. Academics and health-sector policy makers need to be thinking broadly about developing leaders who can meet the challenge of addressing social determinants of health by working creatively with sectors outside of health, as well as the numerous advocacy challenges that lay ahead.

**Concluding remarks**

This review has confirmed the importance of traditional risk factors for health, but at the same time has considered the global context within which we are now promoting health. The global context presents new challenges for health promotion practitioners and policy makers, placing greater emphasis on social determinants of health and intersectoral action. Although not a new idea, we have re- emphasised the need for the field to focus on advocacy to create supportive infrastructure, legislation and healthy public policy, as well as the need for building effective partnerships if it is to redress social inequalities in health. Moreover, performance indicators and methods of evaluation will need to change if these broader determinants of health are to be the focus. Health promoters in the 21st century will have to compete for attention with numerous other priorities and communicators, as well as the stresses and strains associated with uncertainty, busy-ness and the pace of technological and societal change. However, to remain relevant, we cannot ignore the global context in which we seek to achieve our objectives of a healthier society.

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