Health Promotion Journal of Australia, 2017, **28**, 175–177
https://doi.org/10.1071/HEv28n3_ED

Editorial

Health Promotion Futures

Colin Binns [A], ***Peter Howat*** [B], ***Lisa Barnett*** [C], ***James A. Smith*** [D,E] ***and Jonine Jancey*** [A,B,F]

[A]School of Public Health, Curtin University, GPO Box U1987, Perth, WA 6845, Australia.
[B]Collaboration for Evidence & Research in Public Health, Curtin University, GPO Box U1987, Perth, WA 6845, Australia.
[C]School of Health & Social Development, Deakin University, Geelong, Vic. 3220, Australia.
[D]Menzies Centre for Health Policy, University of Sydney, Sydney, NSW 2006, Australia.
[E]Menzies School of Health Research, PO Box 41096, Casuarina, NT 0811, Australia.
[F]Corresponding author. Email: j.jancey@curtin.edu.au

The current editorial team are about to end their five year tenure. Health promotion can look back on many successes that we have been able to chronicle in this journal. We acknowledge those past impacts but we also look to future trends that will impact health promotion during the next five years and that will continue to influence the health of people in our region.

Looking back at the history of health promotion, improvements in health have been largely achieved through modifying structural variables, such as economic, environmental and legislative change borne out of evidence and activism.[1] A few examples of these initiatives include the introduction of compulsory wearing of seat belts in motor vehicles, vaccinations,[1] fluoridation of water[2] and ongoing tobacco control. However, operating in parallel, are social movements aiming to impose less rational restrictions that can be retrogressive.

Right to Life is often discussed in the narrow context of life before birth but in the modern world 99.7% of our lives are spent independent of our mother's uterus. Yet so much discussion is generated about the 0.3% of life, seemingly neglecting the rights of every child to live a life worthy of being called a life, along with the women's rights. However, often women are not visible in such decision making. No clearer example was in early 2017, when the world was jolted into the reality of the new US administration by a photograph of the President signing an order to remove funding from Planned Parenthood and family planning from US aid programs.[3] In the image, Donald Trump was seen surrounded entirely by males, as he enforced a decision that primarily affected women.

The public health example of Romania is worth revisiting as an example of what can happen when women are not included in decisions about their own health. In Romania abortions or terminations, often a preferred term, were made available in 1957, but in 1966 the dictator Nicolae Ceausescu banned terminations.[4] At the same time, contraceptives became unavailable (apparently, not banned, just not sold anymore and consequently black market prices soared). The motivation for the ban was an aim by Ceausescu to increase the population and build a greater Romania.[5] At the same time, young women in high school were taught that it was their duty to have babies as soon as possible and that the state would take care of them. There were several results of this policy. More children were born to urban, educated women, who achieved more years of schooling and greater labour market success.[6] This is because this socioeconomic group had been more likely to have terminations before the policy change, and the relative number of children born to these women increased after the ban. However, in the longer term the ban had more effect on the rural poor who continued to increase their fertility rates.[7] Due to the pressure of poverty large numbers of infants from lower socio-economic families were abandoned and were raised in state run orphanages. Most suffered with poor nutrition, a lack of social stimulation and later the HIV rate soared, as infants became anaemic and received blood transfusions.

Up until 1989, Romania had reported 13 cases of AIDS. In the first four months after the fall of the communist regime, a survey of children in orphanages found a positive HIV rate of 10.5% and thus a public health disaster was revealed to the world.[8,9] The longer-term outcomes of the orphanage disaster are still coming to light. Many of the infants were subsequently adopted into families in overseas countries. The effects of the early life deprivation were modified by the care and nourishment received, but problems persist. A recent follow-up of Romanian adoptees in the UK concluded, 'extended early deprivation was associated with long-term deleterious effects on wellbeing that seem insusceptible to years of nurturance and support in adoptive families'.[10]

For health promotion, 'Right to Life' should signify choice for women regarding caring for their own bodies and the right to a healthy life in a supportive environment. In terms of the child, the first 1000 days of life is critical to the establishment of a trajectory for healthy life through adulthood.[11,12] Every child who is born in Australia has the right to a healthy development including a safe environment, good nutrition and psychological stability. We have previously noted the poorer health outcomes for lower socio-economic Australian children.[13] The lessons for Australia from overseas experience is that women should be central in decision making about their own health and we must be ever aware that sometimes successful strategies may be wound back under the pressure of vested interests.

Climate change, the ageing population, overweight and obesity and alcohol misuse are also important issues for the health promotion community to address. Climate change is having and will continue to have important effects on health in Australia and in our region, providing a challenge for health promotion.[14,15] The Australian Health Promotion Association has shown commitment to this issue by being a member of the Climate Change Alliance, which has mapped priorities for action (see http://www.caha.org.au/priorities).[16] The *Health Promotion Journal of Australia* released a special issue on this topic in 2011(see http://www.publish.csiro.au/HE/issue/6786/),[17] and a virtual issue in 2016 (see http://www.publish.csiro.au/he/virtualissue/1502).[18]

In Australia, the increasing number of heatwaves amplifies the risk of dehydration, heat stress and heat stroke. Climate change will also change our food and water supplies and environmental microbiological contamination. Our remote communities face a triple burden of communicable diseases, chronic diseases and the specific health impacts of climate change disease, including heat, flooding, drought and disruption from severe weather events. Our neighbours in the Pacific islands are some of the most vulnerable communities on the globe and as their countries disappear under the rising oceans they will likely migrate to Australia and New Zealand.[19]

Unfortunately, climate change impacts the poor and most vulnerable populations the most, with the homeless and those with lower incomes most at risk.[20] UNICEF has described the situation '*There may be no greater, growing threat facing the world's children – and their children – than climate change*'.[21] Children are more vulnerable to all of the fluctuations that climate change brings, from increased susceptibly to diseases such as dengue and malaria to decreased food supplies and risk from floods. The National Academies in the USA have just published a new volume on the threats to public health from climate change, defying the US President's repudiation of the Paris agreement and prefaced their argument with a quote from Martin Luther King:

> '*We are now faced with the fact that tomorrow is today. We are confronted with the fierce urgency of now. In this unfolding conundrum of life and history there is such a thing as being too late. Procrastination is still the thief of time. . . . We must move past indecision to action*'.[22]

Australia's ageing population will present challenges and opportunities for health promotion. Thanks to the successes of health promotion, public health and treatment services, we are now living longer and healthier lives.[23] Health promotion has a major role to play in reducing the likelihood of developing chronic disease and supporting independence - there are many prevention strategies that are available.[24] However, we must acknowledge the substantial evidence that older Australians contribute to our society and counter the often projected stereotype that they are burdensome or dependent. Ageist attitudes can stifle innovative ideas and limit the ways issues are conceptualised.[25] Ingrained ageism can promote stereotypes of physical, social and cognitive decline.[26]

Currently overweight and obesity are world-wide problems and there is rightly an emphasis on obesity in our health promotion interventions.[27,28] Some sectors of the health industry are promoting medical solutions, including medications for appetite suppression and surgical solutions, for what is a lifestyle and structural issue. The longstanding campaign against tobacco required, and still requires, a range of health promotion initiatives and the obesity problem will be more complex, requiring more resources. Health parameters have continued to improve, but the full effects of our obesity epidemic have yet to be felt. Treatment does not offer a solution; promotion of healthy lifestyles and structural supports are required. Obesity is listed as a Millennium Development Goal and its management is complex.[29,30] The intake of nutrients and food energy is a U-shaped risk curve, with both those who are under- and over-nutrition being at increased risk of morbidity and mortality. To reduce stunting and wasting, infants require more nutrients; but to reduce child obesity children need less energy and more physical activity and less access to unhealthy foods.[31] As an example, improving children's movement skills so they can engage in physical activity, is a priority for Australian children.[32] While promotion of healthy eating is very important along with opportunities for being active, real progress will require reigning in the fast food and food processing industries.[30] For health promotion professionals current progress is reminiscent of the early years of the tobacco campaigns.[33] Industry are running misinformation programs and making it difficult to control sugar and excess energy in our diets. In addition Australian exports of infant formula are contributing to a growing obesity problem in China and other Asian countries.[34]

Despite being overshadowed by the reporting of illicit drug problems in the mass media, alcohol continues as a priority risk factor for Australians and the leading contributor to the total burden of disease for those aged 0 to 44.[35] Liquor industry forces that normalise excessive alcohol consumption continue unabated. Aggressive promotion and ready availability, along with relatively low prices are important industry 'strategies' for youth recruitment. Alcohol advertising permeates televised high profile sports virtually unrestricted, despite evidence of its influence on youth consumption.[36] Similarly, alcohol continues to become more easily accessible by youth via availability and low prices through the emerging monopoly of the big box liquor outlets (booze barns).[37,38] Federal and State governments and the other authorities that have responsibility to regulate such undesirable influences are well aware of the need for rigorous regulation but continue to take only token actions.[36] Sadly, the powerful advertising and alcohol industries (like the fast food and tobacco industries) are purported to continue to wield far too much political power and this stifles appropriate regulation.

We already know many of the measures that can be effective with our health promotion priorities. Our main challenge will likely continue to be the resistance by persons with vested interests, along with the accordant failure of our governments' to take appropriate actions.[36,37] Care is needed by health professionals that we are not misled by the vested industry's call to focus on 'education programs', as education alone without the relevant organisational, economic and political actions of a comprehensive approach to health promotion will be ineffective.[1]

Reduced support for health promotion and disease prevention programs must be lobbied against as we increasingly see funds released to hospitals, a short sighted policy, or perhaps a response to industry pressures.[39] For example, recently, the West Australian Government only invested $2.1million in prevention out of a health budget of ~9 billion.[40] The challenge for the health promotion and the HPJA in the next five years is not only to keep health promotion alive in the light of continuing cuts, but at the same time to defend the territory/achievements that we have won in the past.

The HPJA is a unique publication with a group editorship (under the direction of a senior editor) that rotates at regular intervals. We hope that the communication of the science behind health promotion during our time at the helm will result in a healthier and happier future for all Australians, regardless of where they live or their socio-economic status. Our tenure as editors of the journal has been a privilege.

References

1. Jancey J, Barnett L, Smith J, Binns C, Howat P. We need a comprehensive approach to health promotion. *Health Promot J Austr* 2016; **27**(1): 1–3.
2. Howat P, Binns C, Jancey J. New international review supports community water fluoridation as an effective and safe dental health promotion measure. *Health Promot J Austr* 2015; **26**(1): 1–3. doi:10.1071/HEv26n1_ED
3. Cosslett RC. This photo sums up Trump's assault on women's rights. Available from: https://www.theguardian.com/commentisfree/2017/jan/24/photo-trump-womens-rights-protest-reproductive-abortion-developing-contries [Verified September 2017].
4. Teitelbaum MS. Fertility effects of the abolition of legal abortion in Romania. *Popul Stud (Camb)* 1972; **26**(3): 405–17. doi:10.1080/00324728.1972.10405910
5. Berelson B. Romania's 1966 anti-abortion decree: the demographic experience of the first decade. *Popul Stud (Camb)* 1979; **33**(2): 209–22. doi:10.1080/00324728.1979.10410438
6. Pop-Eleches C. The impact of an abortion ban on socioeconomic outcomes of children: Evidence from Romania. *J Polit Econ* 2006; **114**(4): 744–73. doi:10.1086/506336
7. Berelson B, Lieberson J. Government efforts to influence fertility: the ethical issues. *Popul Dev Rev* 1979; **5**(4): 581–613. doi:10.2307/1971973
8. Dickman S. Aids in children adds to Romania troubles. *Nature* 1990; **343**(6259): 579.
9. Kozinetz CA, Matusa R, Cazacu A. The burden of paediatric HIV/AIDS in Constanta, Romania: a cross-sectional study. *BMC Infect Dis* 2001; **1**: 7. doi:10.1186/1471-2334-1-7
10. Sonuga-Barke EJS, Kennedy M, Kumsta R, Knights N, Golm D, Rutter M, *et al*. Child-to-adult neurodevelopmental and mental health trajectories after early life deprivation: the young adult follow-up of the longitudinal English and Romanian Adoptees study. *Lancet* 2017; **389**(10078): 1539–48. doi:10.1016/S0140-6736(17)30045-4
11. Rosenfeld CS. Homage to the 'H' in developmental origins of health and disease. *J Dev Orig Health Dis* 2017; **8**(1): 8–29. doi:10.1017/S2040174416000465
12. Fund UNCs. UNICEF the First 1000 Days. UNICEF, New York; 2017 Available from: http://1000days.unicef.ph/ [Verified June 2017].
13. Binns C, Howat J, Jancey J, Smith J. Children, poverty and health promotion in Australia. *Health Promot J Austr* 2016; **27**(3): 181–3. doi:10.1071/HEv27n3_ED1
14. McMichael AJ. Globalization, climate change, and human health. *N Engl J Med* 2013; **368**(14): 1335–43. doi:10.1056/NEJMra1109341
15. Hunter DJ, Frumkin H, Jha A. Preventive medicine for the planet and its peoples. *N Engl J Med* 2017; **376**(17): 1605–7. doi:10.1056/NEJMp1702378
16. Climate Health Alliance. Priorities: policy priorities of the climate and health alliance. 2017.
17. Australia HPJo. Climate Change. CSIRO; 2011 Available from: http://www.publish.csiro.au/HE/issue/6786/ [cited 11 November 2017].
18. Climate change and health promotion. CSIRO; 2016 Available from: http://www.publish.csiro.au/he/content/virtualissues [Verified 11 November 2017].
19. World Health Organization. World Health Organization Regional Office for the Western Pacific, Human health and climate change in Pacific Island countries. WHOWPRO2015, Manilla.
20. Campbell S. Let's not forget climate change in the food insecurity conversation: why the homeless are most vulnerable. *Health Promot J Austr* 2015; **26**: 161–2. doi:10.1071/HE14090
21. UNICEF (UNCsF). Unless we act now: The impact of climate change on children. Division of Data, Research and Policy, New York; 2015.
22. National Academies of Sciences. Engineering and Medicine. Protecting the health and well-being of communities in a changing climate: Proceedings of a Workshop. The National Academies Press: Washington, DC; 2017.
23. Binns C, Howat P, Jancey J. Health promotion success in Australia and a note of warning. *Health Promot J Austr* 2014; **25**(3): 157–9. doi:10.1071/HEv25n3_ED
24. Livingston G, Sommerlad A, Orgeta V, Costafreda SG, Huntley J, Ames D, *et al*. Dementia prevention, intervention, and care. *Lancet* 2017. In press. doi:10.1016/S0140-6736(17)31363-6
25. World Health Organization. World report on ageing and health. Luxembourg 2015.
26. Angus J, Reeve P. Ageism: a threat to 'ageing well' in the 21st Century. *J Appl Gerontol* 2006; **25**(2): 137–52. doi:10.1177/0733464805285745
27. National Health and Medical Research Council. Australian Dietary Guidelines. National Health and Medical Research Council, Canberra; 2013.
28. NCD Risk Factor Collaboration Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. *Lancet*. In press.
29. United Nations. Transforming our World: SDG goals and targets. 2017.
30. Colagiuri S, Lee CM, Colagiuri R, Magliano D, Shaw JE, Zimmet PZ, *et al*. The cost of overweight and obesity in Australia. *Med J Aust* 2010; **192**(5): 260–4.
31. Binns C, Lee MK, Low WY, Zerfas A. The role of public health nutrition in achieving the sustainable development goals in the Asia Pacific Region. *Asia Pac J Public Health* 2017; **29**(7).
32. Barnett LM, Hardy LL, Lubans DR, Cliff DP, Okely AD, Hills AP. Australian children lack the basic movement skills to be active and healthy. *Health Promot J Austr* 2013; **24**(2): 82–4. doi:10.1071/HE12920
33. Colagiuri S. The obesity epidemic and sugar-sweetened beverages: a taxing time. *Med J Aust* 2017; **206**(3): 109–10. doi:10.5694/mja16.00825
34. Zhang K, Tang L, Wang H, *et al*. Why do mothers of young infants choose to formula feed in China? Perceptions of mothers and hospital staff. *Int J Environ Res Public Health* 2015; **12**(5): 4520–32. doi:10.3390/ijerph120504520
35. Welfare AIfHa. Australia's health 2016: 15th Biennial Report on the Health of Australians. AIHW, Canberra; 2017.
36. Jernigan D, Noel J, Landon J, Thornton N, Lobstein T. Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. *Addiction* 2017; **112**: 7–20. doi:10.1111/add.13591
37. Howat P, Binns C, Jancey J. Booze barns: fuelling hazardous drinking in Australia? *Health Promot J Austr* 2013; **24**(2): 85–6. doi:10.1071/HE13068
38. Livingston M. Packaged liquor in Victoria: 2001 to 2016. Foundation for Alcohol Research and Education, Canberra; 2017.
39. Binns C, Howat P, Smith J, Jancey J. The medicalisation of prevention: health promotion is more than a pill a day. *Health Promot J Austr* 2016; **27**(2): 91–3. doi:10.1071/HEv27n2_ED
40. Australian W. State Government. Western Australian State budget 2017–2018. Preventative services. 2017. Available from: http://static.ourstatebudget.wa.gov.au/snapshot/health/index.html/ [Verified 20 October 2017].