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CIS Submission to the Standing Committee on Health and Ageing, Inquiry into Obesity in Australia

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Executive summary

It is widely acknowledged that the rising cost of treating lifestyle-related chronic disease threatens to increase the unsustainability of Medicare as the population continues to age in coming decades. Public health experts routinely advise governments that the best way to address the long-term challenges facing the health system is to ‘invest’ more taxpayer’s money in public health education and promotion policies. The latest version of this advice is that governments should invest more money in ‘preventive’ primary care to control the prevalence and contain the cost of ‘lifestyle disease.’

Yet the evidence—major reports on public health policy in Australia and the United Kingdom, as well as studies of community-wide and high-intensity lifestyle interventions—suggests that decades of spending on prevention has not worked and is unlikely to work in the future. Spiralling rates of obesity and lifestyle-related chronic disease suggest that forty years of public health policies that have targeted diet and exercise habits have had limited effect on behaviour, especially in relation to long-term retention of lifestyle modification.

The evidence points to the demonstrated limits of prevention. It directs attention to the three basic reasons why health education and promotion campaigns have not been as successful as hoped, and have been expected to achieve outcomes they are not capable of in all cases. These reasons are:

1. Governments have extremely limited authority over the individual behaviours that cause and can prevent lifestyle disease.
2. Lifestyle modification and sustaining changes to unhealthy but often pleasurable behaviours is principally an individual responsibility.
3. Success in avoiding lifestyle disease ultimately depends on personal qualities—will, self-discipline, and impulse control—that public health policies struggle to instil in people who do not already possess them.

Nevertheless, the prevailing assumption remains that more spending on ‘preventive care’ will tackle obesity, lower chronic disease rates, and reduce health costs, as if this process is sure and seamless. For example, a paper published last year by the Centre for Policy Development claimed that international evidence shows health systems oriented to-

ward lower cost primary care, rather than higher-cost hospital care, achieve better health outcomes for less, due to the preventive care—advice about lifestyle modification—delivered in the primary care setting. ‘Stronger’ primary care, the claim goes, has a primary preventive effect that reduces lifestyle disease and health costs. This is the argument on which the Rudd government came to base its GP Super Clinics and preventive health policy.

The international evidence is not as authoritative as claimed. Studies that show higher provision of *primary care* produces better health outcomes—because it allows more patients to receive timely diagnosis and referral to secondary care by other specialists and then to necessary tertiary, predominantly hospital-based treatments—contain no evidence that receipt of *preventive care* prevented chronic illness. This suggests that the advocates of ‘stronger’ primary care have mistakenly attributed the effect of the traditional role of primary care—diagnosis and referral—to preventive care. Furthermore, a 2002 cross-country analysis of thirteen OECD countries actually revealed that those with comparatively weaker primary care systems—including Australia—that spent more on hospital care achieved better health outcomes than those with stronger orientations to primary care. In other words, more spending on higher cost hospital care, rather than less spending on lower cost ‘preventive’ primary care, appears to have produced better health outcomes. International comparisons do *not* show that countries with stronger primary care and ‘less focus on specialist/hospital care’ achieve better health outcomes at lower cost.

Nevertheless, based on the rationale that ‘stronger’ primary care has a preventive effect that improves health outcomes and lowers health costs, the Rudd government has committed an initial \$220 million to establish a national network of GP Super Clinics, to reorient the health system away from hospitals and towards primary care. Part of the government’s plan is to boost the primary prevention of lifestyle disease by increasing community access to preventive care. Consistent with the contemporary public health discourse, which redefines obesity and lifestyle disease as epidemics that governments have failed to intervene to control, the government’s preventive healthcare policy maintains that ‘ordinary Australians’ cannot modify their unhealthy lifestyles unless the government provides access to preventive health services. This ignores the fact that studies have shown even high-intensity lifestyle interventions of the kind GP Super Clinics are currently designed to deliver have had a low impact on behaviour, particularly with regard to the key challenge: ensuring the long-term retention of lifestyle changes.

The evidence, therefore, suggests that many recipients of Medicare-funded preventive health services will fail to change their unhealthy

lifestyle, and future governments will have to fund the recurring costs of ineffective preventive care that yields negligible health and cost benefits. The evidence suggests that GP Super Clinics delivering 'preventive care' will only accentuate the challenges facing Medicare.

CIS Submission to the Standing Committee on Health and Ageing, Inquiry into Obesity in Australia

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Introduction: Prevention is the new black

Prevention—in relation to obesity and ‘lifestyle disease’—has been described as the ‘new black’ in Australian health policy. But little about this agenda is new.

As modern medicine has developed more expensive ways to improve our health, health costs have inexorably risen and placed greater pressure on government budgets. In countries such as Australia, which offer citizens ‘free and universal’ taxpayer-funded health care, governments of all persuasions have increasingly come to resent having to fund all the health care they promise to deliver. As the bill has mounted, politicians have grown more desperate to find a circuit breaker.

Enter the public health experts. For the last thirty or forty years, they have argued that if governments took their advice and spent more money on public health education campaigns (that tell people to eat less and exercise more) this would prevent obesity and lifestyle-related illness and contain health costs in the ‘long run.’ Governments of all persuasions have understandably been attracted to the idea that savings could be achieved simply by ‘investing’ more in prevention.

It is very difficult to argue against what appears to be a common-sense course. Our course prevention is better than cure, and if individuals did take better care to promote their own health, governments would have to spend less money treating the sick.

But the point constantly overlooked is that preventive programs targeting diet and exercise lifestyle behaviours continue to consume millions of taxpayers' dollars each year despite failing to deliver the promised outcomes.

Australia is now experiencing rising levels of obesity, which is leading to accelerating rates of 'lifestyle'-related chronic disease. This is placing ever-greater pressure on the health and hospital systems. Piled on top of the ageing of the population and the high cost of new medical technology, it is widely acknowledged that without change, this combination of challenges means Medicare is going to impose intolerable burdens on future generations of taxpayers.

These challenges have, however, given the push to spend even more on 'prevention' a second wind. Public health experts—keen to retain their influence over government policy—keep chanting their mantra about the need to focus more on lower-cost prevention. Politicians—determined to avoid the difficult political issue of health reform—are even keener to tell us that Medicare will be sustainable so long as the experts' advice is heeded.

Thus the merry-go-round continues. Governments readily look to spend even more on prevention policies that have not improved the overall health of the population, and which have actually presided over the emergence of the so-called obesity 'epidemic.'

The problem is that few have been prepared to look squarely at the evidence and question the assumptions that lie behind the perennial claim that more spending on prevention will reduce illness and health costs.

A policy looking for an evidence base— not 'evidence-based policy'

The paper this submission is based upon was highly sceptical of the push for Australian governments to 'invest' greater amounts of taxpayer's dollars on public health campaigns and fund so-called 'preventive care,' based on the poor track record such measures have in combating obesity.¹ The evidence suggests that it is unrealistic to expect many of those suffering or at risk of lifestyle disease in the short to near term to change longstanding unhealthy behaviours in response to preventive initiatives conducted by governments.

¹ Jeremy Sammut, *The False Promise of GP Super Clinics Part 1: Preventive Care*, CIS Policy Monograph 84 (Sydney: CIS, 2008)

Some may see this as pessimistic, but it is simply realistic. I—and the think tank where I am a researcher—believe in lower tax, smaller government, and personal responsibility. If the evidence indicated that more spending on prevention could facilitate these outcomes and improve health and lower health costs, I would support this without hesitation. Wouldn't it be wonderful if everyone did everything they could and should to promote their own health? But it's never as simple as telling people what's good for them. This isn't defeatism, but is to accept human nature and society as they are, rather than as we might like them to be. And realism—together with empiricism—should be the only basis on which health and other government policies are formulated, especially as the long-term sustainability of the health system is at stake.

Vocal critics, however, have been quick to claim there is 'overwhelming evidence' to support the case for greater government spending on anti-obesity interventions.² Though not unexpected, this reaction is surprising coming from certain stakeholders. The president of the Australian Medical Association (AMA), Rosanna Capolingua, for example, asserted that there 'is evidence that these interventions will have a positive impact on obesity if appropriately pursued. The AMA's recently released *Position Statement on Obesity*, refers to studies and evidence to support this.'³

Yet even the AMA's position statement admits the damning point that should be of primary interest to policymakers: 'The available evidence does not point to any single type or set of interventions that will definitely induce those protective behaviours on a population scale. The evidence is also variable as to which interventions will produce weight loss on a population scale.'⁴

The oblique language employed by the AMA is telling: 'limitations in current knowledge about which obesity interventions are effective should not be a reason for inaction.' What is admitted is the major concern: when the evidence is examined, one finds there is precious little to support the claim that preventive interventions—'population-based measures' or 'individual treatments'—will have a 'positive impact' on obesity.

² See comment attributed to the federal health minister, Nicola Roxon: Leo Shanahan, 'Preventive Care "A Waste of Money",' *The Age* (8 May 2008).

³ 'Increased Commitment to Prevention a Must, Australia,' *Medical News Today*, (8 May 2008), www.medicalnewstoday.com/articles/106781.php.

⁴ Australian Medical Association (AMA), 'Australian Medical Association Position Statement: Obesity—2008,' [www.ama.com.au/web.nsf/doc/WEEN-7E98ZB/\\$file/Microsoft_Word_-_Position_Statement_on_Obesity_-_March_2008.pdf](http://www.ama.com.au/web.nsf/doc/WEEN-7E98ZB/$file/Microsoft_Word_-_Position_Statement_on_Obesity_-_March_2008.pdf).

The committee should therefore be aware that in the final reckoning, the case for more spending on prevention amounts to the timeworn cry that governments need to do 'something' about obesity—even though the evidence suggests that the interventions governments are constantly urged to implement are more than likely to prove ineffective.

Key points of this submission: An evidence-based story

While this submission thus runs against the conventional wisdom of the public health community, it follows the grain of the evidence, and relates an evidence-based story, the key points of which are:

- Major reports on public health policy in Australia and the United Kingdom, as well as studies of community-wide and high-intensity lifestyle intervention, suggest that decades of spending public health policies that have targeted diet and exercise habits have had limited effect on behaviour, especially in relation to long-term retention of lifestyle modification.
- The healthy lifestyle message has been well-publicised (through publicly funded initiatives and by the media in general). But while most people know what they should do to protect and promote their health, the evidence directs attention to the three basic reasons why health education and promotion campaigns have not been as successful as hoped, and have been expected to achieve outcomes they are not capable of in all cases
 1. Governments have extremely limited authority over the individual behaviours that cause and can prevent lifestyle disease.
 2. Lifestyle modification and sustaining changes to unhealthy but often pleasurable behaviours is principally an individual responsibility.
 3. Success in avoiding lifestyle disease ultimately depends on personal qualities—will, self-discipline, and impulse control—that public health policies struggle to instil in people who do not already possess them.
- The evidence points to the demonstrated limits of prevention. But public health experts still routinely advise governments that the best way to address the long-term challenges facing the health system is to 'invest' more taxpayers' money in public health education and promotion policies to tackle obesity, lower

chronic disease rates, and reduce health costs, as if this process is sure and seamless. The latest version of this advice is that governments should 'invest' more money in 'preventive' primary care to control the prevalence and contain the cost of 'lifestyle disease.'

- The Rudd government has heeded this advice. The government's Super Clinics policy is designed to bring general practice services together with a wide range of allied health providers—physiotherapists, podiatrists, dieticians—so that Medicare can pay for a whole multidisciplinary team of health professionals to deliver 'lifestyle interventions' and 'facilitate' lifestyle change.
- Expanding Medicare into a weight-loss counselling service might be justified—if it could be shown to work. Unfortunately, studies shows that even these kinds of 'high-intensity' lifestyle interventions have had low impact, particularly with regard to the key challenge: ensuring the long-term retention of lifestyle changes in relation to diet and exercise habits.
- Therefore, rather than 'help' ordinary Australians protect their health, ordinary taxpayers face being lumbered with the recurring cost of ineffective 'preventive care' that yields negligible health and cost benefits, on top of the new funding that is also set to be wasted on further public health campaigns. Instead of alleviating the burden rising health costs will impose on future generations, increasing government health spending in this direction is only going to accentuate the long-term unsustainability of Medicare.

Like the mercenaries of the federal government, the academicians also chant the litany of practicing preventive medicine. ... 'If physicians devoted as much time, energy and skill to minimize the need for medical care as they now devote to its delivery...' goes the chant. Do you know what would happen if we did that? Nothing. ...

Every clinician who has worked with his patients to try to get them to lose weight, slow down, give up smoking, start a moderate exercise program or decrease drinking, knows the incredible frustrations and the enormously low return for the effort expended.

... The government and the professors should give up this time worn litany. The clinicians know it won't work and the public isn't interested. Until they can come up with a method that works, they should spare us this useless advice.

—Gordon Breitman, MD⁵

Long-term challenges: Ageing, rising costs, chronic disease, and sustainability

The demographic and medical realities of the twenty-first century—the ageing of the population and the high cost of new medical technology, combined with the rising prevalence of obesity and the increasing cost of treating 'lifestyle-related' chronic disease—threaten to make Medicare, Australia's 'free and universal' taxpayer-funded health system, unsustainable in coming decades. As the healthcare costs accelerate, either the smaller base of taxpayers of tomorrow will have to pay considerably higher taxes, or government services will need to be cut, and Australians will not continue to receive 'free' access to all the latest medicine as they have become accustomed to.⁶

Though the long-term challenges are real, profound, and yet to be adequately addressed, instead of pursuing the appropriate policy response, politicians prefer to avoid the issue of comprehensive health reform.⁷

⁵ *Western Journal of Medicine* 125:3 (September 1976), 236.

⁶ Jeremy Sammut, *The Coming Crisis of Medicare: What the Intergenerational Reports Should Say, But Don't, About Health and Ageing*, CIS Policy Monograph 79 (Sydney: CIS, 2007).

⁷ The appropriate policy response is to establish a dedicated national stream of self-funded 'health savings' in parallel with the compulsory superannuation system. See the Allen Consulting Group's report to Medicines Australia, *Medical Savings Accounts: A Discussion Paper* (September 2004). One path to creating a more efficient and sustainable health system is a voluntary national system of Medicare opt-outs,

Instead of taking action now to relieve the burden on future generations and move beyond relying on taxpayers to foot the bill, politicians of all persuasions have grown keener to pursue the kind of ‘solutions’ outlined, for instance, in the most recent of the federal government’s Intergenerational Reports:

We need to continue to prepare for the health care we want in the future, and ensure that health spending is as efficient and effective as possible. For example, promotion of healthier lifestyles can prevent many health problems and reduce overall health costs over time.⁸

This is a summary of the advice that experts in the field of public health have routinely given to governments for a generation. The latest version of this mantra is that the way to avert the crisis Medicare faces is for Australian governments to ‘invest’ more money in prevention—especially in preventive primary care—and contain the anticipated growth in future health expenditure by reducing the prevalence of ‘lifestyle disease.’

The prevention mantra

According to this very influential school of thought, the problem with Medicare is not how to finance healthcare in the future. The problem with Medicare is the services the hospital-centric health system does not fund today. The argument is that Medicare, with its fee-for-service rebate structure, is geared to cure the chronic disease consequences of unhealthy lifestyles rather than change the individual behaviours—poor diet and lack of exercise—that cause obesity and increase the risk and prevalence of chronic illness.

There is no doubting the lifestyle-related chronic disease burden is a major challenge facing the health system. Many people contract a chronic condition due to hereditary and genetic factors, often triggered by ageing. But the consensus is that a leading factor in the rising chronic disease burden is the unhealthy lifestyle choices many Austra-

whereby entitlement to publicly funded healthcare could be cashed out in the form of a tax credit and used to fund a Health Savings Account and to pay for day-to-day medical expenses and private catastrophic health insurance. See Peter Saunders, *A Welfare State for Those Who Want One, and Opt-outs for Those Who Don’t*, CIS Issue Analysis 79 (Sydney: CIS, 2007).

⁸ Commonwealth of Australia, *Intergenerational Report 2007—Overview*, (Canberra: Commonwealth of Australia, 2007), www.treasury.gov.au/igr/overview/pdf/IGR2_Overview_Web.pdf, 12.

lians continue to make, especially with regard to poor diet and exercise habits.

Medicare is the reason unhealthy lifestyles are a public policy issue. Because a 'free and universal' health system gives sufferers of lifestyle-related chronic illness financial protection against the healthcare costs stemming from their unhealthy lifestyle, healthy taxpayers are, in effect, subsidising the unhealthy behaviour of those who consume a disproportionate share of taxpayer-funded healthcare.⁹ With modern medicine continually finding more technologically advanced and expensive ways of saving people from the disease consequences of their unhealthy behaviour, the escalating cost of subsidising lifestyle disease by treating it is set to exacerbate the pressures on Medicare in coming decades.¹⁰

Therefore, the logic behind calls for more government spending on prevention—on 'health education,' 'health promotion,' and 'lifestyle modification'—*to bring lifestyle disease under control* seems unassailable. Of course 'prevention,'¹¹ if it works, is better than cure. This is especially so if, as the advocates of preventive policies argue, more spending on the primary and secondary prevention of chronic disease saves money by avoiding the need for higher spending on more expensive treatments, takes the pressure off public hospitals, and helps alleviate the long-term challenges associated with ageing and rising costs.

A 2007 discussion paper issued by the Australian Institute of Health Policy Studies illustrates the extent to which more spending on prevention is consistently singled out in health policy circles as the best way to ensure the long-term sustainability of Medicare: 'Almost every analysis of the challenges facing the health system (ageing, chronic disease, growing demand and consumer expectations) concludes that the health system can only be sustained if there is a fundamental shift to refocus

⁹ Obesity or diabetes can increase the cost of treating hospitalised patients with comorbidities by three to four times. John Breusch, 'Costs Drive Up Health Premiums,' *Australian Financial Review* (16 January 2008).

¹⁰ The Productivity Commission has warned that many new drugs and procedures in the pipeline are the result of research and development specifically undertaken to discover treatments for the major chronic diseases associated with ageing and poor lifestyle. It is these diseases that will impose the greatest disease burdens in Western countries as the population ages. Productivity Commission, *Impact of Advances in Medical Technology* (Melbourne: Commonwealth of Australia, 2005), xlix–lii.

¹¹ For full details and analysis see Appendix 1, Jeremy Sammut, *The False Promise of GP Super Clinics Part 1: Preventive Care*, CIS Policy Monograph 84 (Sydney: CIS, 2008).

upstream on prevention and health promotion.¹² In theory, reorienting the health system away from hospitals to focus instead on providing the community with lower-cost primary and preventive care, and on keeping people well rather than continuing to spend an increasing amount of money treating them once they are already sick, sounds like a good idea. As we shall see, the case for more government spending to ‘refocus’ the health system in this direction has gained even greater policy traction following the election of the Rudd government.

The rationale for GP Super Clinics

This new version of the mantra that governments should spend more on prevention was the central theme of a Centre for Policy Development policy paper by Jennifer Doggett published in June 2007, which articulated the case for a ‘new approach’ to preventive care. Doggett’s paper advocated the national rollout of two hundred ‘GP Super Clinics’ as a major step towards reorienting the Australian health system towards lower-cost primary care.

The preventive healthcare policy documents released before the 2007 federal election by the then-opposition (see especially the ‘GP Super Clinics’ discussion paper) drew heavily on the ‘new approach’ outlined by Doggett.¹³ It is therefore fair to say that the Rudd government has well and truly heeded the call for more spending on prevention. To equip Medicare to deal with challenges of lifestyle and chronic disease, it has committed an initial \$220 million towards the establishment of a national network of GP Super Clinics, the intention being to provide local communities with enhanced access to not just primary care but also preventive health services.

Going by the outline in Doggett’s paper and Labor’s policy documents, GP Super Clinics will be ‘multidisciplinary primary care centres ... established to provide coordinated and preventive primary care,’¹⁴ and they will be purpose designed to boost and make more robust the preventive role that allegedly ‘lower cost’ primary care plays in the health system.¹⁵ The objective is to bring previously dispersed general practitioners, practice nurses, and other allied health workers together under

¹² S. Willcox, V. Lin, R. Watson, and B. Oldenburg, *Revitalising Health Reform—Time to Act* (Melbourne: Australian Institute of Health Policy Studies, 2007), 22.

¹³ Doggett has acknowledged and claimed credit for this. See Jennifer Doggett, ‘What’s Super about Labor’s New GP Super Clinics?’ *Insight* (15 January 2008), cpd.org.au/article/case-primary-care.

¹⁴ Jennifer Doggett, ‘What’s Super about Labor’s New GP Super Clinics?’

¹⁵ Mark Metherell, ‘Prescription to End the Blame Game and Costly Divisions,’ *Sydney Morning Herald* (24 August 2007).

one roof, and to develop new models of 'preventive health services' to fight chronic disease at the 'population health' level.

The Rudd government's Super Clinics policy therefore envisages a significant expansion of Medicare beyond traditional fee-for-service GP primary care. The plan is to provide rising numbers of unhealthy and chronically ill people with enhanced and more convenient access to a range of wellness-promoting services—from dietitians to physiotherapists and psychologists—which, despite recent initiatives, Medicare has provided only limited access to in the past.¹⁶ As the now federal health minister, Nicola Roxon, explained in an opinion piece last August, the overarching goal is to reduce demand for hospital services 'by investing more in primary care services in local communities to keep people in good health and take pressure off public hospitals.'¹⁷

Preventive primary care

For the primary prevention of 'lifestyle disease,' Super Clinics are designed to offer a wellness-based model of primary care. The plan is for Super Clinics to deliver high-intensity, multidisciplinary lifestyle interventions to high-risk patients. These interventions will address the 'lifestyle determinants of ill health'¹⁸—particularly unhealthy diet and lack of exercise—that can lead to obesity and chronic illnesses such as heart disease and diabetes. According to the proponents of the 'wellness' model of 'preventive healthcare':

The lifestyle changes associated with obesity and physical activity can be facilitated by ongoing collaboration by a multidisciplinary workforce—most notably dietitians/nutritionists, and nurse educators working with fitness therapists/lifestyle coaches ... Some of the barriers to exercise can be addressed by fitness trainers, lifestyle coaches, counselors, and a range of complementary therapists.¹⁹

¹⁶ Recognising this, the former federal government introduced the Enhanced Primary Care package in 1999, which established a Medicare Benefits Schedule (MBS) item covering chronic illness and enabled GPs to undertake health assessment, multidisciplinary care planning, and monitoring. Since 2005, patients with complex needs have been able to access Medicare-funded 'GP Management Plans' and 'Team Care' from up to five allied health providers and three dental services per year.

¹⁷ Nicola Roxon, 'ALP Offers the Healthier Option,' *The Australian* (28 August 2007).

¹⁸ CPD (Centre for Policy Development), 'Fact Sheet: Preventative Health,' cpd.org.au/sites/cpd/files/u2/CPDFACTSHEET_Preventative_Health.pdf.

¹⁹ John Stafford, *Wellness Centres Revisited: A New Model of Primary Health Care for North Lakes and Surrounding Suburbs*, submission to the Standing Committee

Does 'preventive' primary care improve health outcomes and lower health costs?

The case for reorienting the health system towards primary care is said to rest on a wealth of international evidence. In her policy paper, Jennifer Doggett claimed that:

A wealth of international evidence shows that health systems oriented towards primary care achieve better health outcomes for a lower overall cost than systems focused on specialist or tertiary care ... For example, cross-country analyses have found that mortality rates and total health care costs are lower in countries with a strong primary care system. Other studies have found that health systems which have more primary care doctors per head of population achieve better health outcomes, including lower rates of mortality from heart disease, cancer and stroke, independent of socio-demographic factors.²⁰

The government's GP Super Clinics policy document repeated this claim almost verbatim:

There is now international evidence to demonstrate that health systems focused on primary care and preventative health care achieve better health outcomes, including lower death rates from chronic diseases like heart disease and cancer, and lower overall cost than health systems which are focused on acute hospital care.²¹

Unpacking this, the rationale for 'investing' in GP Super Clinics is that primary care fulfils two roles at once. Traditionally, *primary care* refers to the general practice encounters sought out by patients seeking diagnosis and referral to necessary secondary care and tertiary treatments. Primary care also encompasses preventive and public health services such as vaccinations and disease screenings, while regular checkups allow for early detection and treatment of conditions. Beyond

on Health and Ageing of the Commonwealth House of Representatives (February 2005), www.aph.gov.au/house/committee/haa/healthfunding/subs/sub081.pdf, 10.

²⁰ Jennifer Doggett, 'A New Approach to Primary Care for Australia,' 8. The discussion that follows draws on the studies cited by Doggett as demonstrating that stronger primary care produces better health and lower costs.

²¹ Kevin Rudd and Nicola Roxon, *New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities* (August 2007), www.alp.org.au/download/now/new_directions_for_australias_health_gp_super_clinics_final.pdf, 17.

these roles, the claim made by Doggett and backed by the Rudd government to support the case for GP Super Clinics is that stronger primary care results in lower health costs and improved health outcomes due to the preventive care delivered in the primary care setting, which is, as Doggett put it, ‘most suited to early interventions, such as lifestyle modifications ... to prevent chronic disease.’²²

The claim, therefore, is that the international evidence shows that compared to health systems oriented towards higher-cost hospital care, stronger primary care leads to long-term savings on secondary, tertiary, and acute hospital costs because strengthening the primary care system is an effective way to prevent lifestyle-related chronic disease.

The international evidence: Does primary care really prevent lifestyle disease?

The international evidence is not as authoritative as claimed. The studies cited by Doggett, mainly from the US, that showed higher provision of primary care produces better health outcomes because it allows more patients to receive timely diagnosis and referral to necessary care and treatment contain no evidence that receipt of *preventive care* prevented chronic illness. This suggests that the advocates of stronger primary care have mistakenly attributed the effect of the traditional roles of primary care—diagnosis and referral—to preventive care. It makes sense that GPs would deliver standard preventive care every day by telling patients to lose weight, improve their diet, and exercise more to improve their health. But even these studies Doggett cited admit they contain no evidence that access to and receipt of primary care actually reduced obesity (modified individual behaviour) or lowered the incidence of (actually prevented) chronic disease.

Moreover, these studies also admit that improved health outcomes depend on an ‘appropriate balance’ between primary and secondary care, and that ‘international comparisons and studies within the United States point to this conclusion.’ For example, a 2002 cross-country analysis of thirteen OECD members showed that countries with comparatively ‘weaker’ primary care systems—including Australia—that spent more on tertiary care achieved better health outcomes than those with a stronger orientation to primary care. In addition, this study revealed that two of the strongest primary care countries did *not* achieve better health outcomes independent of socio-demographic factors, due to the high prevalence of chronic conditions such as heart disease,

²² Jennifer Doggett, ‘A New Approach to Primary Care for Australia,’ 9.

which are purportedly so ‘amenable’ to the preventive interventions delivered in primary care settings.

In other words, this study showed that more spending on higher cost curative tertiary care, rather than less spending on lower cost ‘preventive care,’ appeared to have produced better health outcomes, and that international comparisons do *not* show that countries with stronger primary care and ‘less focus on specialist/hospital care’ achieve better health outcomes at lower cost. The evidence base for GP Super Clinics achieving the promised outcomes thus fails its first test.²³

The false promise of more spending on primary prevention

Therefore, perhaps the most contentious aspect of the rationale for GP Super Clinics is the notion of ‘investing’ in ‘preventive healthcare.’ The question is whether improving community access to ‘wellness’ services, combined with high intensity, professionally guided, government-funded ‘lifestyle interventions,’ cause people to modify their lifestyles and change the unhealthy behaviour of individuals at risk of contracting lifestyle diseases. Here, alas, the Rudd government’s preventive health policy faithfully reflects the central tenets of the contemporary public health discourse, which has redefined obesity and lifestyle disease as epidemics *that governments have failed to intervene to control*. For according to the GP Super Clinics policy document, authored by Kevin Rudd (now the prime minister) and Nicola Roxon (now the health minister) while in opposition:

Preventative health care needs to be made more accessible to ordinary Australians struggling to find the time in their busy lives to look after their own health. We can’t expect people to take better care of their health if we won’t help provide the health services they need to make this a reality.²⁴

The first thing to notice about the case for more government spending on preventive healthcare is that it updates the assumption—pervasive and largely unquestioned in the health debate—that governments can intervene in and thus control the obesity and lifestyle disease ‘epidemics.’ In keeping with all forms of the argument for more spending on prevention, this misconstrues the classic meaning of *preventive medi-*

²³ For full details and analysis see Appendix 1 of Jeremy Sammut, *The False Promise of GP Super Clinics Part 1: Preventive Care*, CIS Policy Monograph 84 (Sydney: CIS, 2008).

²⁴ Kevin Rudd and Nicola Roxon, *New Directions for Australia’s Health*, 12.

cine. It is the latest example of the way that those who advocate more spending on prevention have inappropriately traded upon the legacy and deserved high reputation of preventive medicine since the new socio-medical discipline of 'public health' developed in the 1970s.

Preventive medicine and the prevention of lifestyle disease

Public health measures from industrial sewerage systems to mass vaccination programs, which brought contagious airborne and waterborne diseases such as cholera, typhoid, and polio under control, are a major reason why death rates fell and life expectancy rose so dramatically in the twentieth century. To eradicate disease and protect public health, in many cases governments regulated the noxious public activities—from smokestacks belching pollutants to putrid abattoirs—that fouled the air, water, and food supply, to the point of eliminating them by prosecution and penalties. All people in countries where this was the case have been the passive beneficiaries of preventive interventions that have created a healthier public environment and collectively inoculated the community against the threat of *illnesses that people did not contract due to their own behaviour*.

Public health education campaigns designed to inform at-risk groups about the risks of unhealthy lifestyles do not compare with the proven preventive measures that have compelled individuals and other entities to cease what were clear and specific practices that endangered public health. Properly termed, this is 'behavioural change' medicine rather than preventive medicine. There are clear and crucial differences between this and classic preventive interventions, which achieved a preventive effect but not by inducing at groups at risk of chronic disease to change their lifestyles. The fundamentally different task for public health education campaigns (and for the proposed 'wellness' model of 'preventive' primary care) is to induce individuals to protect and promote their own health and to decide to modify a complex series of private behaviours that are unhealthy, but often pleurably so, to adopt and maintain a new series of healthy behaviours.

Fundamental differences and three reasons for failure

These fundamental differences, combined with the complexity of behavioral change, point to the three basic reasons the health lifestyle message has not always had the hoped-for impact on people's lifestyles. What they suggest that is education campaigns have not been as suc-

cessful as promised because they have been expected to achieve outcomes they cannot in all cases.

The first reason is that lifestyle modification is primarily the responsibility of the individual because individuals have to decide for themselves to change their behaviour and sustain behavioural changes over the long-term. In any meaningful sense, therefore, governments have extremely limited ability to prevent lifestyle disease because (and desirably so in a liberal society) they have extremely limited authority over the individual behaviours that cause it.

The second is that health education campaigns have really been health advertisement campaigns. They have largely operated in what one would think is a seller's market. What stronger incentive is there than the promise of a long and healthy life and, on the obverse side, the avoidance of the pain and fear that accompanies ill health? There are also the strong social pressures in contemporary society to be 'thin' and 'buff.' But linking good health to sex appeal and personal success, to create the desire to purchase a good or service, is not the same thing as promoting behavioural change. We can buy the car or the perfume and kid ourselves that we are like the model in the advertisement, even though we are not.

The third reason is that health education, promotion, and advertising campaigns do not just depend upon creating a desire for good health by informing people about the benefits of lifestyle modification. Ultimately, lifestyle modification depends on personal qualities—will, self-discipline, and impulse control. Public health campaigns might draw upon these qualities where they exist, but public health policy struggles to instil these qualities in people who—as their propensity to contract lifestyle disease may suggest—do not already possess them.

The limits of 'prevention'

The differences between classic preventive medicine and public health education and promotion raise important questions about the case for more spending on prevention as an effective method of controlling lifestyle disease. When one elaborates on these differences, it helps to make sense of the evidence-based story told by decades of failed public health policy.

Public health experts and lobby groups tacitly admit what rising obesity levels amply demonstrate: that public health education campaigns have not been as universally successful as it was hoped they would be. What they tend to suggest, though—to obscure just how unsuccessful these

policies have been—is that the evidence does not yet show what works. They also like to suggest that rising rates of obesity show that not enough of the health budget goes to prevention. The latest version of these diverting arguments is displayed in the government's policy document: individuals are absolved of their primary responsibility for the unhealthy lifestyle decisions they continue to make, and the lifestyle disease 'epidemic' is blamed on lack of government-funded entitlement to preventive care! Rarely considered are the real reasons—the limits of government authority over individual behaviour, and the importance of personal qualities in regulating it—why nearly forty years of health promotion has coincided with ascending rates of lifestyle disease.

Instead, advocates of more spending on lifestyle disease prevention often draw false parallels with the success of the campaign against tobacco smoking. Yet the war on smoking is a special case. Bans on smoking in public places, and higher and higher tobacco taxes, are more of an example of public health regulation than health promotion. The war on smoking has been more like traditional public health measures and the way governments have intervened to compel seatbelt use and attack drink-driving through enforced legislation.

There are also huge differences between the kinds of behavioural change that anti-smoking and diet and exercise campaigns have each aimed to induce. Anti-smoking campaigns have targeted a specific behaviour and cajoled individuals to decide to quit one bad habit. A similar example of behavioural change is the campaign to encourage condom use to prevent the spread of AIDS. Diet and exercise campaigns, by contrast, require people to actively do a series of things to change their lifestyle and to sustain those changes over the long term. The success of the anti-smoking campaign compared with the relative failure of healthy diet and exercise campaigns points to the real and demonstrated limits of the effectiveness of 'prevention.' It is simply very difficult to induce people to initiate and sustain a series of changes to complex and often longstanding behaviours, and to continually decide to make healthy decisions about diet and exercise.

Yet the merry-go-round goes round and round

Nevertheless, prevention lobby groups such as the Australian Chronic Disease Prevention Alliance (ACDPA)—a combination of non-government prevention organisations formed in 2005 to press the gov-

ernments for greater spending on prevention²⁵—continue to promise that ‘investing in promoting increased levels of physical activity and healthy eating in Australians would reduce the burden of chronic disease now and in the future.’²⁶ Hence a recent report by the Australian Centre for Health Research calls for a greater emphasis ‘on personal lifestyle and wellbeing (preventative care)’ and ‘on public health programs that keep people out of hospital,’ which the report assumes ‘should result in medium to long term reductions in overall expenditure,’ as if this process is sure and seamless.²⁷ It is worth pausing to consider just what is riding on this assumption: ensuring the cost of Medicare does not become an unsustainable burden on future generations, as this report puts it. Despite what is at stake, the key question—perpetually glossed over and subsumed beneath the mantra that governments should spend more on prevention—is the only one that counts: does ‘prevention’ actually work?

It is therefore timely to review the evidence. Because when the assumptions are questioned and the evidence examined with a clear eye, what is revealed is that there is actually slim support for the belief that preventive public health policies—be they ‘community-wide’ or ‘high-intensity’ lifestyle interventions—have in the past brought obesity and lifestyle disease under control, or that they are likely to in the future.

Why more spending on ‘prevention’ and ‘preventive care’ won’t control the lifestyle disease ‘epidemic’

In the 1970s, the new socio-medical discipline of ‘public health’ developed around the idea that ignorance was the reason people made unhealthy lifestyle decisions and chose to smoke, overeat, drink too much, and fail to exercise. Over the last three decades, public health experts have promised that government spending on health promotion campaigns targeting diet and exercise would lead to behavioural change by educating the community to make healthy lifestyle choices.

²⁵ Its members are Diabetes Australia, Kidney Health Australia, the National Heart Foundation of Australia, the National Stroke Foundation, and the Cancer Council Australia.

²⁶ ACDPA (Australian Chronic Disease Prevention Alliance), *Chronic Illness: Australia’s Health Challenge—The Economic Case for Physical Activity and Nutrition in the Prevention of Chronic Disease*, (January 2004), www.goforyourlife.vic.gov.au/hav/articles.nsf/pracpages/The_Economic_Case_for_Physical_Activity_and_Nutrition?open, 6.

²⁷ ACHR (Australian Centre for Health Research), *Report into the Operation and Future of the Australian Health Care Agreements and the Funding of Public Hospitals* (Melbourne: ACHR, 2008), 6, 24, 74.

But despite decades of spending on preventive initiatives, sedentary habits, poor diet, and obesity have become major health issues, and the rising toll of lifestyle-related chronic disease is now set to increase the unsustainability of Medicare.

Nevertheless, the response from public health experts and the prevention lobby is to call for even more spending on 'evidence-based' prevention programs based on the promise that greater government spending in this direction can and will bring lifestyle disease under control.²⁸

The long-term cost-effectiveness of additional spending on prevention depends on whether the promised reductions in future cost of treating chronic disease are actually achievable.²⁹ However, the evidence from forty years of preventive policies both in Australia and overseas does not support the view that more spending on public health education and promotion campaigns will be an effective method of inducing behavioural change and lowering the incidence of lifestyle disease.

The limited success and overall failure of prevention policies

Australian governments have conducted public health campaigns promoting healthy diets and active lifestyles since the 1960s, the most memorable the long-running, national 'Life. Be In It' campaign begun in Victoria in 1975. Spearheaded by the work of the National Heart Foundation, there have been thirty-five coronary heart disease prevention programs alone.³⁰

Over this period, mortality rates from heart disease have fallen. In 2004, the prevention lobby group the ACDPA claimed that 'programs to reduce coronary heart disease over the last 30 years have cost \$810 million but created benefits worth \$9.3 billion.'³¹ The source for this claim was *Returns on Investment in Public Health*, a report prepared by Applied Economics for the Department of Health and Ageing in 2003, which attributed 70% of the decline in death from heart disease to reductions in smoking, cholesterol, and blood pressure levels.

²⁸ ACDPA, *Chronic Illness*, 6.

²⁹ Productivity Commission, *Potential Benefits of the National Reform Agenda* (Canberra: Productivity Commission, 2006), 208.

³⁰ As above, 207.

³¹ ACDPA, *Chronic Illness*.

The ACDPA exaggerated the benefits the report specifically attributed to health promotion campaigns that have raised public awareness of the behavioural factors—smoking, diet, and exercise—associated with coronary heart disease. After reviewing the literature and often scant data to assess the impact of these campaigns on behaviour and health outcomes, the authors attributed only 10% of the reduction in smoking and only 30% of the reduction in cholesterol to coronary heart disease (CHD) prevention programs. They also concluded that all of the reduction in blood pressure was due to higher use of more effective drugs.

The report determined that out of the \$9.3 billion figure, CHD prevention programs were responsible for benefits to the total of \$994 million, a figure that included benefits such as 'longevity gains.' The report estimated that CHD programs had resulted in a \$557 million saving in government health care expenditure, which was *less* than the \$810 million estimate spent by Australian governments on these programs.³²

The report was careful to apportion part of the credit for reductions in cholesterol levels to campaigns that targeted saturated fat intake. As in the special case (as we shall see) of the war against smoking, a very simple health message that made specific dietary habits taboo—by discouraging the consumption of milk, cheese, butter, and red meat—had an effect on the behaviour of some people, in some sections of the community more than in others.

The importance of class

How limited the effect on diet and exercise behaviour has been is the key point. The evidence strongly suggests that class and educational factors have determined the effectiveness of health promotion campaigns. Obesity levels are highest in lower-income suburbs and lowest in higher-income suburbs.³³ Middle-class people, it appears, have more keenly heeded the healthy lifestyle message, and have stopped smoking, improved their diets, and begun to exercise more. In a real sense, the 'easy' prevention has thus already been accomplished by those people who have made and continue to make the decision to change their lifestyle choices and adopt a healthy lifestyle. The best one can say is that while health promotion campaigns have spread the message about

³² Applied Economics, *Returns on Investment in Public Health: An Epidemiological and Economic Analysis prepared for the Department of Health and Ageing* (Canberra: Department of Health and Ageing, 2003), 48–49.

³³ As was confirmed by the recent NSW Health study that found obesity was highest in the socioeconomically disadvantaged areas of the state. 'Driven to Be Fat,' *Sydney Morning Herald* (29 January 2008).

the lifestyle modifications individuals need to make to promote their own health, they have failed to induce a consistent pattern of behavioural change across all groups in the community.

This was the conclusion pointed to by the findings of the report *Returns on Investment in Public Health*. When it turned to the effect on lifestyle behaviours, the report found that overall CHD prevention programs had limited influence on diet and exercise risk factors, as '*there was little change in the amount of physical exercise taken and the proportion of overweight persons increased.*'³⁴ In other words, despite decades of investment in healthy diet and active lifestyle promotion, the obesity epidemic took off, and the proportion of overweight men and women in the Australian community continues to increase.

Sedentary and obese, with no solutions: The UK experience

International evidence also confirms how unsuccessful efforts to change the unhealthy lifestyles of increasingly obese populations have been overall. The 2004 Wanless review of public health policy in the UK found that the preventive health policies pursued by both the Blair and earlier Tory governments had comprehensively failed to improve the overall health of the population.

Though report after report had set target after target for 'population health,' and outlined action plan after action plan for 'health improvement,' and though the Labour government designed specific programs to tackle lifestyle disease in lower-income communities, just as in Australia, 'levels of physical activity have remained relatively stable over the last decade, [and] obesity levels have been rising.'³⁵

In addition, the Wanless review commented on the 'very poor information base' and 'lack of conclusive evidence for action,' as well as noting that there was 'generally little evidence about the cost-effectiveness of public health and preventive policies or their practical implementation.' The review also commented on the singular failure of public health policies to promote the health of lower-income people. Its conclusion—that 'there is little evidence about what works among disadvantaged groups to tackle some of the key determinants of health inequalities'—is certainly no cause for optimism that more spending on prevention will work in the future.³²

³⁴ Applied Economics, *Returns on Investment in Public Health*, 3, emphasis added.

³⁵ Derek Wanless, *Securing Good Health for the Whole Population* (London: HM Treasury, 2004), 77.

By way of further example, the centrepiece of the Blair Government's commitment to public health improvement was Health Action Zones (HAZs)—twenty-six of which were launched in economically deprived areas between 1997 and 1999. HAZs implemented a broad, multi-agency or 'whole of government' approach to specific disease prevention and to health improvement in general, with the aim of forging community partnerships to address not just health but issues like housing and employment as well. Following the recommendations of the Acheson Report, HAZs signalled the new government's determination to depart from its Tory predecessor's approach to prevention, which the Labour Party felt weighed individual behaviour too heavily and 'blamed the victim.' The new approach concentrated on addressing the socio-economic determinants of ill health and on reducing 'health inequalities' through the provision of additional government services. The belief in the effectiveness of concerted public health action in disadvantaged areas was so strong that firm targets were set for improving population health over a five- to seven-year span—but to no avail.

The key finding of the 2003 national evaluation was that compared to non-HAZ areas, 'HAZs made little impact in terms of measurable improvements in health outcomes.'³⁶ Throwing more government resources at communities doesn't resolve the problem of obesity either.

The slim evidence base

Does the patchy record of prevention policies show the real problem is inadequate funding of 'evidence-based' strategies? Even though Australian spending on prevention is above the OECD average,³⁷ it is frequently pointed out that under 2% of total government health expenditure goes to prevention—which means, so the slogan goes, that we have an 'illness' system, not a 'health' system.³⁸

The problem remains the lack of evidence that the prophesied benefits of dedicating a higher proportion of the health budget to 'public health activities' are realisable.³⁹ Overall, the 'evidence-base' suggests that

³⁶ K. Judge and L. Bauld, 'Learning from Policy Failure? Health Action Zones in England,' *European Journal of Public Health* 16:4 (2006), 341.

³⁷ 'Using a different definition, [the OECD] found that Australia directed about 3.1 per cent of health spending to public and preventive health, above the OECD average of 2.9 per cent.' John Breusch, 'Funding Focus Shifts to Preventive Care,' *Australian Financial Review* (13 February 2008).

³⁸ John Menadue, 'Obstacles to Health Reform,' *Insight* (25 July 2007), cpd.org.au/article/obstacles-to-health-reform.

³⁹ CPD, 'Fact Sheet: Preventative Health.' The prevention lobby always stresses the scope for prevention to have a positive impact—for example, that a 1% increase in the

government spending on 'prevention' has proven to be an ineffective method of controlling lifestyle disease. Even the ACDPA had to admit that the evidence that lifestyle interventions are an effective and cost-effective means of changing unhealthy diet and exercise behaviours is 'limited' and 'scarce.'⁴⁰

What the evidence does point to is how difficult it is to change lifestyle behaviours. In 2005, a team of researchers from Monash University's Health Economics Unit reviewed the best international studies to assess the link between preventive diet and exercise programs, behavioural change, and health outcomes. While the intention was to establish a platform that would justify the rollout of a new 'evidence-based' policy, the authors ultimately concluded that there were:

critical gaps in the evidence relating to lifestyle interventions across all these areas ... In general, evidence from which to assess community-wide interventions is incomplete and what is available is of poor quality ... Least satisfactory is the evidence concerning physical activity and multiple risk factor interventions, particularly in relation to retention of behaviour change.⁴¹

In other words, so slim is the evidence that prevention works that, as one candid public health academic has truly said, what we really have with regard to calls for more spending on prevention is a 'policy looking for an evidence base.'⁴²

proportion of the population that is sufficiently active would result in estimated saving of \$8 million per annum. ACDPA, *Chronic Illness*.

⁴⁰ ACDPA, *Chronic Illness*, 9, 14. In addition, methods of measuring population health outcomes and monitoring risk factors like obesity, blood pressure, cholesterol, and physical activity are underdeveloped, making it difficult to assess the performance of public health campaigns or estimate the returns on spending. NHPAC (National Health Priority Action Council), *National Chronic Disease Strategy* (Canberra: Australian Government Department of Health and Ageing, 2006), 28, 45–46.

⁴¹ Monash University Centre for Health Economics, *Risk Factor Study: How to Reduce the Burden of Harm from Poor Nutrition, Tobacco Smoking, Physical Inactivity and Alcohol Misuse: Cost Utility Analysis of 29 Interventions*, Research Paper 2005(1), 7–8.

⁴² 'It is laudable to think that research findings will help to inform the evidence base for policy but often there is a sense that we have policy looking for an evidence base.' Annie S. Anderson, 'Obesity Prevention and Management—Evidence and Policy,' *Journal of Human Nutrition and Dietetics* 18:1 (February 2005), 1–2.

Anti-smoking campaigns: The exception, not the rule

Nevertheless, unwarranted encouragement is often taken from the success of campaigns against tobacco smoking.⁴³

For a number of reasons, the anti-smoking campaign is a special case. For one thing, it has involved much more than simply educating the community about the health risks of smoking and the corresponding benefits of quitting. The leading edge has been one shocking and highly emotive mass-media advertisement after another. These have targeted the minority in the community who continue to smoke by setting out, often in anatomical detail, the disease consequences of smoking. The negatives of smoking have been heavily publicised, and this differs from the way that government has fought obesity. On the whole, the strategy for fighting obesity has involved government-funded campaigns that promote the benefits of healthy diet and exercise habits, rather than concentrating on the negatives of obesity.

Properly categorised, the anti-smoking campaign is an example of public health regulation rather than health promotion. It is more like traditional public health measures and the way governments have compelled seatbelt use and attacked drink-driving, through legislation and enforcement. Governments have employed a series of highly interventionist methods to discourage smoking. Along with making cigarette advertising illegal and warnings on cigarette packaging mandatory, governments have also directly harassed smokers by imposing legislative bans on smoking in workplaces and other public areas. Constant increases in the price of cigarettes as governments have levied higher and higher tobacco taxes have been an additional deterrent.⁴⁴

The further difference between the anti-obesity and anti-smoking campaigns is that the community has largely accepted the top-down effort by government to change smokers' behaviour mainly because of the perceived risks of 'passive smoking.' The belief that cigarettes harm non-smokers as well as smokers has transformed smoking into a social

⁴³ Between 1991 and 2004, smoking rates in Australia fell by almost 30%. Presently, 17% of the population aged over fourteen smoke, down from 45% of the adult population thirty years ago.

⁴⁴ The evidence is contested about the effect of higher taxes, though: see Applied Economics, *Returns on Investment in Public Health*, 21–22. However, in Britain, for example, the effectiveness of anti-smoking initiatives has been lower because the effect of tax rises on tobacco consumption has been muted due to the proliferation of cigarette smuggling. Derek Wanless, *Securing Good Health for the Whole Population*, 86.

sin. As a result, the restrictions imposed on smokers to curb their habit are generally accepted by the community as a legitimate piece of public health protection. This is similar, again, to the case of random breath testing, which protects other road users from drink-drivers.

By contrast, obesity has not attracted the same stigma as smoking because the community continues to see obesity as harming only the obese. The impact on the community—the extra imposts on taxpayers and the additional strain on the health system—are not as obvious, and, crucially, other people's obesity does not directly affect the health of their fellow citizens. In the fight against obesity, governments are therefore unlikely to be able to rely on the same social stigmas, punitive levers, and society-wide sanctions. For one thing, politicians will probably be reluctant to single out the expanding constituency of overweight voters for their 'antisocial' lifestyle. What health minister will want to be seen reinforcing 'negative stereotypes' about 'fat people'? For the same reasons, it is unlikely that the disease consequences of obesity will be brought home as starkly as in government-funded advertisements against smoking.

Why prevention polices have not prevented lifestyle disease

It is little wonder, compared to the anti-smoking campaign, that the mild and positive campaigns to promote voluntary lifestyle change have not succeeded. The differences lie not just in the methods used, but also in the different kinds of behavioural change that each campaign has tried to initiate.

Anti-smoking campaigns—again akin to traditional public health measures—targeted a specific behaviour. Cajoling individuals to decide to stop one bad habit and cease smoking is not the same thing as promoting healthy behaviours. While people can quit smoking and the preventive benefit is immediate, people cannot 'quit' being obese or gain any preventive benefit unless they actively do a series of things to change their lifestyle and sustain those changes over the long term.

The different kind of behaviour change that each sets out to achieve would explain the success of the anti-smoking campaign and the relative failure of healthy diet and exercise campaigns. While both have sought to educate people about the behaviour they need to change to protect their health, it is (demonstrably) much harder to get people to promote their own health and initiate and sustain a series of changes to complex and often longstanding behaviours by continually deciding to make healthy dietary and exercise decisions.

This is the significance of the studies that point to the difficulties encountered in sustaining long-term behavioural change. The ‘stickiness’ of lifestyle behaviours means that people are prone to maintain the life-long unhealthy but often pleasurable habits that cause obesity and can lead to chronic illness, no matter how strongly the health promotion message is pushed.⁴⁵ Appreciating this makes sense of the evidence and the story it tells, and directs attention to the principal reason for the limited impact of lifestyle interventions. Since individuals are principally responsible for deciding to modify their unhealthy habits, success (long-term behavioural change) ultimately depends upon on personal qualities (will, self-discipline, and impulse control) that many people at risk of contracting lifestyle disease may not possess.

To combat obesity, could governments apply the more interventionist approach used against smoking? The problem is that it is difficult to conceive how governments could *fairly and effectively* regulate diet and exercise habits. When governments banned smoking in public, they acted on the principle that every cigarette damaged smokers’ health, and penalised smokers only for the behaviour believed to harm non-smokers. Tobacco is also an easy-to-define, noxious substance. But it is difficult to define ‘junk food’—which is neither noxious nor an unhealthy product unless consumed excessively—so that taxes could be imposed or advertising for it could be banned. In addition, the ‘fat taxes’ proposed in emulation of the taxes on cigarettes, as well as new (far-fetched) proposals to employ urban design strategies to curtail car use and compel public transport use, would not just target the unhealthy behaviour of the overweight and obese. Such measures would also penalize people who, for instance, can consume fast foods in moderation and do no harm to themselves, let alone to others. For these reasons, any government that attempts to regulate lifestyle behaviours is liable to face legitimate and justified opposition against unwarranted intrusions upon individual liberty.

A new model of preventive care?

Wellness

Could the failure of health education campaigns to change entrenched lifestyle behaviours mean we do need a new approach to preventive care? According to the ‘father’ of the ‘wellness’ model of ‘preventive healthcare’ that is at the heart of the Rudd government’s Super Clinics plan, John Stafford, the ‘lifestyle changes associated with obesity and

⁴⁵ For a notably sober assessment of these issues, see Productivity Commission, *Potential Benefits of the National Reform Agenda*, 218–220.

physical activity can be facilitated by ongoing collaboration by a multidisciplinary workforce.’⁴⁶

The new wellness model amounts to expanding Medicare to fund a host of new allied healthcare providers that will be responsible for managing their patients’ lifestyle decisions. The federal government is currently reviewing the Medicare rebate schedule and the terms of Australian Health Care Agreement to facilitate a greater role for preventive care along these lines. Supporting and assisting people to change their eating and exercise patterns might seem a reasonable response to lifestyle disease, given that the major problem is that people struggle to sustain long-term behavioural change.

Will this work?

But will what still amounts to prescribing lifestyle modification actually work?

Unfortunately, it is the same story here as in the case of ‘community-wide’ interventions. Once again, studies report that even high-intensity professionally-guided lifestyle interventions have had low impact on behaviour, particularly with regard to the long-term retention of behavioural changes.⁴⁷

Some might point out that the 2003 US Preventive Services Task Force (USPSTF) report found there was ‘fair to good’ evidence that a combination of high-intensity behavioural interventions (diet and exercise counselling, nutrition and skill-development education, and ongoing support) can produce modest, sustained weight loss of between three and five kilograms per patient. It is worth noting that this is not the same thing as achieving weight loss sufficient to place obese people in a healthy weight range. Overall, the USPSTF put the most optimistic gloss on unconvincing evidence.

First, the ‘fair to good’ finding applied only to high-intensity behavioural interventions that targeted patients categorised as obese. Otherwise, the USPSTF ‘found limited data that addressed the efficacy of counselling-based interventions in overweight adults.’ Second, most of the relevant studies were judged only fair in quality, due to small samples and high dropout rates. Third, the studies were marred by ‘se-

⁴⁶ John Stafford, *Wellness Centres Revisited*, 10.

⁴⁷ See M. Hillsdon, C. Foster, and M. Thorogood, ‘Interventions for Promoting Physical Activity,’ *Cochrane Database of Systematic Reviews* 2008:2 (2008), www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003180/frame.html.

lection bias,' which highlighted the importance of cultural and individual factors, since the data supporting the (questionable) effectiveness of high-intensity interventions was derived mostly from white women, with very little data regarding obese men or the elderly.

Fourth, the studies generally reported only average group weight change, not 'frequency of response to the interventions': the percentage of patients for whom the intervention was unsuccessful was not recorded. Finally, the studies 'showed mixed results.' Of the eleven studies, only four showed significant average weight reductions. Several studies showed modest, sustained weight loss over a two- to three-year period, but overall 'trials with follow-up beyond 1 year tended to show a loss of effect.'⁴⁸

Again, the evidence does *not* show that prevention works; rather, it seems to confirm that obesity and lifestyle disease remain difficult to prevent so long as the risk of harm remains relatively remote,⁴⁹ because lifestyle modification is difficult to induce and sustain no matter the form of intervention. Promises that new models of preventive care will more effectively control lifestyle disease should be treated with caution.

From enlightenment to 'soft' paternalism: The muddled public health discourse

The role of government and 'ordinary Australians'

One of the significant things about the new 'wellness' model of preventive care is its testimony to the profound failure of decades of existing health promotion policies. It also epitomises the questionable new policy proposals and outcomes that are starting to flow as a result of

⁴⁸ USPSTF (United States Preventive Services Task Force), *Screening for Obesity in Adults: Recommendations and Rationale*, AHRQ Pub. No. 04-0528A, December (Rockville, MD: USPSTF, 2003).

⁴⁹ This may well explain the success of the Finnish Diabetes Prevention study, which achieved impressive reductions in diabetes by providing middle-aged, overweight pre-diabetes patients diagnosed with IGT (impaired glucose tolerance) with high-intensity lifestyle interventions, though the dropout rate was 10%, the loss of weight achieved relatively small, and some subjects failed to follow up on recommended behaviour modifications. J. Tuomilehto and others, 'Prevention of Type 2 Diabetes Mellitus by Changes in Lifestyle Among Subjects with Impaired Glucose Tolerance,' *New England Journal of Medicine* 344:18 (May 2001), 1343–1350. Note, however, when such trial programs have been replicated in the 'real world' of general practice—as in the Greater Green Triangle program in Victoria and South Australia—the dropout rate has blown out to 23%. Greg Johnson and James Dunbar, 'Working to Fight Obesity,' *Herald Sun* (7 April 2008). Note that this is also more of an example of secondary chronic disease prevention, rather than of primary obesity prevention.

attempts public health experts have made to make 'sense' of the failure of existing prevention measures.

Though loath to admit that 'community-wide' prevention measures have not succeeded, public health experts no longer attribute the persistence of unhealthy behaviour to ignorance. Instead, reasonably enough, some say that health education campaigns have been successful to a point, as most people now are at least aware of the lifestyle modifications they need to make to protect their health and reduce the risk of chronic illness.⁵⁰

'But,' as the Australian Labor Party's 'Fresh Ideas' preventive health-care discussion paper released in June 2007 put it, 'recent history demonstrates that even while most of us already know this, we sometimes need motivation, resources, support and help from the system to turn this knowledge into practice.'⁵¹ Note, as we have seen, there is no evidence that 'help' from the 'system' does 'turn knowledge into practice.' But what this analysis of 'recent history' reveals about the thinking and motivations behind the Rudd government's plan to unfurl a whole new stream of preventive policy is even more alarming.

The government's preventive health policy implies that while the incidence of lifestyle disease has increased because many people have not heeded the healthy lifestyle message despite public health campaign after campaign, the real issue, as the government's GP Super Clinics policy document put it, is that 'Preventative health care needs to be made more accessible to ordinary Australians.' As the policy document continues to argue—and this is the position explicitly endorsed by the prime minister and the health minister—in 2008 'ordinary Australians' cannot be expected to fulfil the basic individual and social duty to protect their own health without government help and without taxpayer-funded entitlements to 'wellness' services.

How has it come to this?

Taxpayers are entitled to ask an obvious question concerning the wisdom of transforming Medicare into a weight-loss advice company. Many private companies already offer such services—won't they not be crowded out of the market if the government provides such counselling for 'free'? It is also fair to believe that people might be more motivated

⁵⁰ These are 'mostly within the power of people to provide for themselves.' Peter Baume, 'It's All About Health,' *On Line Opinion* (5 October 2007) www.onlineopinion.com.au/view.asp?article=6441.

⁵¹ Kevin Rudd and Nicola Roxon, *Fresh Ideas, Future Economy*, 8.

to stick to recommended diets and exercise regimes if they sought help from a private provider and were paying for this advice out of their own pockets. Not only would the financial commitment signal one's real commitment to lifestyle change, this would also create a real incentive not to waste or have to repeat this expenditure.

But rather than insist on and promote personal responsibility, what is alarming about the government's preventive health policy is that it accurately captures (or apes) the remarkable shift that has occurred in the public health discourse as obesity has emerged as a key health issue in recent years. To explain away the failure of education campaigns to eradicate lifestyle disease as promised, public health experts are now in an absurd muddle as they try to justify their continued calls for more 'investment' in prevention.

Rather than accept the real and demonstrated limits to the effectiveness of prevention, the contemporary public health discourse has instead absolved individuals of their responsibility for unhealthy lifestyle decisions they continue to make. In a blatant misuse of the term, obesity has now been redefined as an 'epidemic,' as if it is a contagious disease that somehow people passively contract due to wicked multinational fast-food advertising. Public health experts have also developed the concept of 'health inequality,' which, properly understood, would recognise that the incidence of lifestyle disease is concentrated among lower-income groups that have failed to heed the healthy lifestyle message. But as employed in the health debate, 'health inequality' has redefined the persistence of unhealthy lifestyles as a 'social problem'—lest one 'blame the victims'—that governments have failed to intervene to control. As a result, rising levels of obesity are not attributed to individual choice and personal behaviour, but to 'a catastrophic failure of government and public health authorities to devise and implement concerted, effective evidence-based action.'⁵²

So absurd is the shift away from personal responsibility and towards government responsibility for the cause and cure of lifestyle disease, that it is now commonplace to blame the lifestyle disease 'epidemic' on lack of entitlement to preventive care. According to this remarkable and paternalistic thinking—and the government's preventive health-

⁵² Stephen J. Corbett, 'A Ministry for the Public's Health: An Imperative for Disease Prevention in the 21st Century?' *Medical Journal of Australia* 183:5 (2005), 254. Note the Rudd government has virtually decided to establish the equivalent of a Ministry of Public Health, having flagged support for new taxes on cigarettes, alcohol and fast food to fund a new national preventive health agency. Jessica Irvine and Yuko Narushima, 'Extend Alcohol Tax to Tobacco', *Sydney Morning Herald* (28 April 2008).

care policy documents amply demonstrate this—the reason health outcomes are lower and the incidence of lifestyle disease is highest in lower-income areas is because governments have failed to provide the relevant communities with access to preventive health services.⁵³

A crisis accentuated, not averted: Five problems with ‘prevention’

The evidence invites five conclusions that problematise the notion that governments should ‘invest’ more money in ‘prevention.’

One. Preventive medicine is clearly not the same thing as ‘behavioural change’ medicine. Because lifestyle modification is primarily an individual responsibility, no intervention by government can, with certainty, control what people decide to eat or how much they choose to exercise.

Two. While governments have an obligation to try to inform citizens about what they need to do to protect their health, spending more money on public health campaigns to promote lifestyle modification offers no guarantee that people will have the capacity to initiate and sustain behavioural change. Long-term diet and exercise behaviours are complex and extremely ‘sticky,’ and behavioural change is very difficult to induce and retain regardless of how intensively and expensively the health promotion message is pushed. The probable reason that prevention campaigns have proved less effective than hoped is because many people whose lifestyle is unhealthy but who are yet to develop a chronic illness choose not to modify high-risk but often pleasurable behaviour while the risk of harm and developing a chronic disease is relatively remote.

Three. Optimistic promises that more spending on demonstrably unsuccessful preventive measures will bring lifestyle disease under control, deliver savings on health costs, and improve the sustainability of Medicare are unrealistic.

Four. The Rudd government’s Super Clinics plan to expand Medicare-funded access to a wider range of wellness-promoting allied health services will more than likely increase the challenges Medicare faces. It will build a new structural feature into the commonwealth health budget, which will prove a very expensive, open-ended commitment,

⁵³ Australian Health Care Reform Alliance, ‘Position Papers’ (July 2007), www.healthreform.org.au/content/upload/files/Microsoft_Word_-_Position_papers_July_2007_Summit.pdf, 15.

given the evidence that many recipients of these ‘preventive health services’ will find it difficult to modify and sustain changes to their unhealthy lifestyles. Rather than save on health costs, the danger is that future governments and taxpayers will have to fund the additional recurrent cost of ineffective ‘preventive’ care that yields negligible health and cost benefits. Again, this suggests that in the long-term, Super Clinics threaten to accentuate, not alleviate, Medicare’s unsustainability.

Five. On top of the costs of ageing and new technology, future generations of taxpayers will face pressure to pay an increasingly large bill for treatment of lifestyle disease.

The bottom line therefore is that despite all the talk about the ‘long-term’ benefits of prevention, in reality we cannot afford to continue to avoid adequately addressing the profound long-term challenges Medicare faces. Unless we look beyond the false promise of more spending on prevention, and start to address how to move beyond relying on taxpayers to finance the accelerating cost of health care into the twenty-first century,⁵⁴ Medicare is going to impose unsustainable burdens on future generations.

Greater government intervention: The case against

It is also appropriate to briefly consider some of the arguments against proposed policies which would see governments intervene more heavily into the food market to combat obesity.

Taxing fat

Placing a ‘fat tax’ on ‘fast food’—proposed in emulation of the taxes on cigarettes—is a long-cherished goal among public health experts in the universities and the health bureaucracies. The enthusiasm for forcing recalcitrant individuals to modify their lifestyles (by pricing them out of the fast-food outlets) is another tacit admission that preventive education has not worked. The mystery, therefore, is the enthusiasm for spending even more taxpayers’ money in this direction.

As noted earlier, supporters of a ‘fat tax’ point to the success of anti-smoking public health campaigns, which in combination with higher taxes have driven substantial numbers of smokers to quit the habit.

⁵⁴ See Jeremy Sammut, *The Coming Crisis of Medicare*.

Overlooked, however, are the important differences between using tax plus education to get people to stop smoking and getting them to reduce their intake of fatty foods.

To begin with, it is worth mentioning the terrible snobbery behind the push for a 'fat tax' on 'fast food': the brie and red wine consumed by elites are not to be targeted, only the soft drinks and hamburgers enjoyed by 'ordinary Australians.' The inherent discrimination involved against popular pleasures raises two key points likely to interest the committee:

- While every cigarette you smoke is bad for you, this is not true in relation to fatty foods. Less than a quarter of the population smokes, but the great majority of us eat chips and hamburgers at one time or another. Hence, the fat tax will not just target the unhealthy behaviour of the overweight or obese. It will also penalize people who have heeded the healthy lifestyle message and who eat fast foods in moderation. Consumers who are doing no harm to themselves (and who are certainly not harming other people, for there is no equivalent here to the issue of 'passive smoking') will be targeted. The thin and the fat will be taxed alike.
- Put bluntly, the main aim of a 'fat tax' is to raise the price of fast food so that lower-income communities with the highest rates of obesity will be unable to afford to eat so much 'junk.' But unless the price hike is substantial, it won't work. Estimates suggest that to have even a small impact on eating habits, a fat tax would need to be as high as 15% or 20%. For the tax to work, it will need to financially hurt financially vulnerable people. This is to say that fat taxes are inherently regressive: poor people who consume more fatty foods will pay more than affluent sections of the community.

When presented in these terms, a fat tax hardly shapes up as a politically saleable 'solution' to the obesity 'crisis.' Governments that employ penalizing taxes to regulate lifestyle behaviours will punish the responsible and irresponsible alike, and are liable to face community opposition, not just from those being 'helped' to modify their habits, but especially from people who don't need such help at all.

Note should therefore be taken of the negative public reaction to the recent excise tax increase on 'alcopops' to (allegedly) curb binge drinking. There was resentment in the community that the tax hike punished responsible drinkers, just because they prefer to consume premixed al-

coholic beverages rather than beer or wine.⁵⁵ This illustrated both the principle at stake and the surrounding politics: the unfairness of governments interfering with the choices of responsible citizens and financially disadvantaging those citizens because of the irresponsible overindulgence of others.

Before supporting penalizing taxes on fast foods, policymakers should therefore pause, and especially consider the position of respectable working men and women of Australia, who look after their own health and the health of their children. They are taxed when they earn, taxed when they spend on necessities, and now the proposal is to tax their frugal pleasures more heavily. This may not matter to those with high disposable incomes (who can afford brie and red wine), but for the average family of modest means, the cost of the occasional treat or outing to a fast food restaurant will increase. The politicians responsible for imposing the additional costs will undoubtedly wear the blame and have to bear the political backlash.

Regulating the food market

The failure of existing preventive strategies has led the public health community to encourage policymakers to support more heavy-handed measures to regulate consumption habits. One proposal is that governments should subsidise the cost of fresh fruit and vegetables. This should be dismissed out of hand based on past experience with government subsidies. Rather than bring prices down for consumers, subsidies simply transfer money from taxpayers to businesses.

The committee's attention is also sure to be drawn to the much-discussed Finnish Prevention project of the mid-1970s, which led to reductions in obesity and heart disease as a result of government intervention into the food market.

The Finnish experience is not an example of prevention as in education. In a small, homogeneous country with a closed economy, key staples that formed a major part of the Finnish diet—fatty pork and whole-milk dairy goods—were targeted to lower fat-intake levels. Government milk subsidies based on fat content were phased out, and the development of new products such as low-fat cheese was encouraged.

The issue is whether it is possible or desirable to replicate a similar a regime. In a diverse and open society like Australia, it is impossible for governments to target and regulate the content of one or two foods, and

⁵⁵ See Sarah Elks and Siobhain Ryan, 'Kevin's Drink Tax Hurts a Ute Man,' *The Australian* (15 May 2008).

hope to produce a similar effect on obesity. (After Finland's admission into the EU in 1996, greater choice was introduced into the food market, and obesity increased.) This is also unnecessary. There is no case for government intervention, since the existing character of the food market is not an example of 'market failure.' The food market is *not* dominated by high-fat food; there is an abundance of choice.

This is to say that food producers have already responded to the social trend—as they did in Finland. Across a wide range of food products—particularly dairy and meat—low-fat alternatives are available to consumers in supermarkets and other food outlets. These products are also advertised in the mass media—and increasingly by 'fast food' companies—as the 'healthier option.'

Banning fast-food ads

This contradicts a claim commonly made those who advocate interventionist approaches: that the healthy lifestyle message can't compete with marketing campaigns promoting 'junk foods,' and that therefore the advertising of these products should be restricted or banned.

The arguments against ad bans include:

- As with the fat tax, ad bans are another case of unfairly restricting the liberty—the right to freedom of expression—of one part of the community because of the 'license' (so to speak) of others who make bad lifestyle decisions.
- It simply is not credible to assert that the health lifestyle message is not well-publicised and well-known: a whole arm of the food industry works at informing and convincing consumers to purchase low-fat and healthy alternatives.
- It also is not credible to say that those who overindulge in certain products are the 'victims' of advertisements so seductive that resistance is impossible. The agency each individual has over their own lives and dietary choices should not be denied to make excuses for the unhealthy lifestyles some people lead.

Once again, this identifies the big problem with the contemporary public health approach to 'fighting' obesity. If public health experts and governments were serious about the root cause, they would support policies that singled out and made individuals take responsibility for their unhealthy lifestyles. (A higher Medicare levy for the overweight, perhaps, or refusing the obese 'free' treatment at public hospitals.) Insisting that there be consequences for unhealthy behaviour would be

'hard' paternalism, as opposed to the 'soft' paternalism dominant in the obesity debate. Soft paternalism sends the message that individuals are not responsible for the unhealthy decisions they continue to make and that the government will find a solution for them. It does not hold people to account for their lifestyle, but instead blames 'society,' blames ads, blames fast-food multinationals, and ultimately, somehow, blames governments.

The absurdity of making governments responsible for preventing the unhealthy lifestyle choices can be demonstrated by pondering what banning ads would really achieve. Short of outright prohibitions against the sale of fast, fatty, and sugary food (and denying freedom of choice to all citizens), governments will continue to have extremely limited authority over the individual behaviours that cause and can prevent lifestyle disease. The amount of fatty foods individuals consume will remain a matter of individual choice, self-regulation, and personal responsibility (or, in the case of childhood obesity, a matter of parental control, and the will to instil moderation and restraint in youngsters). Whether it is advertised on TV or not, those who overindulge will still know (as they do now) that eating lots of 'junk food' is bad for them. But they are just as likely (as now) to continue to do it anyway.

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