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**Health Group Strategies Pty. Limited**
(INC. IN NSW) ABN: 16 003 974 507

AND

**INSTITUTE OF HEALTH ECONOMICS AND TECHNOLOGY ASSESSMENT**
ST CHRISTOPHE EN BRIONNAIS, BURGUNDY, FRANCE

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# SUBMISSION

**to the**

**House of Representatives Standing Committee on Health and Ageing Inquiry into Obesity in Australia**

Paul Gross

Director, Health Group Strategies Pty Ltd
Australia and Greater China

Parts of this paper were presented as invited papers at the Childhood Obesity Summit in Sydney on 11 December 2007 and at the National Preventative Health Summit, in Sydney on 15 October 2008

PO Box 4232
Balgowlah Heights, NSW 2093
28 October 2008

The Secretary,
House of Representatives Standing Committee on Health and Ageing,
Parliament House,
Canberra, ACT 2600

Dear Sir,

The attached submission to your inquiry into obesity in Australia is intended to address some elements of your second term of reference, viz.,

*"The Committee will recommend what governments, industry, individuals and the broader community can do to prevent and manage the obesity epidemic in children, youth and adults."*

My prime concern in this submission is to pull together evidence that emphasises both the role of personal responsibility as a foundation stone of social solidarity, and the limitations of government regulations and sin taxes in preventing obesity.

In putting forward some suggestions on these matters, I discuss briefly some of the directions proposed in the October 2008 discussion paper of the National Preventative Task Force as its deliberations on obesity prevention overlap with those of your Committee.

A secondary goal is to emphasise the components of a comprehensive approach to the prevention of obesity at all ages, and in the final section I have identified some benchmark developments in other nations that might be emulated in Australia.

Please contact me if any aspect of this submission requires further amplification.

Yours sincerely

Paul Gross
Director, Institute of Health Economics and Technology Assessment,

**AUSTRALIAN HEALTH POLICY SERIES 2006-2008**

1. PF Gross." New healthcare funding sources for a fatter Australia with more chronic illness: new evidence on the impact of integrated obesity management, economic incentives for lifestyle change and workplace interventions that increase national productivity". February 2006.

2. PF Gross. "Mind the gaps: increasing personal health security via prevention and economic incentives". First Menzies Winter Series Lecture, University of Sydney, July 2006.

3. PF Gross." Transforming Medicare: obesity is the immediate threat to national productivity, personal responsibility is weakened by today's subsidies, and economic incentives that change unhealthy behaviour are being introduced elsewhere". Second Menzies Winter Series Lecture, University of Sydney, July 2006.

4. PF Gross. "Funding real health security: higher transparency of price and quality of care while transforming Medicare subsidies to governments and households". Third Menzies Winter Series Lecture, University of Sydney, July 2006.

5. PF Gross. "Patient safety and quality of care under pay-for-performance hospital reimbursement: early lessons from US, UK and Australian applications, and implications for health IT budgets and the next Australian Healthcare Financial Agreements". November 2006

6. PF Gross. "Healthier youth, workforce and ageing under a transformed Medicare: the next five-year Australian Health Care Agreements and Broader Health Cover as the change agents". February 2007

7. PF Gross. "The audacity of hope: are private health insurance and Medicare on converging paths to improved access, efficiency, equity and quality?" June 2007

8. PF Gross. "The business case to reduce absenteeism and presenteeism in the Australian workforce: measuring the economic impact of prevention and management of chronic conditions". August 2007.

9. PF Gross. "Paying for modern drugs in Australia: safety nets, patient copayments, private health insurance and OTC switches". September 2007.

10. PF Gross. "Informed and educated consumers accessing a more transparent healthcare system: the case for a national self-care alliance". December 2007.

11. PF Gross. " Taking the actions that speak louder than the glut of words about the obesity epidemic: Australia needs a funded national strategy for behaviour change and collaborative platforms on diet, nutrition, physical activity and health". December 2007.

12. PF Gross." National savings and health care expenditures with rising disability and ageing: the potential role of medical savings accounts in funding care in retirement and improved national productivity". December 2007.

13. PF Gross." Public hospital financing via the Mersey route, the Rudd carrots and sticks or by slugging private health insurers". December 2007.

14. PF Gross." Provider payment currencies: US, UK, German and Australian DVA paths to higher quality, efficiency and coordination of chronic disease management via 'Pay-For-Systemness'". 23 February 2008.

15. PF Gross. "Australia's $100 billion healthcare system and the election promises: priorities for undoing complacency and enhancing transparency". 10 March 2008.

16. PF Gross." The high performance, transparent health system: leadership needed to improve population health, patient safety, and chronic disease management via provider payment reform". 11 April 2008.

17. PF Gross. "Self-care, personal responsibility and the potential impact of economic incentives for healthy behaviour". 12 October 2008.

18. PF Gross. “A new national prevention strategy for obesity and related chronic conditions must include early intervention and enhanced personal responsibility supported by Medicare and private health insurance ”. 20 October 2008.

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## EXECUTIVE SUMMARY

Eleven years after the first substantive report on the national obesity problem by the National Health and Medical Research Council, we are still talking about how hard it is to prevent obesity at all ages.

A myriad of expert committees are at work looking at related issues. The National Health and Hospitals Reform Commission, the National Preventative Health Task Force, the National Primary Care Strategy External Reference Group and the House of Representatives Standing Committee on Health and Ageing are diverse in their goals but obesity is a common issue.

The Task Force has issued a discussion paper that overlaps in part with the deliberations of the Standing Committee in its inquiry into obesity in Australia.

In evidence tended to both organisations - and in the discussion paper - there seems to be an undercurrent of enthusiasm for the regulatory route and taxes (often called sin taxes) to balance out the perceived effects of the unfettered marketplace that allows advertising to children of particular types of energy-rich foods.

First, here is little evidence to support the use of regulations and taxes as preferred tools against obesity. Second, I fear that the preoccupation with regulation is not balanced by equivalent effort to reinforce the role of personal responsibility in obesity prevention, and the subsequent need to find incentives to help individuals make healthier choices in energy intake and energy expenditure, the two arms of the energy balance that affect weight gain.

My concern in this paper is to summarise some evidence on these two facets of the debate noting that elsewhere in the world, committees of experts have often ignored this evidence, proposed solutions that do not accord with opinions of individual experts, and made it very difficult to persuade parliaments to accelerate comprehensive solutions to obesity that are already underway in many nations, including a reinforcement of personal responsibility as a form of social solidarity.

In this submission to the House of Representatives Standing Committee on Health and Ageing I traverse five topics that are relevant to the deliberations of both the Standing Committee and the Task Force:

- some key issues surrounding obesity in the Preventative Health Task Force discussion paper released on 10 October 2008;
- international trends shaping prevention, the role of the informed consumer and enhanced personal responsibility for healthy lifestyles;
- available evidence on the need for paternalism via government regulation of advertising of, or taxes on, fatty foods;
- what governments can do to "nudge" behaviour change in providers and households via Medicare, health insurance and tax reform; and
- what I hope to see recommended in the final reports of both the House of Representatives Standing Committee on Health and Ageing inquiry into obesity and the National Preventative Health Task Force.

## INTRODUCTION

We are at a critical juncture in health policy formulation in particularly worrying economic times.

Eleven years after the first substantive report on the national obesity problem by the National Health and Medical Research Council, we are still talking about how hard it is to prevent obesity at all ages.[1]

A myriad of expert committees are at work looking at related issues. The National Health and Hospitals Reform Commission, the National Preventative Health Task Force, the National Primary Care Strategy External Reference Group and the House of Representatives Standing Committee on Health and Ageing are diverse in their goals but obesity is a common issue.

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First, here is little evidence to support the use of regulations and taxes as preferred tools against obesity. [2] Second, I fear that the preoccupation with regulation is not balanced by equivalent effort to reinforce the role of personal responsibility in obesity prevention, and the subsequent need to find incentives to help individuals make healthier choices in energy intake and energy expenditure, the two arms of the energy balance that affect weight gain. [3]

My concern in this paper is to summarise some evidence on these two facets of the debate, noting that elsewhere in the world committees of experts have often ignored this evidence, proposed solutions that do not accord with opinions of individual experts, and made it very difficult to persuade parliaments to accelerate comprehensive solutions to obesity that are already underway in many nations, including a reinforcement of personal responsibility as a form of social solidarity.

With these concerns paramount, I traverse five topics that are relevant to the deliberations of both the Standing Committee and Task Force:

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[1] K Ball and D Crawford."Healthy weight 2008: still waiting on Australia to act?" *Australian Journal of Nutrition and Dietetics* 2004; 61 (1): 6-8. This editorial comment noted that the concerns about obesity were evident in George Bray's report over 25 years earlier.

[2] As I note many times in this paper, I am not arguing for zero government regulation. For tobacco control, the regulatory route had an impact when "all else" failed. For binge drinking, we are at the stage where regulations on access by the young are required but I am not sure about alcopop-type taxes. With obesity control, I am not yet at the point where evidence on the costs and benefits of regulations or sin taxes tells me that they are the preferred solutions. In the absence of data on unintended side-effects of different regulations and taxes, the "precautionary principle" is not applicable.

[3] The unwillingness to address the needs of individuals and personal responsibility reminds me of the old canard that this is just "victim-blaming".

- some key issues surrounding obesity in the Task Force discussion paper released on 10 October 2008;
- international trends shaping prevention, the role of the informed consumer and enhanced personal responsibility for healthy lifestyles;
- available evidence on the need for paternalism via government regulation of advertising of, or taxes on, fatty foods;
- what governments can do to "nudge" behaviour change in providers and households via Medicare, health insurance and tax reform; and
- what I hope to see recommended in the final reports of both the House of Representatives Standing Committee on Health and Ageing inquiry into obesity and the National Preventative Health Task Force.

# 1. THE NATIONAL PREVENTATIVE HEALTH TASK FORCE DISCUSSION PAPER AND POLICIES FOR OBESITY

## 1.1 Content and targets

Never intended as a costed national strategy for prevention of three large health problems (smoking, excessive drinking and obesity), the Task Force discussion paper[4] is a high-level review of these problems that lists some prevention strategies against three health issues: smoking, excessive alcohol consumption and obesity.

It seeks public input on the many options canvassed by the Task Force, and many of those options will no doubt be reviewed in the House of Representatives Standing Committee.

Given the size of the problems listed in its paper, the Task Force is modest in its expectations in setting its deadlines for improvements.

*"The Taskforce is convinced that we can achieve the following targets by 2020:*

- *Halt and reverse the rise in overweight and obesity*
- *Reduce the prevalence of daily smoking to 9% or less*
- *Reduce the prevalence of harmful drinking for all Australians by 30%*
- *Contribute to the 'Close the Gap' target for Indigenous people, reducing the 17-year life expectancy gap between Indigenous and non-Indigenous people."*

## 1.2 Preferences for the regulatory route

Though fairly balanced in its discussion of today's weight gain problem and its potential consequences, the Task Force is pro-regulatory in its preferred solutions for obesity, ostensibly moved by advice that obesity can be reduced with the regulatory and tax tools used in tobacco control from the 1980s onwards.

*"Consumer demand needs to be redirected towards healthier choices. This can be achieved by industry producing, promoting and marketing much healthier products. We also need effective legislation and regulation, using pricing, taxation and*

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4 National Preventative Health Taskforce. *Australia: the healthiest country by 2020 A discussion paper*. Canberra October 2008.

*subsidies as a means to encourage healthier choices. It could be suggested that the community is not yet ready for some of these ideas, but just think how unlikely it would have been 25 years ago to have introduced the approaches to tobacco control that are now commonplace*".

That recourse to tobacco control pushed into the reader's consciousness, the Task Force expresses its desire to "shape" behaviours rather than prohibit them.[5]

"*The necessary actions to reduce tobacco smoking are clear. They include making cigarettes more expensive, eliminating all forms of promotion and marketing, and revitalizing public education campaigns. Lessons from tobacco control are instructive, but approaches to obesity and alcohol will differ as governments, industry and communities work together to reshape consumer demand and support individuals in exercising healthy choices. The emphasis will be on reshaping attitudes and behaviours, rather than prohibiting them.*"

It expands the above statement when listing its preferred routes to "*halt and reverse the rise in overweight and obesity*":

- *"Reshape industry supply and consumer demand towards healthier products by increasing availability and access to healthier food and activity choices and through the development of comprehensive national food policy (e.g. modelled on the UK's Food Matters).*
- *Protect children and others from inappropriate marketing of unhealthy foods and beverages, and improve public education and information.*
- *Embed physical activity and healthy eating in everyday life through school, community and workplace programs. At the same time these are reinforced by individuals and families choosing to become more active and to eat healthier foods.*
- *Reshape urban environments towards healthy options through consistent town planning and building design that encourage greater levels of physical activity and through appropriate infrastructure investments (for example, for walking, cycling, food supply, sport and recreation).*
- *Strengthen, skill and support primary health care and the public health workforce to support people in making healthy choices, especially through the delivery of community education and advice about nutrition, physical activity and the management of overweight and obesity.*
- *Close the gap for disadvantaged communities through the development of targeted approaches to overweight and obesity for disadvantaged groups, particularly Indigenous and low-income Australians, pregnant women and young children.*
- *Build the evidence base, monitor and evaluate the effectiveness of actions."*

With the obvious exception of the regulatory threats underpinning the first two interventions that "reshape" and "protect", this list is mostly incontrovertible. Minor variants of the first seven in the list have been announced in other nations since about 2000.

[5] ibid Sec 2, page viii

It foreshadows a role for private industry as one of the "shapers" of healthier dietary choices.[6]

*"Industry (especially the food and beverage industry and restaurant and catering industries) can make an important contribution by providing information (for example, product and menu labelling and responsible marketing); placing healthy products in more prominent positions in supermarkets; improving the food supply (for example, making healthier and affordable food products available); and developing a more environmentally sustainable food chain."*

## 1.3 A new national agency to carry the prevention agenda

It proposes a new national agency to carry the national prevention agenda forward.[7]

*"At the national level, such an agency is needed to support the coordination of partnerships and interventions, ensure the relevance and quality of workforce training activities, effective social marketing and public education, and the monitoring and evaluation of interventions. By bringing together expertise across the relevant areas, a national agency would provide leadership for the implementation of the National Preventative Health Strategy and build national prevention systems with strong capabilities.*

*Among its tasks, a national agency would:*

- *Ensure the delivery of a minimum set of evidence-based, illness prevention/health promotion programs that are accessible to all Australians.*
- *Engage key leaders and build new partnerships across federal, state and territory governments, national agencies, professional associations, local government, peak community groups, non government organisations, the private sector, the philanthropic sector and academia.*
- *Commission and promote the uptake of new monitoring, evaluation and surveillance models for illness prevention.*
- *Serve as an authoritative source of information on evidence, policy and practice.*
- *Develop the evidence base on prevention through the design, implementation and evaluation of large-scale programs to improve the health and wellbeing of the population, or population sub-groups, by testing innovative strategies, programs and policies for illness prevention/health promotion.*
- *Ensure the development of the necessary national workforce for illness prevention/health promotion, working with and through relevant national, state and local agencies to build capability in:*

  *- surveillance, prevention research, evaluation, economic impact research and modelling*
  *- social marketing and public education*
  *- legislation, regulation, economics and taxation*
  *- leadership and management."*

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[6] ibid, page 12.
[7] ibid, Sec2:, pages xiv-xv

These four capabilities suggest that the Task Force has in mind an organization resembling the current US Centers for Disease Control in Atlanta, with economics and taxation expertise added.

However, the other tasks listed seem to be saying that much research and evidence are needed before we can do much about prevention. Some readers will ask whether this is an excessively academic view that downplays the urgent need to instigate practical solutions now that do not require regulations and taxes as first choices to 'reshape' and 'protect'.

### 1.4 Shared responsibility for prevention

The discussion paper tells us where joint and separate responsibilities for action lie, drawing on the "community-driven" principles espoused in the earlier report of the National Health and Hospitals Reform Commission.

*"All Australians share responsibility for our health and the success of the health system. As individuals we each make choices about our lifestyle and behaviours; as a community we fund the health system; and as patients we make decisions about how we use the health system. The health system has an important role to play in helping people to become more self-reliant and better able to make the best choices to manage their own health needs.*

*Business and industry both have important roles to play for obesity and alcohol, and governments have a responsibility to coordinate preventative health reform, to deliver prevention programs and action, and to make sure adequate supports are put in place to enable individuals, families and communities and the health system to make useful contributions".*

These are *desiderata* long espoused in other nations, and the final report of the Task Force must propose specific actions to engage all the actors listed above.

With many exemplars of such engagement already seeking to control obesity in other nations, this overdue Australian engagement does NOT require a national agency-as the major response of government, but it does require strong leadership from the Prime Minister and the Minister of Health.

### 1.5 Relevance to the work of the Standing Committee

Two gaps in the discussion paper are relevant to the ongoing inquiry into obesity by the House of Representatives by the Standing Committee on Health and Ageing.

First, there was no assessment of the extensive gaps in health literacy that forestall effective prevention and "self-reliance" in Australia. The Minister for Health, Nicola Roxon, had set the tone for the debate in her Bathurst Light-On-The-Hill speech in September 2008,[8] and I am therefore surprised that the it did not canvass the gaps in health literacy in some depth.

[8] THE HON NICOLA ROXON MP. "The Light on the Hill: History Repeating". Annual Ben Chifley Memorial "Light on the Hill" Dinner, Panthers Leagues Club, Bathurst, 20 September 2008.

Second, there was minimal discussion of comprehensive obesity prevention reforms now underway in other nations and their potential relevance in shortening the 2020 deadline set by the Task Force by say 8 years. [9]

Those international innovations started years ago, they are well documented, and they represent potential solutions to the Australian obesity problem. For example,

- Norway has driven its reforms via a national strategy;
- the Arkansas state government reforms across a broad front have had some immediate effects on child obesity, and
- Kaiser Permanente's policies for risk measurement and clinical management of obesity demonstrate the value of regular measurements of body mass index (BMI) and other measures of obesity within a data-driven, population health management strategy.[10]

In this paper, I suggest that Australia can quickly forge a pragmatic national prevention strategy that takes account of other issues noted in **PARTS 2-4** below, such as

- repairing gaps in health literacy so as the accelerate informed self-care and trait formation that increases health capital (**PART 2**);
- recognising the dangers of accepting opinions about priorities for prevention of obesity that are not based on evidence (**PART 3**); and
- recognising that most proposals for regulation of advertising to children and taxes on energy rich foods have costs not acknowledged by their advocates and those costs may not be outweighed by the benefits (**PART 4**).

With **PARTS 2-4** as background**, PART 5** lists the minimal components of a comprehensive national strategy to control obesity.

- Underlining a case for urgent action rather than more academic studies, this strategy could be given a kick-start in the May 2009 Budget.
- The Standing Committee's deliberations and report should therefore not accept unquestioningly the 2020 horizon of the Task Force for obesity outcomes. We can do better.

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[9] It is a sad fact that calls to speed up the reform agenda in healthcare in Australia are often labelled as premature, or the response is that our healthcare system, basically a good system when judged by aggregate measures against other nations, just needs tweaking. With obesity, we have obfuscated since 1997 so any proponent of a 2020 horizon is wasting valuable time in forming coalitions to do what other nations have done, viz., taken action rather than talked incessantly.

[10] Kaiser Permanente released data on some outcomes of its Healthy Lifestyles Program as at 30 September 2008. In the 2.4 million members who enrolled in the program and used it nearly 360,000 times, the following outcomes were reported: "*55 percent of members using the weight management program experienced weight loss after six months; 52 percent of members who participated in the smoking cessation program were still tobacco-free six months later [and] [e]arly feedback shows that 94 percent of members using the new diabetes program report they are able to better manage their condition, 82 percent said they now communicate better with their doctor, and 77 percent improved their medication habits*"- see: Kaiser Permanente." Kaiser Permanente Adds New Online Health Tools for Chronic Conditions to KP.org Member Site". Oakland, PR Newswire, 22 October 2008. Kaiser Permanente is also the most "wired" organisation in US healthcare, with Kaiser Permanente's electronic health record, KP HealthConnect™, operating in 12 Southern California hospitals, and with all of the region's 3.3 million members covered by an end-to-end electronic health record

## 2. INTERNATIONAL TRENDS THAT SHOULD SHAPE A NATIONAL PREVENTION STRATEGY FOR OBESITY

In this section, I identify four directions of health policy that should be taken into account in the design of a new national prevention strategy:

- trends affecting the roles of individuals in prevention (**Section 2.1**);
- health literacy as a core component in prevention (**Section 2.2**);
- theories of trait formation that suggest the importance of early intervention to enhance personal responsibility (**Section 2.3**); and
- problems in the provider payment system that limit the cost-effectiveness of many types of prevention (**Section 2.4**).

In **Section 2.5**, I summarise some elements of a new prevention strategy that recognise these events.

### 2.1 Trends affecting modern prevention and the role of individuals

The future national policies for prevention of major chronic conditions, including obesity, will be influenced some established or emerging trends listed below.

Many of them relate to the role of the individual in self-care (the Task Force called it "self-reliance").

1. While Australia remains high in world rankings based on aggregated health indicators, gaps are appearing in the care system that threaten these past health gains. The absence of national policies supporting self-care is one such gap. By contrast, the UK National Health Service and the German Social Security Code have positioned the informed individual at the core of new national policies for better health.
2. The Chronic Care Model (due to Dr Ed Wagner) is widely accepted in health policy planning worldwide, and in that model self-care education is explicitly embedded.[11]
3. Because of rapid technological and economic change, a national self-care policy is today more feasible than it was a decade ago.[12]
4. While community support and worksite interventions that buttress individual self-care are accepted elsewhere, they rarely exist in Australia. Victoria's

[11] Some difficulties of operationalising the CCM are evident in: DR Rittenhouse et al., "Measuring the medical home infrastructure in large medical groups". Health Affairs 2008; 27 (5): 1246-1258.

[12] As I have noted elsewhere, the nine major drivers include: 1. Increased demand for healthcare [associated with ageing, an increased burden of chronic conditions, a growing wellness focus, and the burden of lifestyle diseases], 2. Increasing public expectations [e.g., the growth of personalised medicine, convenient access, and active consumers of website advice]. 3. Shortages in the supply of traditional carers [ e.g., GPs and nurses], 4. Higher government outlays for prescribed medicines and the political costs of rising copayments. 5. Payments for team care that are draining MBS budgets [e.g., allied health professionals and practice nurses] 6. Online social networks are changing the relationship between patients and healthcare practitioners. 7. Supporting technology is promoting the consumer role in health care [telemedicine, the PHR (UK HealthSpace, US Microsoft HealthVault), ambient technology, social networks, switching of Prescription Only Medicine to Over the Counter drugs, new fortified foods, nutraceuticals, theranostics, combinations of diagnostics, devices and drugs]. 8. New developments in the neuro-economics of reward that emphasise the central role of intrinsic motivation and self-efficacy in behaviour change [for example via incentives for self-care]. 9. Evidence on the impact of self-care emerging from the UKNHS and Australia.

March 2008 proposals recognise the potential gains in national productivity via an informed workforce, and the Colac model for community-based obesity prevention (noted in **PART 5**) are commendable exceptions.

5. Shortages of key health professionals are forcing governments to allow disabled persons the choice of purchasing their own care in accordance with their perceived needs. Such self-directed care with cash and counselling options[13] is rare in Australia, the number of available carers is diminishing because of burnout and giving carers a new superannuation scheme may be too-little-too-late.
6. Economic incentives for healthier lifestyles via self-care are diffusing elsewhere- but we are have ignored their potential impact because we lack a comprehensive population health management strategy.
7. Genomics is redefining what we call "prevention" because it is creating a range of diagnostic self-test kits that can be sold direct-to-consumer without rigorous reviews of effectiveness or safety. In 2008 we need to consider the potential costs and benefits of a new public health genomics strategy that better informs the nation about costs and benefits of such individualised genomic profiling (aka personalised medicine).[14]

Illustrating the last point, **FIGURE 2** below[15] assumes that genomic profiling will ultimately emerge in future prevention and that "individual and earlier secondary prevention" has a non-trivial cost.

**FIGURE 2: Genomic profiling in future national prevention strategies: Brand 2007**

[13] Cash and counselling demonstration projects have been used in a few US states in care of the disabled, They allow the beneficiary of certain government welfare programs to purchase the care they need and pay the carers directly, rather than wait for the formal care networks to provide the fixed menu of services usually available from such services on a 9-5 basis.

[14] Dutch concerns are evident in : D Stemerding." Public health landscapes: patterns, similarities and challenges". School of Management and Government, University of Twente, 6 pages, nd but circa 2008. A paper given at the 2008 meeting of the American Public Health Association identified other issues in the growth of screening for the metabolic syndrome and whole body CT scanning- see: M Donaghue." Scans and scams: Direct to consumer marketing of unnecessary screening tests". Paper at APHA 2008 Annual Meeting & Exposition in San Diego, CA October 25-29, 2008.

[15] Source: Angela Brand. (Public Health Genomics European Network)". European Health Forum, Gastein, 5 October 2007; Khoury CDC, 20 September 2007.

| Time period -> / Factor | PAST PREVENTION | PRESENT PREVENTION | FUTURE PREVENTION |
|---|---|---|---|
| Target group | Whole population | Family | Individual |
| Rationale | Identify high risk groups based on attributable risk | Identify high risk families based on relative risk | Identify disease clusters<br>Predicting individual risk |
| Method | Screening of sub-populations<br>• Newborns<br>• Prostate cancer<br>• Breast cancer<br>• HIV<br>• Specific options for migrants<br>• Carrier screening | Family screening<br>• Disease clusters of breast cancer, prostate cancer and multiple myeloma<br>• Disease clusters of obesity, asthma and non-Hodgkin Lymphoma | Individual genomic profiling<br>Newborn "screening" for individual genomic profiling = "newborn profiling" (e.g. re-sequencing chips, high-throughput sequencing). |
| Goals | Secondary prevention | Family-oriented secondary prevention | Individual and earlier secondary prevention, diagnostics, therapy and rehabilitation |

If obesity is shown to have genetic and environmental components,[16] such profiling will become more commonplace in the 60%+ of adults who are obese or overweight.

We need policies now to evaluate whether genomic testing that seems likely to be a high-volume activity can prevent later costs emerging. Compared with the other two entries in the bottom line, the interventions in the bottom right-hand corner shown in red would send the health budget skyrocketing unless there were offsetting health benefits.

In her recent review of the changing face of prevention, Starfield concluded[17] that "prevention" has lost its meaning as we equate "risk factors" (such as obesity) to "diseases". She concluded that future prevention strategies needed to focus on

- population-attributable risk rather than individual relative risk;[18]
- the estimation of the costs and benefits of population health strategies and the distribution of health status within a population; and
- priority-setting based on reduction of illness and adverse events, while attempting to reduce inequalities in health.

All four foci are relevant to future national policies for obesity and to the inquiry of the Standing Committee on Health and Ageing on obesity in Australia. The first focus above assumes the existence of a population health management strategy (see further on).

The above observations set a backdrop for the following brief review of the current levels of health literacy, and the roles of individuals and governments in preventing

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[16] This is not a new thought-see: JR Speakman."Obesity: the integrated roles of environment and genetics". *Journal of Nutrition* 2004; 134: 2090S-2105S.
[17] Starfield, B., Hyde, J., Gervas, J & Heath, I. (2007). The concept of prevention: a good idea gone astray. *Journal of Epidemiology & Community Health*, 62: 580-583.
[18] The last column of the above table would then be counter-balanced by the population –based risk assessment.

some very costly chronic diseases via policies for healthier lifestyles and weightloss.[19]

## 2.2 Health literacy and prevention

### 2.2.1 Warning signals about gaps in health literacy

Because of prior benign neglect by both sides of politics over 20 years, health illiteracy in Australia is associated with rising risks to health status- and not only because the public do not yet view obesity as a clear and present danger to the health of all age groups.

A new report by Australian Bureau of Statistics[20] tells us that in 2006, 60% of Australians aged 14-79 years did not have the tools or skills needed to help them make better-informed decisions affecting their health.

This is only one study, but read alongside the other recent studies listed in **FIGURE 3** below, it is yet another warning that health illiteracy is widely prevalent in Australia, and that some types of self-care support are in place, and that we will need to support a broader range of primary care educators.

**FIGURE 3: Six recent studies of the manifestations of health illiteracy and six studies demonstrating the potential impact of different forms of self-care**

| STUDY | KEY FINDINGS |
|---|---|
| 1. Review of Veterans Home Care[21] | Beneficiaries seek information to help navigate their way through the personal care maze |
| 2. Productivity Commission review of aged care[22] | Carers need information to understand available support services |
| 3, SCIPPS project (Australian Health Policy Institute interviews with seriously chronically ill persons[23] | Patients are seeking information on their prognosis and are often bewildered by transitions in their care |
| 4. Numerous reports of the Commonwealth Fund comparing Australia with other nations[24] | Australia's ranking in the provision of information to seriously ill patients and the overall coordination of care is not ranked highly |
| 5. ABS Health Literacy, 2008 | 60% of the Australian population aged 14-79 years lack basic knowledge and skills needed to understand and use information about their health |
| 6. ABS and Deakin University surveys ca 2005[25] | "89 per cent of parents of overweight 5—6 year-olds and 63 per cent of parents of overweight 10—12 year-olds " *were unaware their child was overweight" and "...71 per cent of parents of overweight 5—6 year-olds and 43 per cent of* |

[19] These chronic conditions have been emphasised in many submissions to the Committee and are not repeated here.
[20] Australian Bureau of Statistics. *Health literacy, Australia 2006.* Canberra, ABS cat no 4233.0, 25 June 2008
[21] Centre for Health Service Development. *Options for the future of Veterans' Home Care (VHC) Volume One: Final Report*. University of Wollongong, December 2007
[22] Productivity Commission. *Trends in aged care services: some implications.* September 2008 (at page xxiii)
[23] Comments by Professor Stephen Leeder, Symposium on Self-Care, Australian Health Policy Institute, University of Sydney, 14 October 2008.
[24] The latest data on information given by providers to seriously ill patients in seven nations is available in : C. Schoen, R. Osborn, M. Doty, M. Bishop, J. Peugh, N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (Oct. 31, 2007).
[25] ABS 4364.0-National Health Survey: Summary of Results, 2004-05. Canberra, ABS, 27 February 2006. Australia is not alone- see: Reuters. 'Teens, parents may not see a weight problem". 19 February 2008. Downloaded 22 February 2008 from: http://today.reuters.com/news

| | |
|---|---|
| | *parents with overweight 10—12 year-olds did not think their child's weight was a problem*". |
| 7 HCF-sponsored trials of telephone-based support for patients with chronic conditions[26] | Expert telephone counselling reduces the number of ER admissions by better informed individuals with mental disorders |
| 8. UK trials of Expert Patients Program[27] and the subsequent self-directed care (direct payment) pilot projects for old and disabled persons[28] | Expert Patients Program: Reduction in use of primary and secondary care services as a result of people attending the course in the Newham pilot project, as well as improved participation in lifestyle change education |
| 9. US trials of Cash-and-Counselling incentives to disabled families[29] | Families are capable of acquiring and providing the care needed at any time using cashed out vouchers |
| 10. UK NHS and Australian economic evaluations of self-medication using over-the-counter medicines[30] | Self-medication may be as cost-effective as many other medical interventions |
| 11 US evaluations of the impact of incentives on healthy behaviour[31] | Incentives are associated with high participation rates in health risk appraisal, reduce medical care demand and reduce health insurance expenditures |
| 12. Australian studies of the role of the pharmacist in self-care support via the EPS[32] | 80% of pharmacists already offer at least one non-prescription service that facilitates self-care management |

At the core of the first six studies are the majority of Australian consumers of healthcare, basically uninformed about how to use self-care, defined below.

The last six studies tell us that we can change this dismal picture - and the last two studies are particularly relevant to any review of national policies for obesity prevention.

### 2.2.2 Health literacy: definition and relevance to obesity

At the onset, the concepts of health literacy and self-care need to be defined.

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[26] G Andrews. Presentation at Australian Health Insurance Association Annual Conference, October 2008.

[27] A Kennedy et al.," The effectiveness and cost-effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial". *Journal of Epidemiology and Community Health* 2007; 61; 254-261

[28] In the ongoing UK NHS pilot projects in self-directed care (direct payment) in Oldham, Barnsley, Manchester, Gateshead, Coventry, Lincolnshire, Leicester, Kensington and Chelsea, Barking & Dagenham, Norfolk, Essex, West Sussex, Bath & NE Somerset, the target groups include older people, disabled people, people with learning disabilities and people with mental health needs. The Scottish equivalent is outlined in http://www.scotland.gov.uk/Publications/2006/09/28113843/0 See also: http://www.barnsley.gov.uk/bguk/Health_Wellbeing_Care/Individual_Budgets_and_Self_Directed_Support

[29] A recent assessment of this US form of self-directed care noted: *"An approach pioneered by the Cash and Counselling demonstration and evaluation (CCDE) goes further; it gives consumers "budget authority" not only to hire their workers, but also to purchase other goods and services of their choosing, such as assistive technologies, home modifications, transportation, and personal care supplies. States have been interested in consumer-directed services for a number of reasons: to respond to consumer demand for more choice, to improve consumer satisfaction and outcomes, and to alleviate worker shortages."*-see: National Health Policy Forum." Long-Term Services and Supports: Consumers in Charge—Consumer Direction and Money Follows the Person". Forum Session 7 November 2008.

[30]. PF Gross. "Informed and educated consumers accessing a more transparent healthcare system: the case for a national self-care alliance". December 2007.

[31] PF Gross. "Self-care, personal responsibility and the potential impact of economic incentives for healthy behaviour". 12 October 2008

[32] See for example: CG Berbatis, VB Sunderland, A Joyce, M Bulsara and C Mills "Enhanced pharmacy services, barriers and facilitators in Australia's community pharmacies: Australia's National Pharmacy Database Project". *IJPP* 2007, 15: 185–191

*Health literacy* is the ability of an individual to take decisions that improve his/her health.

Why is health literacy critical? A recent UK analysis told us why:[33]

- *"Health literacy is an essential life skill for individuals: it may help individuals seek and use information and take control over their health.*

- *Health literacy is a public health imperative: building health literacy improves population health.*

- *Health literacy is an essential part of social capital:[34] low health literacy is a strong contributor to health inequalities.*

- *Health literacy is a critical economic issue: low health literacy costs the US economy US $73 billion per year."*

### 2.2.3 Self-care: definition, scope and relevance to obesity

In our consideration of paths to improved health literacy, we should identify the role of self-care *per se*.

*Self-care* means taking some personal responsibility for health and well-being, and it includes at least the following eight actions by individuals working in conjunction with their healthcare advisers:

- Staying fit and healthy
- Risk factor reduction
- Seeking advice on the quality providers of care
- Appropriate use of all medicines
- Seeking care for minor conditions
- Adherence to advice on chronic conditions
- Self-directed choice by disabled persons of their carers and support services
- Work absenteeism management[35]

The first two actions affect obesity more than the others. Observing the challenges ahead in promoting self-care initiatives, it is obvious that information, education and communication tools need to be in place across the age and illness spectrum to meet the full range of needs in all eight activities.

With obesity, we need to reflect on one more question: while it is clear that all ages need self-care support and information, where in the lifecycle should we start the process of self-care education that shapes health traits or healthy behaviours?

I hope that in its final report, the Standing Committee will acknowledge that:

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[33] I Kickbusch, S Wait, D Maag. The role of health literacy. London, Alliance for Health and the Future, International Longevity Centre-UK, nd but circa 2007, 24 pages

[34] I return further on to this aspect in my advocacy of the trait formation premises of James Heckman.

[35] This looks the odd man out, but it refers to the ability of individuals to not go to work when they may be carrying flu viruses that might spread to fellow workers. Knowing the symptoms of such transmittable diseases might be a hallmark of an informed health consumer.

- new research on trait formation suggests that early intervention in childhood is one arm of a strategy to prevent obesity and a range of chronic conditions associated with this particular risk factor;
- we need to be more proactive about trait formation and the role of personal responsibility, and not be overwhelmed by exhortations that government regulation can make healthy choices easier; and
- we will need new primary care educators such as pharmacists and GP practice nurses if the GP workforce is not to be swamped by a higher demand for self-care education.

## 2.3 New premises on prevention via early trait formation

### 2.3.1 Two schools of thought about obesity prevention

Two often-polar schools of thought tend to pervade the academic debates about effective prevention of obesity.[36] While in theory not mutually exclusive, the first school has more vocal Australian adherents than the second school, and the costs and benefits of the proposals of each school are rarely juxtaposed in the same debate.

I look to both the House of Representatives inquiry into obesity and the National Health Preventative Task Force to address this information asymmetry.

For brevity, the views expressed below assume only these two schools of thought. I realise that a range of opinion exists, not just these two points.

One school, running through much of the Task Force chapter on obesity, says that we might require regulation of hazardous environmental stimuli because whatever an individual does to lose weight and get fitter, media advertising promotes fast lifestyles and high-energy fatty foods (so we should ban certain types of advertising) and a toxic urban planning system (and a range of other impediments or environmental hazards) has reduced the amount of recreational space or facilities available for physical activity (so we should use the law to mandate appropriate spatial solutions to the physical inactivity problem).

In this paternalist view of the world, obesity management needs to be supported by (1) an expansion of social torts (New York City instigated class actions against fast food outlets which sell fatty foods or use trans-fats) and (2) stronger prohibitions banning TV and other advertising to children (the UK media regulator Ofcom started this process in 2007).

The second school say that the first school has the wrong focus and that it will not necessarily have an immediate impact on obesity across the age spectrum. The second school says that real behaviour change requires a range of interventions, and using the law is the recourse to lazy assumptions that what worked in tobacco control will also work for obesity prevention.

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[36] As I note many tomes in this paper, they need not be polar.

My concern is that, as presently presented, the "public health law" perspective offers a very limited view of the challenges ahead of real-world population health management.

- It is at odds with many directions of accepted health policy, particularly the Chronic Care Model's assumption that self-care management IS critical in any national attack on a chronic condition. Obesity IS a chronic condition.
- It stretches the evidence base to present tobacco control and obesity control as comparable problems with some common regulatory solutions, when many experts have pointed out their non-comparability.[37]
- It rarely mentions the costs of the regulatory strategies proposed and it often fails to mention the known limits of the so-called sin taxes that it often links to the regulatory regimen.
- Overall, it is not yet an evidence-based public health intervention and as such, the precautionary principle should not be invoked as the rationale for its use in obesity prevention. [38]

I summarise some of these concerns below.

### 2.3.2 Population health management embeds prevention

I first try to identify where prevention of obesity and related chronic conditions fits within contemporary population health management (PHM).

In simple terms, PHM is the measurement of, intervention in and re-distribution of resources across the care spectrum from healthy to dying so as to improve the population's health status, quality of life or social welfare.[39]

In my admittedly over- simplified view of the world, PHM has at least three core components.

(1) It assumes the existence of *organisations designed for population health measurement and patient care.* Four internationally recognised models of PHM are Kaiser Permanente,[40] Intermountain Health[41], the Geisinger Health System,[42] and the US Department of Veterans Affairs[43], all using different

[37] The most recent demolition of the myth that the two are similar is: SA Schroeder." We can do better: improving the health of the American people". *New England Journal of Medicine* 2007; 357: 1221-1228

[38] If all else fails and better data emerge, I will willingly recant. We are nowhere near that situation now.

[39] See the first estimate of the US distribution of healthcare expenditures across this spectrum in: J-A Lynn et al. " Using population segmentation to provide better health for all: the 'Bridges to Health' model". *Milbank Quarterly* 2007; 85 (2): 11 pages, Table 6. I have reported my Australian estimates in PF Gross. Australia's $100 billion healthcare system and the 2007 election promises: priorities for undoing complacency and enhancing transparency. Sydney, Institute of Health Economics and Technology Assessment, Australian Health Policy Series No 15, April 2008.

[40] A recent review of its achievements and continuous innovation were reported at its 2008 annual meeting, See: PR Newswire." Focus on Unconscious Bias to Enhance Care Delivery Featured at Annual Conference 'Themed 'Diversity Integration: the Key to Performance Excellence'': Oakland (California), Kaiser Permanente, 14 October 2008.

[41] See an early recognition of its strengths in: Thomas H. Lee, Shoji Shiba, Robert Chapman Wood. *Integrated Management Systems: A Practical Approach to Transforming Organizations*. John Wiley and Sons, 1999,336 pages.

[42] A recent evaluation of the Geisinger transition from 2005, its strengths and their potential relevance in other systems is: RA Paulus, K Davis and GD Steele." Continuous innovation on health care: implications of the Geisinger experience". *Health Affairs* 2008; 27 (5): 1235-1245; 10.1377/hlthaff.27.5.1235

combinations of disease management, case management, electronic health records, linked data and risk assessment tools.[44]

(2) It assumes the existence of a *funded stream of prevention* that links the current primary-secondary-tertiary-quaternary boundaries[45] into public health genomics and personalised medicine. To obtain the funding for this new stream of prevention tools, care has been taken to explain to the Treasury why
 (a) prevention might be moving from
  - attributable risk of populations (the past)[46] through
  - relative risk of families (today) to
  - individual risk in genomic medicine (10+ years hence-maybe??),
 (b) without more self-care, there will be increased workloads for GPs, community nurses and practice nurses
 (c) we require a new Medicare fee that better links primary health care at the individual level with public health interventions at the community level,
 (d) we need to rank prevention priorities and associated budget requirements, and
 (e) we need to remove any barriers to access to effective interventions, such as barriers caused by rising copayments.

(3) To promote trait formation and enhanced personal responsibility from the earliest age, it creates accessible tools for *self-care education and information.*

This third component of PHM places me firmly in the school that says that rather than using the law as the *prime*[47] "shaper" and "protector" (viz., the first two of the preferred seven responses against obesity proposed in the Task Force discussion paper), real PHM requires a serious prior attempt to enhance personal responsibility and form traits early in life if the prevention of obesity at all ages is our goal.

### 2.3.3 Trait formation and prevention

In my dual advocacy of enhanced personal responsibility and trait formation as a preferred route, I am guided by two recent developments in behavioural economics.

One is due to James Heckman[48] (an economist who thinks well outside this discipline's usual boxes[49]), and the other is due to the neuro-economics school[50]

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[43] See for example: A Oliver. "The Veterans Health Administration: An American Success Story?" *Milbank Quarterly* 2007; 85( 1):

[44] See a recent example of the risk stratification of outcomes in a PHM strategy in: I Duncan, M Lodh, G Berg, D Mattingly "Understanding Patient Risk and its Impact on Chronic and Non-Chronic Member Trends". *Population Health Management.* 2008, 11(5): 261-267.

[45] This vagueness of these boundaries was noted in different ways in Starfield et al 2008, ibid; and by: LM Russell, GL Rubin and SR Leeder." Preventive health reform: what does it mean for public health?" *MJA* 2008; 188 (12): 715-719.

[46] Recall Starfield's contrary opinion mentioned earlier.

[47] As I note a few times in this paper, we may need the law if all else fails. My argument is that it is not the *prime* tool of policy choice, and certainly not helpful in forming traits at early ages.

[48] JJ Heckman. "Human Capital, Skill Formation, Early Intervention, and Long-Term Health". Presentation at AEI Symposium' *Beyond More Health Insurance Coverage, toward Better Health Outcomes*', Washington, D.C., 23 July, 2008.

[49] JJ Heckman."The Economics, Technology and Neuroscience of Human Capability Formation". Bonn, Institute for the Study of Labor, IZA Discussion Paper No. 2875, June 2007

[50] C Camerer, G Loewenstein and D Prelec." Neuroeconomics: How Neuroscience Can Inform Economics".

(economists who work with biologists and neurologists to understand how the brain reacts when decision-making is required).

Heckman argues that traits affect choices. He says that:[51]

- *"Behaviors are shaped by abilities and motivations.*
- *These traits emerge early, and are strongly influenced by the family.*
- *A neglected avenue of health policy is early intervention programs that help form positive traits.*
- *Cognitive and non-cognitive skills – self-regulation, motivation, time preference, far-sightedness, adventurousness and the like – affect the evolution of health capital through choices made by parents and children"*

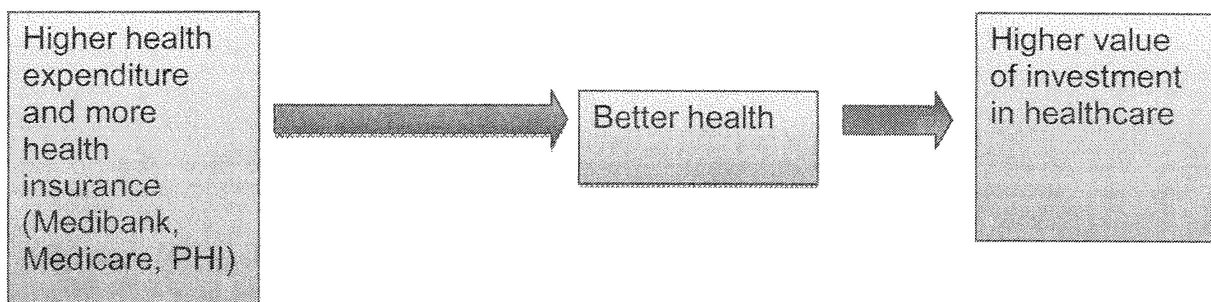
## 2.4 Without payment reform that encourages personal responsibility, does more money = better health?[52]

How does Heckman's theory help guide a debate about how to achieve value for money from public and private investment in "better health", surely the prime goal of any national prevention strategy?

US policy analysts have recognised a constraint often ignored by those seeking more money for hospitals and health insurance rebates for traditional healthcare. That constraint is the seemingly irrational nature of the provider payment systems and the associated copayments made by patients, such as we have in the current Medicare Benefits Schedule, the hospital casemix payment system and even the Pharmaceutical Benefits Scheme.

Traditionally in every annual budget, we assume the direct relationships of "health" and higher budgets for health as are assumed in **FIGURE 4** below, leading to a further presumption that investment via the health sector represents value for money:

**FIGURE 4: Explicit assumptions about the value of higher budgets for healthcare and value for money**




But there is an inherent flaw in these assumptions. We cannot gain the full value of additional healthcare spending if the payment systems that now reimburse doctors,

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*Journal of Economic Literature XLIII (March 2005), pp. 9–64*

[51] Heckman 2008 *op cit*

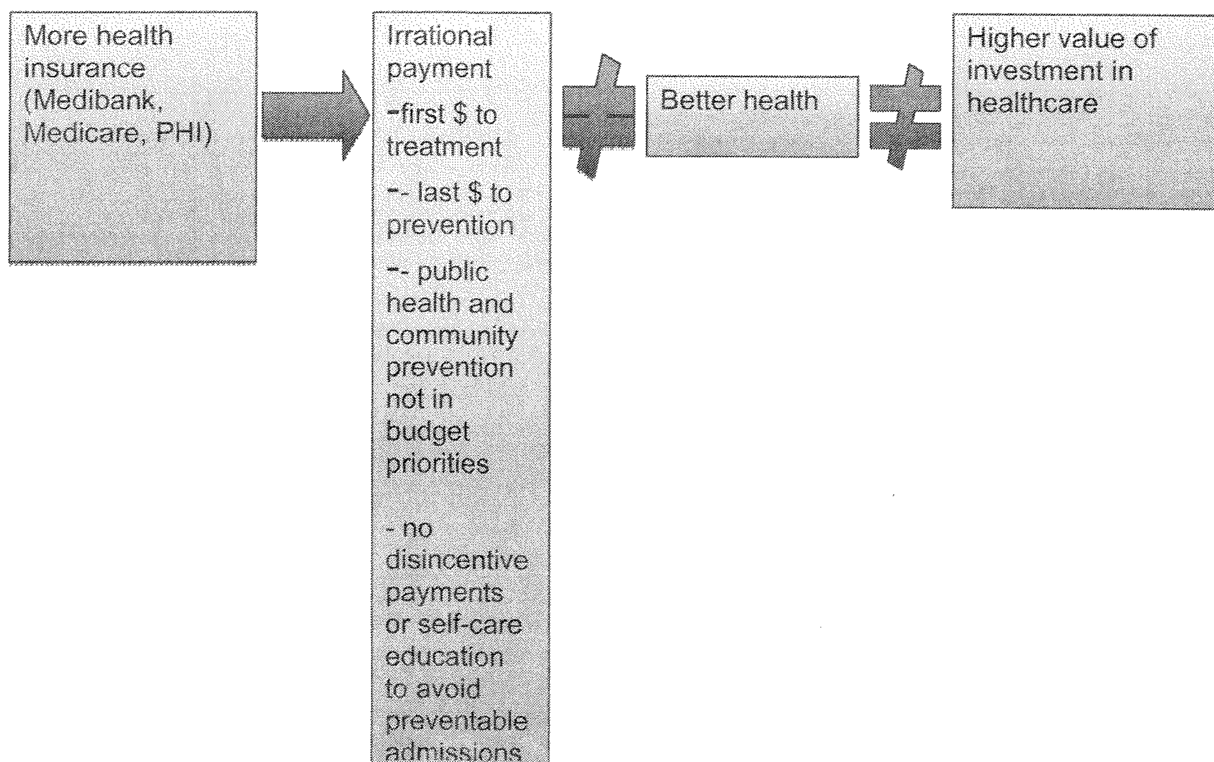
[52] Jack Hadley (then at the Urban Institute in Washington DC) wrote a book with this title in 1982 - and we still are asking the same question in 2008.

hospitals and other providers are irrational or if we continue to ignore waste in the current allocation of resources due to preventable hospital admissions and readmissions.

- Ignoring copayments, Medicare and private insurers pay first dollar coverage for most treatments, but few dollars go to prevention and almost nothing goes to community-based prevention.
- Many effective methods of prevention still attract copayments, and such uninsurable gaps may retard wider access to interventions that prevent or control some major chronic conditions.[53]
- We continue to report data preventable hospital admissions in every issue of *Australian Hospital Statistics* produced by AIHW, two-thirds of the nearly 10% of preventable admissions each year are due to chronic conditions, but we do not enact national payment reforms to help reduce many (NOT all) such admissions.

**FIGURE 5** below depicts this current situation.

**FIGURE 5: Irrational payment systems do not guarantee better health or a high return on investment in healthcare**

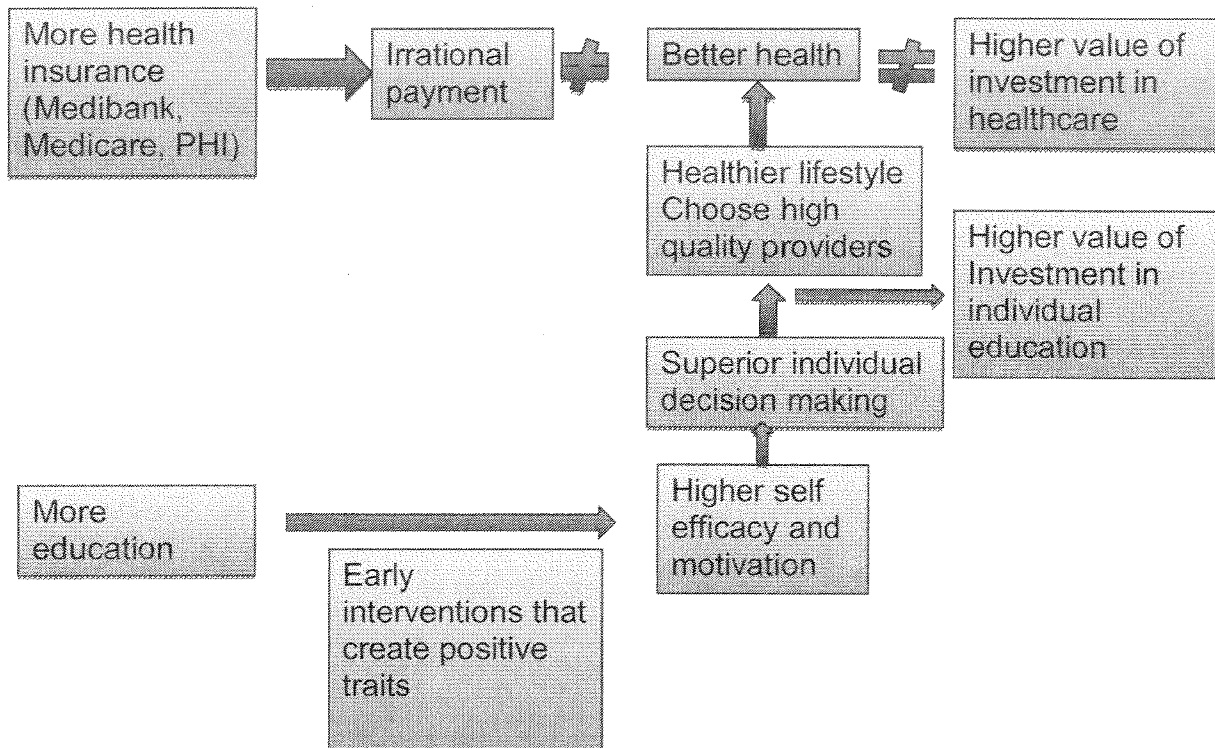



[53] In her speech to the AHIA conference on 8 October 2008, Nicola Roxon noted the size of uninsurable charges and the dismal trend. "The 2007 IFC Consumer Survey tells us that 42% of all private patients surveyed incurred a gap, with an average gap of $787. If we look at the average gap per practitioner episode, between 2006 and 2007 it increased 18% to $495. In 2004, there was a lack of informed financial consent and therefore a 'surprise' gap in 21% of hospital episodes. This improved to 16% in 2006, and then rose again slightly to 17% in 2007 - See; N Roxon. "Speech to the Australian Health Insurance Association annual conference". Sydney, 8 October 2008.

I now embellish **FIGURE 5** by adding Heckman's theory about the potential impacts of early educational interventions on trait formation and self-efficacy. His premise is that the impacts include faster health capital formation (which certainly includes healthier lifestyles and better health). If Heckman is correct, Treasurers would then presumably recognise that a higher investment in early education is highly desirable.

The bottom line of **FIGURE 6** below overlays **FIGURE 5** with his premise.[54]

**FIGURE 6: Investment in education to achieve better "health"**

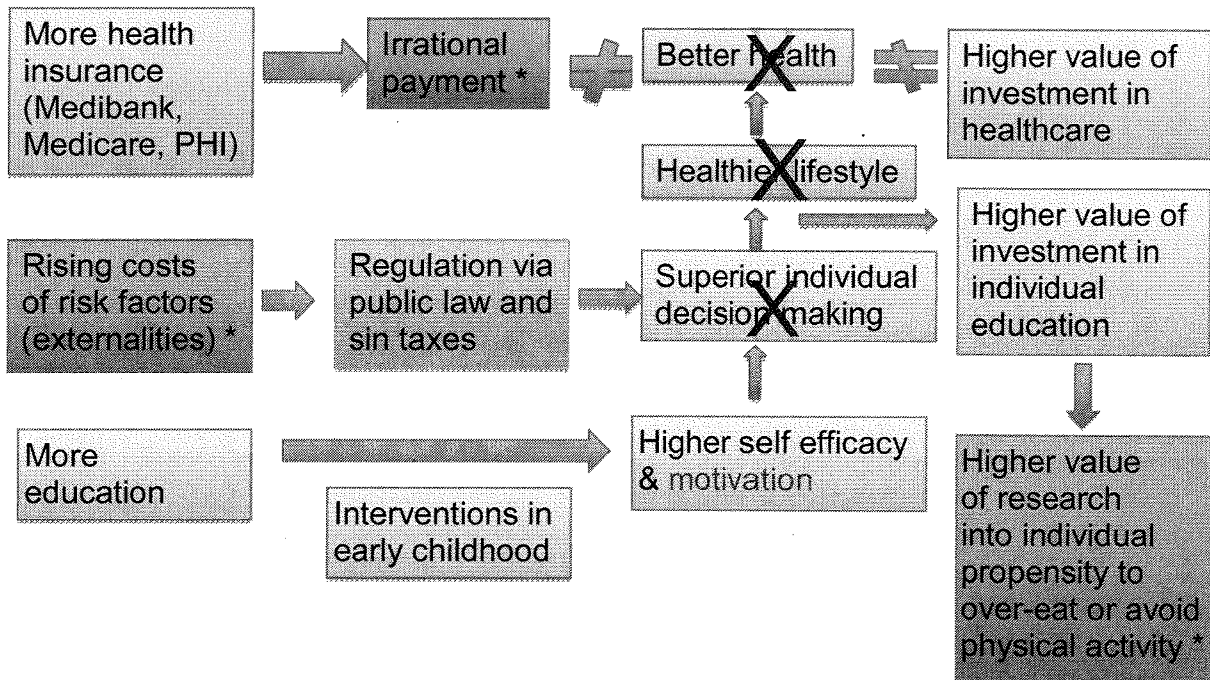



Acceptance of the Heckman premise does not necessarily pre-empt public health law as the preferred "solution" to societal problems such as obesity, but his premise seems to enhance individual responsibility and trait formation in ways that public health law cannot.

The middle row of **FIGURE 7** below inserts my assessment of the impacts of using public health law and sin taxes to relieve the individual of any need to develop healthier traits.

[54] The trait thesis linked to human capital theory is outlined in: J Heckman. "Human Capital, Skill Formation, Early Intervention, and Long-Term Health". Presentation at AEI Symposium '*Beyond More Health Insurance Coverage, toward Better Health Outcomes*', AEI Washington, D.C., 23 July, 2008.

**FIGURE 7: Regulation and six taxes do not improve individual decision-making and may not improve "health"**




I assert that the valued outcomes in the three original boxes of **FIGURE 5**, now marked 'X" in **FIGURE 7**, will not necessarily eventuate if we use public health law and social torts as first-line weapons because they do not enhance individual trait formation, higher self-efficacy and motivation, all associated with behaviour change.

Herein lies one of the major challenges noted recently by US analysts,[55] viz., in any recommended actions for obesity prevention to reconcile the red boxes marked * in **FIGURE 7** that represent

- the economist's *"externalities" of obesity* (in lay terms, these are the extra costs falling on society because of obesity and the nearly 20 chronic conditions with which it is associated);
- an *irrational payment system* that pays GPs little for effective prevention, offers no incentives for patients via Medicare rebates, and leaves preventable hospitalisations from obesity-related chronic conditions untouched; and
- *gaps in health services research* and *social psychology research* that have produced few studies of why individuals over-consume and under-exercise, and what self-care support they need to deal with these challenges

## 2.5 Implications for new prevention strategies and cost-effectiveness

The types of prevention that might lead to better health are many in theory, as indicated in a recent proposal by Bill Richardson, a former candidate for US

[55] I cannot recall who proposed this reconciliation of the three boxes at a recent US meeting, but I applaud the sentiment without owning it. Hopefully some avid policy wonk will prompt me with the source.

President.[56] All his interventions listed in **FIGURE 8** below are probably defensible as tools of prevention – but are they all cost-effective?

**FIGURE 8: One list of potential investments in prevention BUT how many are cost-effective?**

1) *"Paying for (preventive) coverage now, avoid emergency care later.*
2) *Promoting coordinated care and disease management.*
3) *Increasing the use of generic drugs.*
4) *Requiring that all health plans cover a standard set of proven preventive services.*
5) *Supporting local, state, and regional efforts to prevent and manage chronic diseases.*
6) *Providing incentives to businesses to invest in their employees' health.*
7) *Asking the [citizens] to do what they can within their own lives to help stem the tide of chronic diseases.*
8) *Instituting a nationwide ban on smoking in workplaces.*
9) *Preparing for natural and man-made disasters"*[57]

Items 1, 5, 6 and 7 in the above table are relevant to the prevention of obesity.

**FIGURE 9** lists some specific goals and support tools that I believe are needed in a new national prevention strategy.

**FIGURE 9: Some new goals and support tools for effective prevention of chronic conditions**

| Goal | New tools |
|---|---|
| Redefine the ambit of prevention | Risk stratification that allows risk management<br>An expanded primary care workforce<br>A national public health genomics policy<br>Policies to reduce preventable hospital admissions via a population health management strategy |
| Enhance personal responsibility and the patient role in self-care | Create tools for informed self-care<br>Change the roles of the health professions to make more efficient use of a range of skills<br>Use modern information technology to support households in informed self-care |
| Expand early interventions against chronic conditions and their risk factors | Funding of early interventions to enhance cognitive and non-cognitive skills that build human capital via better choices by elders, parents and children |
| Set national productivity targets tied to national health targets | A national health and productivity framework |
| Create community partnerships with established providers | Funding from the Innovations Fund for pro-active communities and expanded social networking |

[56] Former US Presidential candidate Senator Bill Richardson's US health policy, Kaiser Family Foundation video 2007.

[57] The needs of the elderly in disaster planning are outlined in: Aldrich N, Benson WF. Disaster preparedness and the chronic disease needs of vulnerable older adults. *Prev Chronic Dis* 2008;5(1). http://www.cdc.gov/pcd/issues/2008/jan/07_0135.htm . Accessed [May 2008].

Most of the new tools listed above are pertinent to obesity prevention. In obesity prevention, I affirm the need for new coalitions of households, communities, employers, private industries creating foods and beverages, physical fitness organisations and payers of health care.

In listing these preferences, I reject explicitly as first choices the public health law route, more government regulation and higher sin taxes. I concede that all may be needed if all else fails, but "all else" has not yet been tried in Australia, perhaps because eminence-based policy debate is more prevalent than evidence-based policy debate.

I next illustrate this phenomenon in the obesity prevention debate.

# 3. EVIDENCE-BASED PREVENTION POLICY FOR OBESITY AND SOME LIMITS OF EMINENCE-BASED POLICY

In the evolution of policies to prevent obesity, two schools of thought have emerged, often at both ends of the spectrum of policy choices from regulation to unregulated..

In this part of the paper, I summarise

- a paternalist view of the obesity problem and the population health management challenge (**Section 3.1**);
- two recent examples of rankings of priority actions against obesity that should cause concern about the strength of the evidence and how it is used to set priorities for obesity prevention (**Section 3.2**); and
- my argument that personal liberty and social solidarity do not require regulatory interventions as a first priority (**Section 3.3**).

## 3.1 When should governments intervene? Paternalists and the precautionary principle

The paternalist school is a very broad church, from the *asymmetric paternalists* who say in effect that 'government should mandate bans on TV advertising without further delay') to the milder *liberal paternalists* who say we need only to "nudge" people towards desirable ends and they will make better decisions on their lifestyle, choice of food in a cafeteria, in saving for retirement, and other important life situations.[58].

I summarise the perspective of reviewers of "Nudge",[59] an important book written by two leaders in the liberal paternalist school:

*"1. People sometimes face decision problems in which certain options are immediately very attractive – but will, if chosen, tend to frustrate the satisfaction of other preferences.*

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[58] Richard H. Thaler and Cass R. Sunstein. *Nudge: Improving decisions about health, wealth, and happiness.* Caravan Books, 2008.

[59] MJ Rizzo and DG Whitman. "Little brother is watching you: new paternalism on the slippery slopes". Online manuscript, New York University, 4 August 2008, 61 pages, downloaded 4 August 2008.

*2. These other preferences are viewed by the targeted agents or experts as more important or fundamental.*
*3. The decision problems faced by the target agents are exogenous to their behavior.*
*4. Therefore, only some exogenous factor (a deus ex machina) can extricate them from potentially welfare-reducing choices. Call this factor "paternalism.""*

The precautionary principle is often used in public health advocacy to justify asymmetric paternalism. Wikipedia tells us that *..."[t]he precautionary principle is a moral and political principle which states that if an action or policy might cause severe or irreversible harm to the public or to the environment, in the absence of a scientific consensus that harm would not ensue, the burden of proof falls on those who would advocate taking the action... The principle implies that there is a responsibility to intervene and protect the public from exposure to harm where scientific investigation discovers a plausible risk in the course of having screened for other suspected causes. The protections that mitigate suspected risks can be relaxed only if further scientific findings emerge that more robustly support an alternative explanation. In some legal systems, as the European Union Law, the precautionary principle is also a general and compulsory principle of law."*[60]

There are some key phrases in this definition: the notion of a plausible risk, where the burden of proof lies, and the role of scientific findings to support an alternative path of action (read: better evidence). In the obesity debate, these factors are rarely discussed and weighed by paternalists.

In this section, I summarise some recent developments in the obesity debate that might inform the Standing Committee on criteria for government intervention in the private market where individuals choose their nutritional intake and physical activity, two critical elements of the energy balance affecting excessive weight gain.

## 3.2 Some limits of eminence-based policy recommendations for obesity prevention

I summarise two recent examples of the eminence-based approach versus the evidence-based approach in proposing national policies for obesity.

In October 2006 after much consultation, the European Public Health Alliance summarised its preferences for obesity prevention. The Alliance drew on the work of expert obesity task forces in 14 nations in the European Union that had fed their preferences into a review by the European Heart Network.[61]

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[60] http://en.wikipedia.org/wiki/Precautionary_principle

[61] Over 100 local, national, regional and European non-governmental (NGOs) and not-for-profit organisations are members of the European Public Health Alliance (EPHA). Downloaded 28 September 2007 from: http://www.epha.org/a/2522
Its role is described in the November 2006 report of the EHN. *"In March 2004, the European Heart Network (EHN) started a 32-month project on children, obesity and associated avoidable chronic diseases (CHOB). The aim of the project is to contribute to tackling the obesity epidemic among children and young people. The first phase of the project, March 2004 to February 2005, concentrated on the marketing of unhealthy food to children, not because this is the only reason why children are getting fatter, but because it is clearly part of the problem and is of growing interest in European policy circles. Information was collected on the extent and nature of food marketing to children in 20 European countries and on existing measures (legislation, voluntary agreements, codes, interventions, etc) at national level with regard to counteracting the effects of food marketing to children. Phase two of the project, from March 2005 to November 2005, was dedicated to disseminating the results of the data collection which were published in a report on the marketing of unhealthy food to children in Europe. During*

All nations selected from the same list of 20 options drawn up by consensus and all respondent nations and committee rankings used the same eight evaluative criteria to assess each intervention, viz.,

- *Efficacy - will it have an impact on obesity?*
- *Cost – is it worth paying this?*
- *Reach – will enough children be affected?*
- *Inequalities – does it help low-income families?*
- *Sustainability – will it last?*
- *Side effects – are there social benefits?*
- *Acceptance – will it be popular?*
- *Feasibility – can it be implemented?*

These are valid criteria though others exist that force attention to the unintended side-effects of regulation of obesity.[62]

**FIGURE 10** below are the final rankings of the peak group that oversaw the study and the rankings of committees of experts in the 14 nations that responded using the same criteria. I commend these criteria to the Standing Committee.

*the last phase of the project, phase three, running from December 2005 to October 2006, a Europe-wide stakeholder consultation on policy options took place with a view to achieving consensus on a small number (five) of policy options to be achieved as priorities within the participating European countries as well as at a European level."*

[62] See for example: E Finkelstein. "Economic evaluation of obesity interventions". Paper presented at the USDA Agricultural Outlook Forum, 2004, 26 pages.

**FIGURE 10: Comparison of rankings of priority interventions against obesity, peak committee versus individual experts in 14 EU nations**

| TOP TEN POLICIES | EU PEAK CTEE | AU | BEL | DEN | EST | FIN | GER | ICE | IRE | ITA | NETH | NOR | SLO | SWE | UK | TOTAL SCORE 14(nation |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Food and health education: Include food and health in the school curriculum | | X | X | X | X | X | X | X | | X | X | X | X | X | | 12 |
| Controlling sales of foods in public institutions: Limit the provision and sale of fatty snacks, confectionery and sweet drinks in public institutions such as schools and hospitals | **X** | X | X | | | X | X | X | X | X | X | X | X | | X | 11 |
| Controls on food and drink advertising: Controls on the advertising and promotion of food and drink products | **X** | | X | | | | X | X | X | X | X | | X | | | 7 |
| Subsidies on healthy foods: Public subsidies on healthy foods to improve patterns of food consumption | | | X | X | X | | | X | X | | | X | X | | | 7 |
| Change planning and transport policies: Encourage more physical activity by changing planning and transport policies | | | | X | X | | | X | X | | | X | | X | X | 7 |
| Improve communal sports facilities: Improve provision of sports and recreational facilities in schools and communities | | X | | [] | | | X | X | | X | X | [] | | | X | 6 |
| Improve training for health professionals: Improve training of health professionals in obesity prevention and diagnosing and counselling those at risk of obesity | **X** | | X | | X | X | | | | | | | | | X | 4 |
| Improved health education: Improved health education to enable citizens to make informed choices | | X | | | X | | | | | X | | | X | | | 4 |
| Common Agricultural Policy reform: Reform of the EU's Common Agricultural Policy to help achieve nutritional targets | **X** | | | | | | | | | | | | | X | X | 2 |
| Mandatory nutritional information labelling: Mandatory nutritional information labelling for all processed food, for example using energy density traffic light system | **X** | | X | | | | | | | | | | | | | 1 |

As shown in the second column in yellow, the five top-listed EPHA priorities in its peak committee were as follows:

- Controlling sales of foods in public institutions to ensure that only healthy foods are sold in schools, pre-schools etc.
- Controls on food and drinks advertising on TV, the Internet and in schools
- Mandatory nutritional information labelling that is clear and easy for the consumer to understand

- Common Agricultural Policy reform and subsidies on healthy foods, i.e. fruit and vegetables
- Improve training for health professionals so that they are able to recognise and diagnose obesity risks in infancy, childhood, and adolescence. It is also important that professionals are able to offer advice without appearing prejudiced or patronizing

However, we see that the rankings drawn up by this peak committee differ markedly from the rankings by expert committees within each of the 14 nations in the blue columns and their overall rankings in the white column.

- Even if due weight is given to restrictions on price supports imposed under international free trade and European Commission rules, economic incentives in the form of subsidies for healthy foods were third ranked by the national experts and not ranked at all by the peak group experts.
- Some options ranked low by national committees were promoted far higher in the peak group rankings.
- The top ranked intervention of the 14 nations, which is also supported by Heckman's early intervention argument, was not ranked by the peak committee.

This situation has been labelled "eminence-based" policy-making, when individuals with strong opinions draft their own conclusions (as I am now doing!), regardless of what other qualified persons might have recommended. There is no simple explanation for these differences: perhaps peak groups have an inner sense of priority-setting not available to mere mortals, or maybe peak group biases overwhelm other criteria and individual experts.

The second expert report[63] in 2007 was by the Blair government's Foresight program in the UK Cabinet Office. Reviewing the same evidence as was available to the EHN experts, it listed its five preferences for interventions against obesity:

- Modifying the built environment so that walking and cycling are made easier and more accessible
- Controlling the availability of, and exposure to, foods that cause obesity (e.g. junk foods, soft drinks)
- Targeting health interventions for those who are at high risk of obesity;
- Increasing the responsibility of organisations for the health of their employees
- Early life interventions at birth or in infancy

We note the dissimilar priorities of this expert peak group and the experts in the 14 EU nations listed above. The Preventative Health Task Force's seven priorities are more like the EU peak committee list.

My preference for early intervention (*a la* Heckman) and for a healthier workforce could lead me to endorse the last two preferences of the UK Foresight team – but then I would be falling into the "eminence-based" school.

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[63] Government Office for Science FORESIGHT. *Tackling Obesities: Future Choices – Summary of Key Messages*. London, October 2007.

Similar inconsistencies have appeared in the advocacy of regulations and sin taxes by Australian equivalents of EPHA and Foresight, documented in many submissions to the current House of Representatives inquiry on child obesity.

Evidence-based policy design is never feasible when eminence-based opinions abound, and this is particularly confusing when we are trying to define the role of prevention and self-care in a new population health management strategy.

### 3.3 Population health management and obesity: context and place as pivots?

Recent advocacy by the public health law school redefines the tasks ahead of population health management (PHM). A recent Australian paper[64] repeated earlier US legal sentiments[65] about the potential role of the law in preventing obesity.

One of its premises was that in the prevention of obesity, modern PHM should use the law to change "context" and "place" rather than seek inroads through enhanced personal responsibility.

I contrast two of its interventionist assertions with my alternative view.

| ASSERTION | MY ALTERNATIVE VIEW |
|---|---|
| 1. Social change via the law makes it easier for the whole community to take responsibility for diet | There is no evidence that social policy torts or other legal interventions are preferable or that they work quicker than incentives |
| 2. Food marketing bans, traffic light labels and taxes on fat foods leave individual liberty intact | All bans have hidden costs, labels may not be read, taxes are regressive with unpredictable health effects, and individual liberty is enhanced by personal responsibility |

In support of my comment in the bottom row of the above table, I reference two very different authorities in rejecting the assertion as having any basis in history or real-world prevention of overweight and obesity.

First, there is the statement by Martha Bayles in her Bradley Lecture at the American Enterprise Institute in December 2006.[66] She was speaking about America's position in defence of liberty in the world and not about obesity when she noted the following derivations of liberty and the role of individuals and communities:

*"To people educated in the Western tradition, it should be clear that "liberty" comes from the Latin, libertas, meaning an acquired state of independence that bears certain duties. "Freedom" comes from the German Freiheit and the Old English*

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[64] RS Magnusson. "Rethinking the blame game: liberty, personal responsibility, and challenge of 'lifestyle disease'". Menses Centre for Health Policy 2007 Oration, 17 September 2007.

[65] Mensah GA, Goodman RA, Zaza S, Moulton AD, Kocher PL, Dietz WH, et al. Law as a tool for preventing chronic diseases: expanding the spectrum of effective public health strategies. *Prev Chronic Dis* [serial online] 2004 Jan [*8 October 2008*]. Available from: URL: http://www.cdc.gov/pcd/issues/2004/jan/ 03_0033.htm

[66] Martha Bayles. "The Ugly Americans: How Not to Lose the Global Culture War". Transcript of Bradley Lecture, American Enterprise Institute, 4 December 2006.

*folcfre, meaning kinship within a community not ruled by outside power. Both linguistic traditions carry strong connotations of responsibility and capacity for self-government on both the individual and the community levels."* Responsibility at the individual level surely encompasses personal responsibility for healthy lifestyle choices, and it is consistent with her notion of liberty.

Second, noting that Bayles identified the roles of individuals and communities, I note the German Parliament's view that personal responsibility is a component of the legal basis of social solidarity, as summarised in the Social Security Code in **FIGURE 11** below:

**FIGURE 11: Personal responsibility supports social solidarity in Germany**

*1. Solidarity in the German health system: legal basis*

*1.1 The law states that there must be solidarity in the health system:*
*Paragraph 1, Social Security Code (SGB) V:*

*"It is the responsibility of health insurance, as a form of collective solidarity, to preserve, restore and improve the health of those insured.* ***Those insured share in the responsibility for their health; they ought to lead a health-conscious lifestyle, take precautionary health measures in good time, and actively participate in treatment and rehabilitation in order to help prevent the onset of illness and disability and to overcome its consequences.*** *Health insurance companies must help those insured to do this and to work towards healthy lifestyles by providing explanations, advice and services."*

I am not opposed to government regulation of society when the measured benefits exceed the measured costs. As demonstrated in recent financial fiascos involving sub-prime mortgages and financial derivatives, the absence of effective (or any) government regulation has been devastating for the international economy.

And with tobacco, regulation of cigarette advertising and higher taxes on tobacco were both valid policies in my view when the tobacco companies steadfastly ignored rising community concern, the demonstrably high costs of tobacco-induced diseases, and their own internal advice that cigarette addiction occurs at early ages when adolescents are vulnerable.

In obesity prevention, the law may be needed to achieve behavioural change when all else fails. My contention is that "all else" has not been given a run yet in Australia, and individual liberty and personal responsibility are not strengthened by regulations, bans and taxes.

### 3.4 Summary

Any political zeal to go down the regulatory and tax paths to prevent obesity needs to be tempered by the absence of any evidence that such asymmetric paternalism works.

The precautionary principle, sometimes referenced as a crutch to promote legal interventions against obesity, may be a valid principle when all else fails- but in the case of obesity, its application by government would represent precaution without any evidence of principle.[67]

Advocates of the precautionary principle in Australia also need to be cognisant that the full costs of a regulatory regime should be first identified in a regulatory impact assessment, a matter to which I now turn.

# 4. REGULATION VERSUS INDIVIDUAL RESPONSIBILITY AND BEHAVIOUR CHANGE VIA INCENTIVES: SOME EVIDENCE

So far I have asserted that there is no evidence that the pro-regulatory, pro-tax route should have a high priority in a national prevention strategy targeting obesity.

Drawing on my earlier remarks about the role of neuro-economics and behavioural economics, I assert that the carrots of incentives might be more effective – and faster – than the sticks of the interventionist school.

My evidence base is disparate, of variable strength and suggestive rather than conclusive.[68]

- Once we start down the regulatory route to obesity, the early evidence is that further regulations then follow.
- Sin taxes have unexpected side effects and the tax set would have to be so high as to be politically infeasible in the prevention of obesity
- All forms of paternalism have costs, many of them hidden – and those costs are ignored by the interventionist school.
- Most regulations have costs that do not fall evenly on all parties – but at least those costs should be measured before any new regulation or tax is proposed.
- The current evidence on the impact of financial incentives suggests that many payers worldwide accept incentives – and they change participation in risk assessment, personal behaviour and healthcare costs.

## 4.1 The dangers of slippery slopes in regulation

The weakest component of the interventionist school argument is to promote the legal/regulatory route to reduce food advertising because they see it having similar impacts on obesity as the bans on tobacco advertising had on smoking behaviour. I have noted earlier refutations of that similarity.[69]

Take for example a recent statement in a submission to the House of Representatives enquiry on obesity. [70]

[67] I cannot recall who uttered this phrase, but I endorse the thought. Perhaps some astute reader will locate the original source.
[68] This evidence might fall into a category that some wit called as 'bereft of hard data but sociologically intriguing",
[69] Schroeder 2007, *op cit*
[70] Obesity Policy Coalition submission to House of Representatives Inquiry into Obesity, 13 June 2008, page 15.

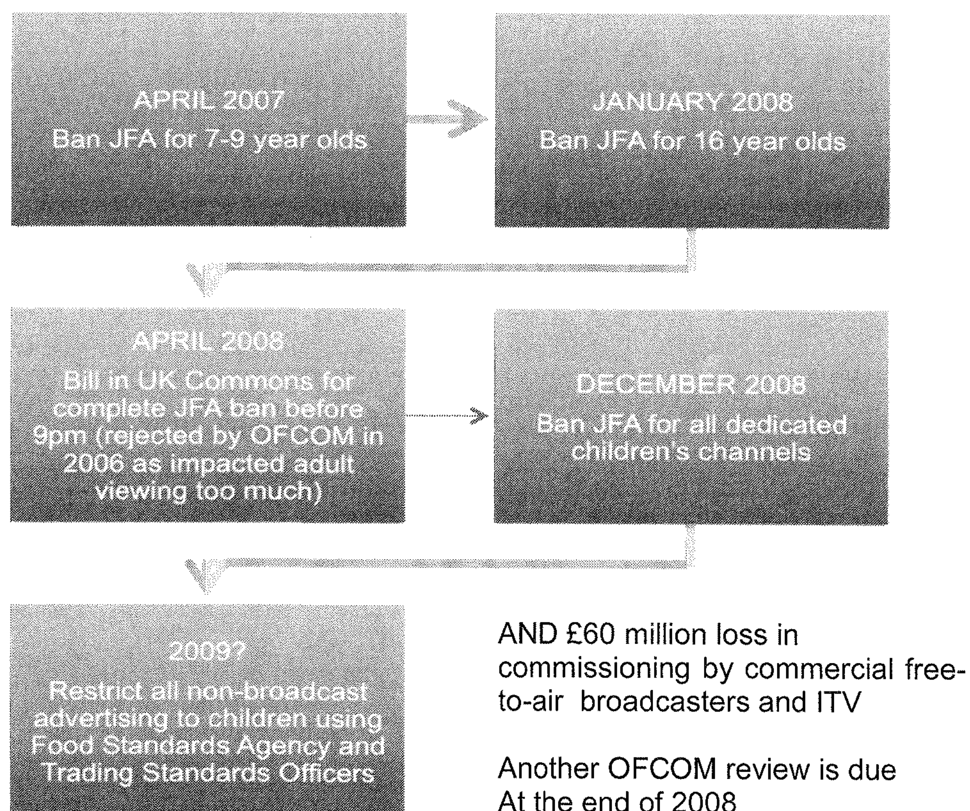
*"To be effective, restrictions on food promotion should apply across all media, since the food and beverage industry would be likely to respond to restrictions applying only to certain media by increasing their marketing expenditures on marketing through other non-restricted media. This was the response of the tobacco industry when broadcast advertising bans were introduced.*

*An international review of the effect of tobacco bans on tobacco consumption concluded that 'a comprehensive set of advertising bans can reduce tobacco consumption but a limited set of advertising bans will have little or no effect.' "*

This Coalition of many respected scientists and health professionals supports the recent banning of junk food advertising to children, a policy introduced by the UK government.

But they must surely also be aware of extensions of this path summarised in **FIGURE 12** below:

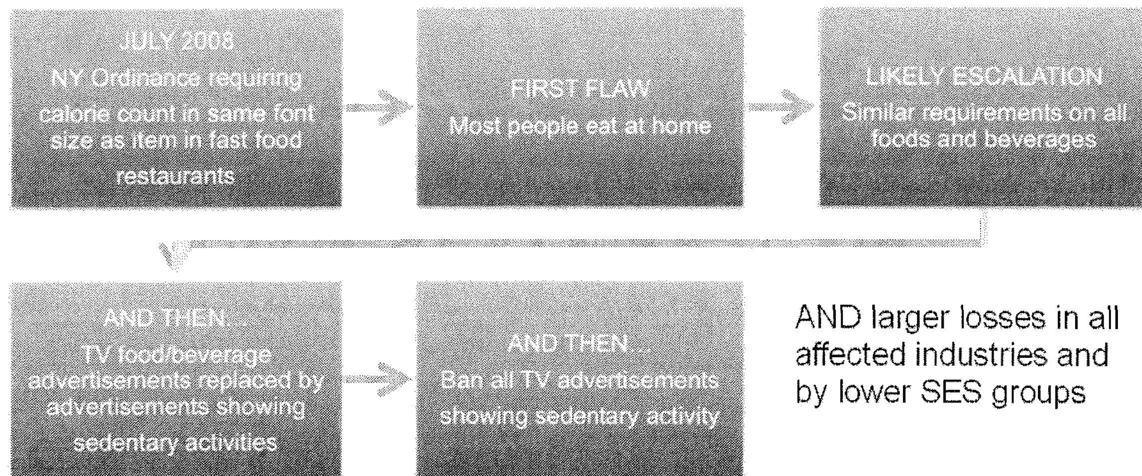
**FIGURE 12: My view of the UK slippery slope on banning junk food advertising (JFA)**




The slippery slope of regulation gets worse. In July 2008, New York City enacted an ordinance requiring a calorie count in fast food restaurant menus and advertising. **FIGURE 13** is my forecast of the next steps down the slippery slope.[71]

[71] This is admittedly conjecture, but the reader is invited to stay with me till I get to the Japanese slope.

**FIGURE 13: New York City law on calories July 2008: where next if the first step fails?**




The slippery slope looks positively frightening in the new Japanese law on obesity[72] enacted in April 2008. This law uses waist size (as defined in **FIGURE 14** below) as the tool of regulation, and it actually tells us what the escalating trajectory of regulatory escalation (bold sentences not in the original) will be.

**FIGURE 14: Japan regulations on waist size, April 08: the slippery slope is actually foreshadowed (bold text not in the original)**

*"Under a national law that came into effect two months ago, companies and local governments must now* ***measure the waistlines of Japanese people between the ages of 40 and 74*** *as part of their annual checkups. That represents more than 56 million waistlines, or about 44 percent of the entire population.*

***Those exceeding government limits — 33.5 inches for men and 35.4 inches for women****, which are identical to thresholds established in 2005 for Japan by the International Diabetes Federation as an easy guideline for identifying health risks —* ***and having a weight-related ailment*** *will be given* ***dieting guidance if after three months*** *they do not lose weight. If necessary, those people will be steered toward* ***further re-education after six more months****.*

*To reach its goals of shrinking the overweight population by 10 percent over the next four years and 25 percent over the next seven years, the government will* ***impose financial penalties on companies and local governments*** *that fail to meet specific targets. The country's Ministry of Health argues that the campaign will keep the spread of diseases like diabetes and strokes in check."*

[72] Source: N Onishi "Japan, Seeking Trim Waists, Measures Millions". *New York Times* 13 June 2008.

## 4.2 Sin taxes have political limits and unanticipated effects

### 4.2.1 Arguments in other submissions to the House of Representatives Standing Committee

Even in Australia, the interventionists who favour taxing of fatty foods have moved from their naïve preferences of 1-2 years ago towards a new tax policy that would hit fatty foods. For example, a submission to the House of Representatives Standing Committee on Obesity[73] made what looks to be an eminence-based recommendation in **FIGURE 15** below:

**FIGURE 15: Australian advocates of taxes change tack: Obesity Policy Coalition submission number 93 to House of Representatives Standing Committee on Obesity, June 2008**

> *"Research modelling the impact of taxation on consumption has found that merely adding an impost to unhealthy food is not enough to change behaviour, in fact it is likely to lead to lower consumption of healthy food such as fruit and vegetables.*
>
> *As a result it is proposed that a tax on unhealthy food should be coupled with a subsidy of healthy foods, such as fruit and vegetables."*

Two years ago similar Australian coalitions were mainly advocating the first paragraph but wiser heads have prevailed. In this new submission, the first policy in the second paragraph (the unhealthy food tax) is regressive, and adding the food subsidy would be a waste of scarce budget resources if it did not reduce overconsumption of unhealthy food.

Any effective prevention policy must influence both energy consumption and energy expenditure.

Any call for taxes and subsidies should be measured against the evidence base.

### 4.2.2 Sin taxes on fats and sugars: evidence from five recent studies

In their policy prescriptions, the pro-regulatory school favours taxes on fatty foods, arguing (wrongly for reasons identified earlier[74]) that fatty foods are like cigarettes, and that we knocked cigarettes out by regulating advertising and taxing them heavily.

Most observers, certainly most economists, agree that sin taxes hit different targets and have adverse impacts on the poor.

Consider the prime targets listed in the four regulatory and four tax interventions listed in **FIGURE 16** below:[75]

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[73] Obesity Policy Coalition submission to House of Representatives Inquiry into Obesity, 13 June 2008, page 19.
[74] Schroeder 2007 *op cit*
[75] Source: PF Gross. *Actions speak louder than words: accelerating national policies for obesity and related chronic illness*. A thesis submitted for the degree of Doctor of Philosophy at The University of Queensland accepted 23 January 2007, Chapter 6. The last tax is the idea of Mr Felix Ortiz, state congressman from New York-, quoted in ."The Fat Tax: A Controversial Tool in War Against Obesity," *Forbes* 11 January 2006. The proposal for this "twinkie tax" was mooted in 1994 by a Yale academic psychologist, Kelly Brownell.

**FIGURE 16: Eight types of regulatory and sin tax policies against obesity and their major targets**

| Public policy | Prime target |
|---|---|
| 1. Mandatory food labelling to include calorie counts | Producers |
| 2. Mandatory labelling for restaurant food | Producers |
| 3. The elimination of food and beverage vending machines in schools | Producers/suppliers |
| 4. Restrictions on media advertising to children | Producers |
| 5. Taxes on marketing of fatty foods | Producers |
| 6. Taxes on foods that are high in salt, added sugar, fats and calories | Producers |
| 7. Taxes on fat people | Obese individuals |
| 8. Taxes on food ads to pay for obesity programs | Advertisers, producers |

Few of the flow-on effects of any of these interventions are documented, but recent research shows some unintended consequences of the sixth intervention.[76]

The use of taxes on nutrients, including saturated fats, was evaluated in a recent UK analysis.[77] The study used data from the UK National Food Survey (2000) that excluded food prepared outside the home, confectionery, soft drinks and alcohol. It found that the nutrient purchases varied little between poor and rich UK households, but the poor would pay relatively more tax with virtually any type of tax on food.

A second UK analysis[78] concluded that any tax on one nutrient is a blunt instrument, and that the unintended consequences include reformulation with other unhealthy nutrients (requiring more regulations or taxes?) and a limit on the differentials between high and low fat varieties.

A third UK analysis of a fat tax[79] concluded that

- *"...[t]axing foodstuffs can have unpredictable health effects if cross-elasticities of demand are ignored. A carefully targeted fat tax could produce modest but meaningful changes in food consumption and a reduction in cardiovascular disease...*
- *...Our model suggests that there could be a variety of unintended potentially detrimental effects, caused by the estimated cross-price elasticities of demand. For example, we observed that reducing saturated fat consumption tended to increase salt consumption and that fruit consumption tended to fall as a result of taxation on milk and cream...*
- *...Food consumption is relatively insensitive to price changes, such that a taxation rate of 17.5% is likely to reduce the intake of nutrients such as salt*

[76] O Mytton,A Gray, M Rayner and H Rutter." Could targeted food taxes improve health?". *J Epidemiol Community Health* 2007;61: 689–694.
[77] A Leicester and F Windmeijer." The 'fat tax': economic incentives to reduce obesity". London, Institute for Fiscal Studies, Briefing Note BN49, June 2004.
[78] J Landon. 'The 'fat tax': economic incentives to reduce obesity?". Presentation at the National Heart Forum, London, 2007. The author conjectured that while EU rules prevent reductions in VAT, an added VAT is not blocked, with the additional revenue going to health care, reduce other taxes or subsidise healthy foods.
[79] O Mytton,A Gray, M Rayner and H Rutter."Could targeted food taxes improve health?". *J Epidemiol Community Health* 2007;61: 689–694.

*and saturated fats by no more than 5–10%. So the scope for significantly altering the national diet by judicious use of VAT seems limited. Greater change could be achieved with a higher level of taxation, but this is unlikely for political and economic reasons".*

A fourth study in 2007 by US economists[80] sheds light on the value of a tax on soft drinks in the fight against child obesity. The effects of soft drinks are a matter of some debate following recent reviews of the effects of fructose[81] and the lack of impact of school-based prevention of carbonated drinks, [82] so this US study is important. Using state data on weight gain and BMI from the Behavioral Risk Factor Surveillance Surveys from 1990 to 2002, and tax rates on soft drinks, the authors reported that

- the behavioural response to average tax rates of around 3% was small;
- it would take a very large increase in soft drink taxes to influence weight distribution;
- if that tax was comparable to the current *ad valorem* tax of 58% on cigarettes, the BMI reduction would be 0.16 and overweight would fall 0.7 percentage points, which is roughly 5% of the increase in overweight status in the 1990s;
- "*...while these weight changes are non-negligible, they will not substantially combat the 'obesity epidemic'*", and
- the tax would be regressive.

A fifth study by US agricultural economists[83] found that while a 10% *ad valorem* tax on the percentage of fat in dairy products would certainly raise tax revenue, it would also reduce fat consumption by less than a percentage point, it would be extremely regressive, and the elderly and poor would suffer greater welfare losses than the young or richer consumers.

## 4.3 Paternalism has hidden costs

The pro-regulatory school have never put forward a regulatory impact assessment of their wishlists. Some of those costs are inter-generational, as I note below in the regulatory costs of bans on advertising.

Klick[84] identified a number of costs of generic paternalism, and these are summarised in **FIGURE 17** below.

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[80] JM Fletcher, D Frisvold and N Tefft." Can soft drink taxes reduce population weight?" School of Public Health, Yale University, 18 August 2007, 22 pages

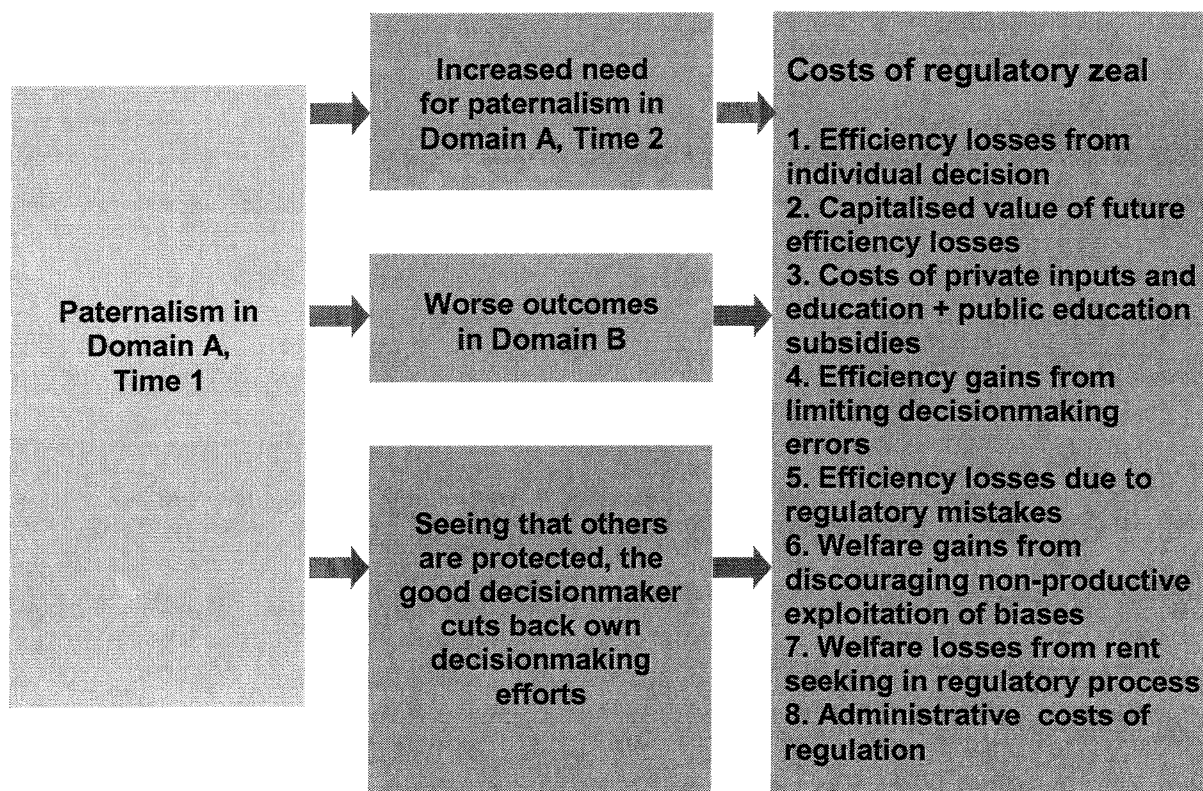
[81] See for example: T Nakagawa et al.," A causal role for uric acid in fructose-induced metabolic syndrome". *Am J Physiol Renal Physiol* 2006; 290: F625-F631; I Aeberli et al., "Fructose intake is a predictor of LDL particle size in overweight schoolchildren".*Am J Clin Nutr* 2007; 86: 1174-1178; A Drewnowski." The real contribution of added sugars and fats to obesity". *Epidemiologic Reviews* 2007; 29 (1): 160-171; GA Bray. "How bad is fructose?" *Am J Clin Nutr* 2007; 86 (4): 895-896; and LR Vartanian, MB Schwartz, KD Brownwll." Effects of soft drink consumption on nutrition and health: a systematic review and meta-analysis". *American Journal of Public Health* 2007; 97 (4): 667-675.

[82] J James, P Thomas and D Kerr." Preventing childhood obesity: two year follow-up results from the Christchurch obesity prevention program in schools (CHOPPS)". *BMJ*, doi: 10.1136/bmj.39342.571806.55 (published 8 October 2007), downloaded from http://bmj.com on 22 November 2007.)

[83] HH Chouinard, DE Davis, JT La France and JM Perloff. "Fat taxes: big money for small change". *Forum for Health Economics and Policy* 2007; 10 (2): Article 2.

[84] Jonathan Klick. Presentation at US Federal Trade Commission workshop 2007.

**FIGURE 17: Relevant costs in a regulatory impact assessment of paternalistic policies**



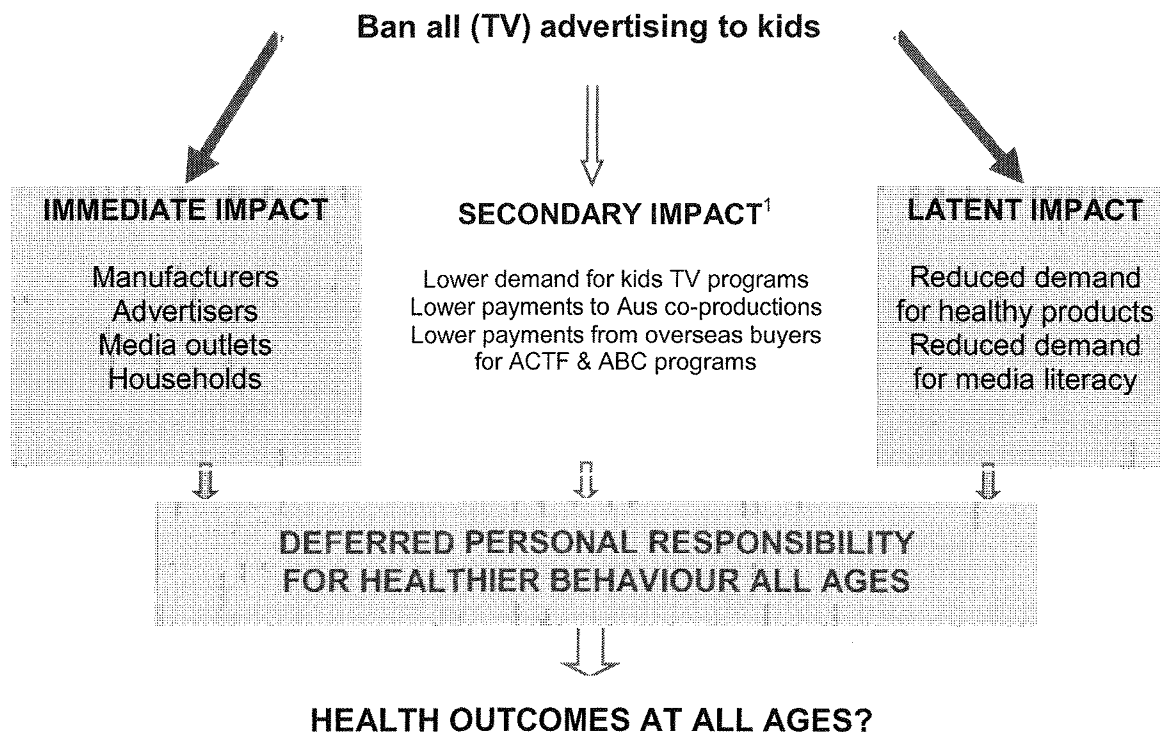

While I cannot be sure how large some of the costs might be in Australia and while some of them pose significant problems of measurement, at the very least we should try to estimate some of them in a regulatory impact assessment before we propose regulation as the preferred route to lower obesity.

## 4.4 Regulations on advertising have more easily measured costs

Despite all the evidence in the 2005 report of the US Institute of Medicine rejecting causation between advertising and child obesity in three different age groups of children, the paternalist school seems to favour bans on advertising to children.

Banning advertising is a blunt weapon that has some costs that the affected industries have indicated to many inquiries in many nations. While the UK media regulator (Ofcom) ignored many relevant costs and the IOM evidence of non-causation in its 2007 report, the costs listed in **FIGURE 18** below are measurable in a regulatory impact assessment.

**FIGURE 18: Some costs and outcomes of banning advertising to children**




Note 1: NOTE 1. In its submission of 31 August 2007 to the CTS Review, the Australian Children's Television Foundation notes that *"...the commercial broadcaster industry group Free TV Australia has already threatened that' further advertising restrictions would seriously undermine funding for children's programming"' (at p. 2).*
*would seriously undermine funding for children's programming"' (at p. 2).*

The last two boxes are inferences, not proven outcomes. They warrant further political debate.

Reading the national mood, in October 2008 the food and grocery industry in Australia took independent action to propose voluntary guidelines for product advertising by food and beverage manufacturers to children under 12 years.[85] This will be another test for self-regulation, with the EU Commission watching over a similar initiative up to 2010 in EU nations.

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[85] This initiative means that there would then be three self-regulatory frameworks. One of the three sponsoring entities, the Australian Association of National Advertisers, will probably support the scheme as it does not impose restrictions on junk food advertising in prime time television slots, and there is an ombudsman. The fast food industry, not covered by the Australia Food and Grocery Council proposal, has already taken steps to create voluntary guidelines for marketing to children.

## 4.5 Incentives to individuals are in widespread use by governments, employers and health insurers

Elsewhere[86] I have identified gaps in recent UK and Australian academic analyses of the impact of economic incentives on a range of behaviours.

If you took a quick poll of health economists on whether incentives can change unhealthy behaviour, my guess is that three common responses would be that

- they might influence single events (such as whether to have a child vaccination),
- they will not change more complex behaviours that require sustained daily actions and other parallel support (as is demonstrably the case in obesity reduction), and that
- proponents of incentives must ensure that equity considerations are not ignored when some people cannot respond to any incentive (because they are chronically ill, illiterate, unmotivated, or otherwise disenfranchised) and that they are penalised further by an incentive scheme.

The first two responses are in part a consequence of the research techniques used by academic theorists without a strong base in workforce productivity measurement, health insurance design and operations, or benefit design in government programs.

The third response is valid- but we need smarter, more caring targeted social and tax policies to redress the equity issue, and we also need to motivate the 80% of the population who are not so disenfranchised.

Most recent academic reviews of the impact of incentives are at best incomplete, providing minimal guidance to policy makers on the (1) relative effectiveness of different combinations of incentive in achieving participation in risk assessment programs, (2) the size of financial and non-financial incentives that have been used in a variety of settings, and (3) the early impact on risk factors of some of the employer-based incentive schemes that have been used by US health insurers.

These limitations are affected by their choice of interventions to be analysed, including

1. their inclusion in meta-analyses of only randomised trials of interventions that used incentives;
2. their inclusion of dated studies of older incentives that have no relevance to modern incentives such as medical savings accounts, frequent flyer points, lower cost health insurance and larger cash payments; and
3. their failure to ask why, in a world replete with resource constraints and cut-throat market competition, a large number of large employers and governments are actively promoting employee incentives (or were doing so up to the current world

[86] PF Gross." Self-care, personal responsibility and the potential impact of economic incentives". Invited paper, Symposium on selfcare and personal responsibility, Australian Health Policy Institute, University of Sydney, 13 October 2008

recession),[87] and such innovations would not normally be funded unless the interventions reduced the use of healthcare or reduced risk factors in some measurable fashion that improved the bottom line of those companies.

This last observation underlines the limits of reliance on randomized trials of social interventions because the take-up of incentives-based rewards systems in health promotion suggests that companies have done their estimates of return on investment (ROI) on employee incentives for better health, and accepted that the ROI passes the company investment hurdle rate.

Randomised trials may be superfluous if the ROI of incentives is already acceptable to chief financial officers. [88]

Even with these perceived limitations, the University of Aberdeen systematic review in 2008 summarised the impact of monetary incentives on weightloss as follows:

- One US study in 2007[89] concluded that programs with financial incentives linked to weight are associated with greater weightloss, and the larger the financial incentive, the greater the weight lost at 6 months.
- Another UK systematic review in 2008[90] found significant weight loss (p=0.04) in studies employing monetary reward but no difference (p=0.40) in studies not employing financial incentives.

Focusing only on weight loss and not other related risk factors, these data understate other impacts of incentives. For example, the US Safeway chain observed significant reductions in medical visits and lower health insurance costs after employees were offered premium reductions for participation in healthier lifestyles.

## 4.6 Health insurance, incentives, prevention coverage and the Henry tax review

The ongoing Henry tax review might, in the light of international economic uncertainty, decide to do nothing to the tax system that would increase existing government subsidies to private health insurance. That seems like a reasonable response if we ignore some consequences:

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[87] A 2007 Metlife survey of 1,380 full-time employees and 1,652 managers at companies with a minimum of two employees found that "*...57 percent of employers with 500 or more workers provide some sort of wellness program such as smoking cessation, weight management, an exercise plan or cancer screening...About four out of five employers with wellness programs add incentives, with 40 percent offering gym memberships, 36 percent awarding gifts or prizes and 27 of employers offering a discounted employee contribution to medical plans....Only nine percent of employers impose financial penalties on employees who do not meet wellness guidelines, a percentage that has remained steady for two years*". See: Reuters." U.S. employers offer and value wellness programs". Washington DC, Reuters, 21 October 2008

[88] This acceptance is by no mean universal, for reasons raised in many conferences on health and productivity in recent years- see for example the paper by Thomas Parry (Integrated Benefits Institute) on a national CFO survey presented at the Washington Business Group On Health Joint Forum on Health, Productivity & Absence Management, San Diego, 5-7 December, 2005. And the levels of acceptance up to early 2008 could decline in the current economic turmoil.

[89] Finkelstein E, Linnan L, et al. A pilot study testing the effect of different levels of financial incentives on weight loss among overweight employees. *Journal of Occupational and Environmental Medicine* 2007;49:981-989.

[90] Virginia Paul-Ebhohimhen and Alison Avenell . Financial incentives in treatments for obesity and overweight; a systematic review of randomised controlled trials. Health Services Research Unit, University of Aberdeen, August 2008

- Left to their own resources, many Australian health insurers are happy with the *status quo*- and the *status quo* regulations prohibit incentives to members for healthier lifestyles that could generate the reductions noted in the Safeway initiative above;
- The current design of health insurance allows no linkage of products to household medical savings accounts- and Australia's low savings rates will need to be boosted if superannuation savings are further devalued by the recession.

The current economic situation is frightening enough without seeking a full overhaul of health insurance legislation to allow such incentives. However, we should consider how elements of Singapore's medical savings accounts might be allowed to evolve with minimal modification of health insurance legislation. If national savings and superannuation accounts wither under the new economic downturn, tax-protected savings accounts can achieve a number of purposes.

If new health insurance product design is one outcome of relaxing the current rules, it is conceivable that we could see lower cost insurance with higher front-end deductibles, 100% coverage of effective prevention, and medical savings accounts that can evolve into other uses such as paying for education and housing in a very different post-recession economy.

The Standing Committee should consider this option for funding prevention with incentives embedded and with the new insurance policies allowing 100% coverage of effective prevention. US developments of such tax-protected savings accounts by about 2% of the US population suggest that high take-ups of preventive services occur, with online self-care support tools adding to the value of this type of health insurance.

## 5. PREVENTING FUTURE OBESITY AND RELATED CHRONIC CONDITIONS: FIVE REASONABLE EXPECTATIONS

My hope that the final recommendations of the House of Representatives Standing Committee will state unequivocally that:

(1) we need to promote personal responsibility to enhance liberty and social solidarity;
(2) we need a national Health and Wellness Council to take prevention in directions that may not require a national prevention agency;
(3) Medicare's payment systems to doctors are archaic and irrelevant – and new methods are needed to pay providers of care for effective prevention;
(4) new incentives can help individuals at all ages adopt healthier lifestyles; and
(5) we need a national policy for obesity prevention that draws on world-best practice and is implemented no later than the May 2009 Budget.

## 5.1 Why not embrace the German version of personal responsibility if you want social solidarity?[91]

The Standing Committee should acknowledge and reaffirm this path to social solidarity via an enhanced role of personal responsibility.

Labor governments do not usually resile from the notion that social solidarity is a desirable goal of Medicare (and less so private health insurance). Both the government and the opposition should therefore be happy about a refurbished Medicare with enhanced personal responsibility as an explicit goal.

Since the Coalition is not usually reticent about personal responsibility or liberty, bipartisan support to restructure both Medicare and private health insurance might be achieved.

The Standing Committee, with its bipartisan composition, might advance that hypothesis in its final report.

## 5.2 Why not a National Health and Wellness Trust?

I am not persuaded by the Task Force's advocacy of a prevention agency that sponsors academic research from Canberra. If the Task Force in its final report promotes that path, then we missed a chance to lift the prevention game to address health and wellness with the same zeal with which we pay for an "illth" treatment system in Medicare and private health insurance.

A new prevention agency in Canberra, without bipartisan support and dependent on the Budget, cannot do the same job as an expert council that, reporting to the Parliament, could use earmarked funding to achieve specific wellness goals within 5-10 years.

### 5.2.1 A new national organisation

So I lean towards a new national entity whose auspices, bipartisanship and visibility signify that we are concerned about national health and wellness. A new entity is not sufficient: government must be willing to give it a budget that brings to the table three levels of government, the health insurers, private industry and healthcare consumers, and then all three sets of actors should pursue new wellness initiatives that engage the population in healthy eating and exercise.

We can affirm the importance of wellness by creating a new Health and Wellness Council that sets national goals for prevention and health promotion. If we want a bipartisan national prevention strategy that is longer than the average 3-year term of governments, this new entity should report directly to the Parliament.

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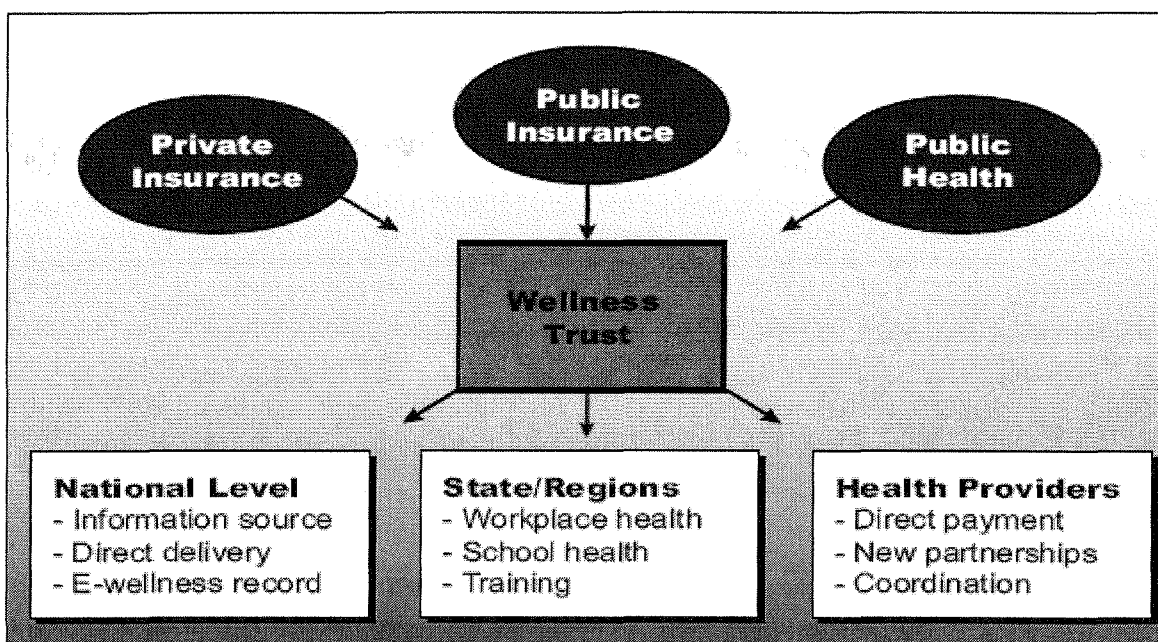
[91] Hans J Ahrens. "The Mature Patient: The Mature Patient: Between Solidarity and Between Solidarity and Personal Responsibility". Paper presented at World Healthcare Congress, Barcelona, 28 March 2007.

### 5.2.2 New national funding for health promotion and self-care

From the halcyon days of the Better Health Initiative in the mid 1980s, wellness has had many proponents but few active funders. There is no queue for prevention and it has very few willing payers.

We therefore need a funding mechanism to support the Council, so I opt for the recent model of a National Wellness Trust proposed by US analysts and depicted in **FIGURE 19** below. [92]

**FIGURE 19: A wellness trust at the national level linked to states and health funds: Lambrew**




However I would fund the red box above using a variants of the German disease management and health promotion initiatives where an earmarked federal pool (200 million Euros at its inception (say A$300 million at today's exchange rate) is accessible by federal government (20%) for overall planning, and by state governments (40%) and health insurance funds (40%) for targeted interventions.

To put this budget in perspective, A$300 million represents 0.3% of total healthcare expenditures of about A$100 billion in 2008.

That funding pool could be created via one of four routes: a national health promotion fund approved in the annual budget; earmarked funding from the current Public Health Outcomes agreement;[93] a designated percentage of total Medicare funding

[92] Jeanne M. Lambrew and John D. Podesta. *Promoting Prevention and Preempting Costs: A New Wellness Trust for the United States.* Center for American Progress, 5 October 2006; and JM Lambrew. "A Wellness Trust to prioritise disease prevention". Hamilton Project, Brookings Institution, April 2007, 36 pages.

[93] The PHO funding was folded into the general financial agreements earlier this year, but it could easily be resurrected in the next AHFA.

and PHI rebate subsidies; or new funding from the Innovations Fund. I lean towards the last option.

## 5.3 Why not new Medicare, DVA and PHI payments to providers for prevention?

We have many problems in the MBS payments to doctors, most of them retard medical inputs to obesity prevention, and some alternatives listed in the right-hand column of **FIGURE 20** below have some merit. [94]

**FIGURE 20: Retooling MBS payments for prevention: ROOTS 2007**

| Current payment systems | Alternatives that need further consideration |
|---|---|
| 1. Inadequate payments for counselling, education and monitoring patients | Increased MBS fee for all such time, OR MBS/PHI/DVA Preventive Care Management payment per year |
| 2. MBS fee paid only for face to face visits, ignoring 13-14% of GP time[95] spent on non-clinical paperwork, calls and emails | Nurses, doctors and others could be paid under a new Extended Care Plan item on the MBS, covering telephone/email contacts and an expanded role for practice nurses |
| 3. MBS fee based on the service provided, not on outcomes achieved | New payment for services with a demonstrable effect on health outcomes, and extra payment if outcomes exceed agreed target |
| 4. MBS copayments for preventive services | Zero or reduced copays for high-value prevention services<br>Payments to GPs for helping patients lose weight and sustain weight loss<br>Payments to GPs for helping chronically ill obese patients to use a portable, web-based, secure medical record to track health indicators |

All alternatives 1-4 above have potential merit in any national attack on obesity using the medical and nursing workforce. Why waste an opportunity to impart self-help during the 120 million interactions of doctors and their patients?

## 5.4 Why not create new incentives for personal responsibility?

I have argued above that incentives might be more effective than sticks in the prevention of obesity.

However, we need to have much longer debates about the role of incentives, and the final reports of the House of Representatives Standing Committee, the National

[94] ROOTS. *Incentives for excellence: rebuilding the healthcare payment system from the ground up*. Pittsburgh, Jewish Healthcare Foundation and Pittsburgh Regional Health Initiative, 2007, 40 pages.
[95] T Bodenheimer." Coordinating Care - A Perilous Journey through the Health Care System'. *N Engl J Med* 2008; 358 (10): 1064-1071.

Health and Hospital Reform Commission and the National Preventative Health Task Force should provide a balanced discussion of questions such as:

- Are incentives feasible in enhancing personal responsibility for healthier lifestyles?
- What specific lifestyles?
- With which target groups as the highest priority?
- What types of incentive might work in different target groups?
- What size of financial incentive might be effective in specific problems such as child and adolescent obesity?
- What non-financial incentives might also be needed?
- What do we do about those who cannot change lifestyles or reduce risk factors?
- Does public health law have a supportive role in this early stage of the debate?

### 5.5 Why not a comprehensive obesity prevention strategy building on the best role models?

I believe that a new comprehensive strategy for obesity prevention and weight loss management should include all of the components summarised in **FIGURE 21** below:

**FIGURE 21: Minimal components in a national population health management strategy to reduce obesity at all ages: Gross 2007**

| COMPONENT | INTERVENTIONS |
|---|---|
| 1. National leadership | A new National Health and Wellness Commission reporting to Parliament, appointed from the public and private sectors |
| 2. National funding | 1. A new policy designated Healthy Australia 2012, setting national targets for healthy diet and physical activity<br>2. A new National Health and Wellness Fund to fund projects at state, regional and school district and workplace levels<br>3. Medicare and private health insurance subsidies for self-management of healthier lifestyles<br>4. Infrastructure investment incentives for employers, local governments and states to develop healthier neighborhoods and worksites |
| 3. Clinical focus | 1. Obesity designated as a chronic condition and a national health target<br>2. GP driven, team care, school health<br>3. Body mass index (BMI) measurements at all opportunistic encounters with health and education services, all data available to the individual in a personalized health record of the types represented by HealthVault or Google Health, and, if the individual so wishes, the sharing of such data with trusted health professionals[96] |
| 4. Supply side priorities | 1. Assessment, followed by risk stratification to enable appropriate interventions by self-care or through the primary care system<br>2. Monitoring of BMI[97] at all ages in early childhood and primary education |

[96] I am acutely aware of the limitations of the BMI and of recent studies suggesting the value of waist circumference and other measures. It is however a universal measure allowing comparisons with other nations and trends in Australia over time, so until it is disproven, it stays in my preferred measures of population health.
[97] While I rely on the results from the Kaiser Weight Management Initiative to justify the value of *monitoring* BMI in children and adults, I am not advocating *screening* children for overweight and obesity if we do not have validated

| | |
|---|---|
| | 3. School reports on exercise available to or undertaken by all children |
| 5. Demand side imperatives | 1. Incentives via Medicare rebates<br>2. Weightloss tools<br>3. Multiple information, education and communication tools made widely available, including new tools for ranking the nutritional content of food & drinks, such as ONQI[98]<br>4. Culturally sensitive telephone support services and web advice |
| 6. Multiple interventions | School and community (EPODE model France and now EU)[99]; Somerville (Mass) |
| 7. Public health surveillance and impact assessment | 1. School surveillance data measuring nutrition and physical activity<br>2. A new Australian Behavioral Risk Factor Surveillance Survey measuring nutritional intakes and physical activity and guiding population health management<br>3. Annual public health impact statements |
| 8. Continuing medical education programs to instruct health professionals and teachers about childhood obesity | Kaiser Permanente Weight Management Initiative program on age-specific physical activity and healthy diets |
| 9. Build interventions based on widely recognised exemplars of obesity prevention[1] | 1. EPODE France and EU[2]<br>2. Kaiser Northern California<br>3. Maine Youth Overweight Collaborative<br>4. Envision New Mexico<br>5. Arkansas state-wide program<br>6. Somerville (Massachusetts)<br>7. El Paso (Texas)<br>8. Colac (Be Active Eat Well) |
| 10. Supporting community-based participatory research[100] and translation research[101] | Culturally sensitive research into barriers, impact of incentives |

In box 9 above, the Colac project is Australian, it did not involve regulation or taxes, and it was associated with a 68% reduction in the consumption of sweet drinks, a

interventions see for example ; M Westwood, D Fayter, S Hartley et al.," Childhood obesity: should primary school children be routinely screened? A systematic review and discussion of the evidence". *Archives of Disease in Childhood* 2007; 92: 416-422.

[98] The prospect of multiple tools for nutritional content rating is imminent if judged by the competition between the *transparent rating scales* (such as the new scoring system developed by Adam Drewnowski at University of Washington) and the commercially sensitive, *black box rating scales* (such as the Overall Nutritional Quality Index of 30 nutrients developed by the Yale-Griffin Prevention Research Center and the "Guiding Stars" rating system developed by Hannaford Brothers Company) – see: A Martin." Is it healthy? Food rating systems battle it out". *New York Times* 1 December 2007; Topco Associates LLC." At-a-glance system for ranking nutritional quality to launch in supermarkets nationwide". Skokie (Indiana), 28 November 2007; and PRWEB." Top nutrition scientists develop scoring system to rank order foods on overall nutritional quality- conference for scientists, policy makers, & press on Nov. 30 in Wash DC". Derby (Connecticut), PRWEB, 4 page press release.

[99] Sources: 1. S Raffin." EPODE-Together, we can prevent childhood obesity". Presentation at Adelaide Food Summit, 16-17 October 2007. The first phase of the project in two cities asked three questions: 1) Do the children have better nutritional knowledge? 2) If yes, has this changed family food habits? 3) If yes, what consequences on BMI and prevalence of obesity on a long-term period?; and C Homer and L Simpson." Childhood obesity: what's health care policy got to do with it?" *Health Affairs* 2007; 26 (3): 441-444.

[100] See for example: S Kumanyika." Bringing evidence and practice closer together: models for obesity prevention in African America". ICO Satellite Conference, Geelong, September 2006.

[101] See for example: J Dearing."Applying diffusion of innovation theory to intervention development". Stockholm Conference on Implementation and Translational Research, 15 October 2007, Stockholm; and E Waters et al., "A cluster randomised controlled trial to assess the effectiveness of knowledge translation strategies for obesity prevention". Deakin University, presentation at PHAA, 2007.

57% increase in healthier foods in lunchboxes, and a 68% increase in the numbers of children participating in after-school physical activity. It was limited by available budgets, and it did not include the full range of population health management activities.

Rather than talk about regulation and sin taxes as solutions to anything in the real world, we would benefit more from many Colac's in Australia, funded from a new Health and Wellness Council to achieve the goals of real population health management.

## CONCLUSION

In 2020, in the absence of such innovations the Standing Committee on Health and Ageing will be long gone, and we will still be howling at the moon, asking whether we are making any impact on obesity at any age.

Hopefully the Standing Committee will lead the political debate about reducing obesity at all ages long before 2020. Lower child obesity by 2012 is a reachable target, and a levelling out of adult obesity is achievable by 2015 with real political leadership and enhanced personal responsibility.