

The False Promise of GP Super Clinics

Part 1: Preventive Care



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Jeremy Sammut

Papers in Health and Ageing (3)

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Executive summary

This is the first of a pair of policy monographs entitled *The False Promise of GP Super Clinics, Part 1: Preventive Care*, and *Part 2: Coordinated Care*. These monographs examine the evidence base and assumptions of four key health policy areas. Each of these areas is widely considered to be pertinent to whether the Medicare system will be sustainable into the twenty-first century, given the demands of the ageing of Australia's population, the rising chronic disease burden, and the anticipated acceleration of health costs in coming decades. These areas are:

1. the perennial promise that more spending on primary prevention will control the prevalence of lifestyle-related chronic disease, and contain the cost of treating it
2. the merits of the commonwealth government's planned national network of 'GP Super Clinics,' which are currently designed to reorient the health system away from higher-cost hospital services and towards lower-cost general practice primary care, and to boost the primary prevention of obesity and lifestyle disease by providing local communities with enhanced access to a range of Medicare-funded 'preventive health services'
3. the implications of the government's plan to use GP Super Clinics to boost the secondary prevention of chronic disease and 'take the pressure off hospitals' by 'coordinating' the primary care the chronically ill receive, with particular regard to the real impact coordinated primary care is likely to have on both health costs and on demand for hospital services
4. the merits of an alternative plan where Super Clinics would substitute inpatient hospital care with community-based outpatient services, and ensure integrated tertiary care is delivered in the most cost-effective setting

The second monograph discusses the third and fourth of these points, the present monograph the first and second. In both, the much-publicised claims the proponents of GP Super Clinics have made about the benefits of more federal government spending on preventive and coordinated care are subjected to evidence-based scrutiny. Together, these monographs find that while Super Clinics are promoted as an effective method of addressing the major challenges facing the Australian health system, the evidence strongly suggests that Super Clinics will *not*, as has been promised, prevent 'lifestyle disease,' lower health costs, or take the pressure off hospitals.

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

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

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

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

Nevertheless, the prevailing assumption remains that more spending on ‘preventive care’ will tackle obesity, lower chronic disease rates, and reduce health costs, as if this process is sure and seamless. For example, a paper published last year by the Centre for Policy Development claimed that international evidence shows health systems oriented toward lower cost primary care, rather than higher-cost hospital care, achieve better health outcomes for less, due to the preventive care—advice about lifestyle modification—delivered in the primary care setting. ‘Stronger’ primary care, the claim goes, has a primary preventive effect that reduces lifestyle disease and health costs. This is the argument on which the Rudd government came to base its GP Super Clinics and preventive health policy.

The international evidence is not as authoritative as claimed. Studies that show higher provision of *primary care* produces better health outcomes—because it allows more patients to receive timely diagnosis and referral to secondary care by other specialists and then to necessary tertiary,

predominantly hospital-based treatments—contain no evidence that receipt of *preventive care* prevented chronic illness. This suggests that the advocates of ‘stronger’ primary care have mistakenly attributed the effect of the traditional role of primary care—diagnosis and referral—to preventive care. Furthermore, a 2002 cross-country analysis of thirteen OECD countries actually revealed that those with comparatively weaker primary care systems—including Australia—that spent more on hospital care achieved better health outcomes than those with stronger orientations to primary care. In other words, more spending on higher cost hospital care, rather than less spending on lower cost ‘preventive’

primary care, appears to have produced better health outcomes. International comparisons do *not* show that countries with stronger primary care and ‘less focus on specialist/hospital care’ achieve better health outcomes at lower cost.

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

The evidence, therefore, suggests that many recipients of Medicare-funded preventive health services will fail to change their unhealthy lifestyle, and future governments will have to fund the recurring costs of ineffective preventive care that yields negligible health and cost benefits. The evidence suggests that GP Super Clinics delivering ‘preventive care’ will only accentuate the challenges facing Medicare.

The evidence suggests that GP Super Clinics delivering ‘preventive care’ will only accentuate the challenges facing Medicare.

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

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

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

—Gordon Breitman, MD¹

Introduction

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

The demographic and medical realities of the twenty-first century—the ageing of the population and the high cost of new medical technology, combined with the rising prevalence of obesity and the increasing cost of treating 'lifestyle-related' chronic disease—threaten to make Medicare, Australia's 'free and universal' taxpayer-funded health system, unsustainable in coming decades. As the healthcare costs accelerate, either the smaller base of taxpayers of tomorrow will have to pay considerably higher taxes, or government services will need to be cut, and Australians will not continue to receive 'free' access to all the latest medicine as they have become accustomed to.²

Though the long-term challenges are real, profound, and yet to be adequately addressed, instead of pursuing the appropriate policy response, politicians prefer to avoid the issue of comprehensive health reform.³ Instead of taking action now to relieve the burden on future generations and move beyond relying on taxpayers to foot the bill, politicians of all persuasions have grown keener to pursue the kind of 'solutions' outlined, for instance, in the most recent of the federal government's Intergenerational Reports:

We need to continue to prepare for the health care we want in the future, and ensure that health spending is as efficient and effective as possible. For example, promotion of healthier lifestyles can prevent many health problems and reduce overall health costs over time.⁴

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

The prevention mantra

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

There is no doubting the lifestyle-related chronic disease burden is a major challenge facing the health system (see box 1). Therefore, the logic behind calls for more government spending on prevention—on 'health education,' 'health promotion,' and 'lifestyle modification'—to bring

lifestyle disease under control seems unassailable. Of course ‘prevention,’ if it works, is better than cure. This is especially so if, as the advocates of preventive policies argue, more spending on the primary and secondary prevention of chronic disease saves money by avoiding the need for higher spending on more expensive treatments, takes the pressure off public hospitals, and helps alleviate the long-term challenges associated with ageing and rising costs.

Box 1: The rising toll

Responsible for 80% of the total disease burden, chronic disease—cancer, heart disease, type 2 diabetes, kidney disease, and arthritis—costs the public health system an estimated \$34 billion annually. Projections suggest that by 2020 the rising cost of treating chronic disease will consume 80% of total health spending.

Many people contract a chronic condition due to hereditary and genetic factors, often triggered by ageing. But the consensus is that a leading factor in the rising chronic disease burden is the unhealthy lifestyle choices many Australians continue to make, especially with regard to poor diet and exercise habits.

The chief problem is increasing levels of obesity, which is linked to a higher risk of chronic disease. Over 60% of Australians are classified as overweight, and 19% of males and 17% of women are classified as obese. The prevalence of type 2 diabetes—a condition closely linked to obesity—has doubled since 1996. In 2005–06, public hospitals admitted more patients for renal dialysis—a treatment for end-stage kidney disease, of which diabetes is one cause—than for any other reason.

Unhealthy lifestyles are a public policy issue because of Medicare. Because a ‘free and universal’ health system gives sufferers of lifestyle-related chronic illness financial protection against the healthcare costs stemming from their unhealthy lifestyle, healthy taxpayers are, in effect, subsidising the unhealthy behaviour of those who consume a disproportionate share of taxpayer-funded healthcare.⁵

With modern medicine continually finding more technologically advanced and expensive ways of saving people from the disease consequences of their unhealthy behaviour, the escalating cost of subsidising lifestyle disease by treating it is set to exacerbate the pressures on Medicare in coming decades.⁶

A 2007 discussion paper issued by the Australian Institute of Health Policy Studies illustrates the extent to which more spending on prevention is consistently singled out in health policy circles as the best way to ensure the long-term sustainability of Medicare: ‘Almost every analysis of the challenges facing the health system (ageing, chronic disease, growing demand and consumer expectations) concludes that the health system can only be sustained if there is a fundamental shift to refocus upstream on prevention and health promotion.’⁷ In theory, reorienting the health system away from hospitals to focus instead on providing the community with lower-cost primary and preventive care, and on keeping people well rather than continuing to spend an increasing amount of money treating them once they are already sick, sounds like a good idea. As we shall see, the case for more government spending to ‘re-focus’ the health system in this direction has gained even greater policy traction following the election of the Rudd government.

* So as not to be misunderstood, it is important to make clear what this paper isn’t talking about when it refers sceptically to ‘prevention.’ It is not talking about the proven (or ‘modern’) methods of prevention such as vaccinations, screening, and blood pressure and anti-cholesterol medications. Medical interventions such as these clearly are effective methods to detect and treat diseases early or delay their onset. It is also correct that enhanced access to primary care allows for early detection and less expensive treatment of latent lifestyle-related conditions such as type 2 diabetes, compared to the cost and complexity of treating such conditions only once they become manifest and/or acute. These kinds of preventive measures can certainly be cost-effective as well as reducing suffering from the conditions and allowing people to lead longer, healthier lives. However, as others have pointed out, the cost of screening entire populations for diseases and providing medications to everyone considered at risk can exceed the savings on future treatment costs, since many of those screened or medicated would never have gone on to develop chronic or acute conditions anyway. Joshua T. Cohen and others, ‘Does Preventive Care Save Money? Health Economics and the Presidential Candidates,’ *New England Journal of Medicine*, 358:7 (2008), 661–663.

The rationale for GP Super Clinics

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

The preventive healthcare policy documents released before the 2007 federal election by the then-opposition (see especially the ‘GP Super Clinics’ discussion paper) drew heavily on the ‘new approach’ outlined by Doggett.⁸ It is therefore fair to say that the Rudd government has well and truly heeded the call for more spending on prevention. To equip Medicare to deal with challenges of lifestyle and chronic disease, it has committed an initial \$220 million towards the establishment of a national network of GP Super Clinics, the intention being to provide local communities with enhanced access to not just primary care but also preventive health services (see box 2).

Box 2: The new approach to primary and preventive care

Jennifer Doggett:

The author recommends the reorientation of Australia’s health system towards primary care, to be achieved through the roll-out of around 200 integrated Primary Health Care Centres, each servicing a population of 100 000 on average.

The Centres would:

- Be the main focus of program delivery and consumer-focused, integrated primary care and preventive health services;
- Provide full/part-time GPs, dentists, nurses, pharmacists, physiotherapists, psychologists, other health services, plus specialist and day services where viable;
- Be funded to manage the overall health of the local population, to provide pre- and post- hospital care, plus screening, education and other preventive health services.⁹

The Australian Labor Party:

Federal Labor will invest \$220 million in the health system to establish GP Super Clinics in local communities – bolstering frontline health care for Australian families.

Labor’s investment will ensure more Australian families have access to doctors, nurses, specialists and allied health professionals, such as physiotherapists, podiatrists, dieticians and psychologists, all in one centre, in their local community where they need them...

And by having renovated or purpose-built facilities that allow space for group sessions and a range of staff, the Super Clinics will have a particular focus on assisting people to stay well, or better manage existing chronic conditions.

Combined with the prevention strategies Labor has already announced, Labor’s GP Super Clinics will help take the pressure off hospitals long term, [and] provide a greater focus for tackling the challenge of chronic disease in local communities ...¹⁰

Going by the outline in Doggett’s paper and Labor’s policy documents, GP Super Clinics will be ‘multidisciplinary primary care centres ... established to provide coordinated and preventive primary care,’¹¹ and they will be purpose designed to boost and make more robust the preventive role that allegedly ‘lower cost’ primary care plays in the health system.¹² The objective is to bring previously dispersed general practitioners, practice nurses, and other allied health workers together under one roof, and to develop new models of ‘preventive health services’ to fight chronic disease at the ‘population health’ level.

The Rudd government’s Super Clinics policy therefore envisages a significant expansion of Medicare beyond traditional fee-for-service GP primary care. The plan is to provide rising numbers of unhealthy and chronically ill people with enhanced and more convenient access to a range of wellness-promoting services—from dieticians to physiotherapists and psychologists—which, despite recent initiatives, Medicare has provided only limited access to in the past.¹³ As the now

federal health minister, Nicola Roxon, explained in an opinion piece last August, the overarching goal is to reduce demand for hospital services ‘by investing more in primary care services in local communities to keep people in good health and take pressure off public hospitals.’¹⁴

Preventive and coordinated primary care

There are two distinct aspects to the government’s proposed approach to prevention-focused primary care.

For the secondary prevention of chronic disease, Super Clinics will enable the primary care of patients with established chronic illnesses, especially elderly patients, to be ‘coordinated.’ Coordinated primary care (which is sometimes referred to as ‘managed care’ and also ‘disease management’) involves either a GP or a practice nurse monitoring the condition and managing the care of chronically ill patients to ensure they receive all available care from a wide variety of allied health providers. Coordinated care also involves better educating patients about their disease so they can better self-manage their condition and maintain their health, with particular regard to the secondary prevention of lifestyle related comorbidities (an additional one or more chronic conditions—diabetes, for instance, can lead to heart disease and stroke), that can cause complications and more frequent, longer, costlier hospital stays.

The attractive idea is that coordinated care will lower health costs by preventing chronic conditions from deteriorating, and will therefore prevent patients from requiring higher cost secondary care and emergency department and inpatient services. If the primary care received by the chronically ill is coordinated and this keeps patients well and out of hospital, they will supposedly not need referral to secondary specialist and hospital-based tertiary care, and their condition will be less likely to deteriorate to the point where they require urgent, unplanned, and ‘avoidable’ admission into hospitals. Champions of investing in coordinated care therefore suggest that while it is more expensive than traditional primary care, the cost will be offset by the savings achieved by substituting cheaper primary care for more expensive treatments, and by reducing the utilisation of higher-cost hospital-centred services.

GP Super Clinics will add to the demand and cost pressures public hospitals already face.

These claims are the subject of the second part of this monograph (forthcoming), which examines the evidence that strongly suggests that rather than keeping people well and out of hospital, GP Super Clinics providing coordinated chronic disease care are highly likely to put more people in hospital by uncovering unmet need for secondary care and tertiary treatment. It argues that in the absence of other reforms to substitute community-based for hospital-based services, GP Super Clinics will add to the demand and cost pressures public hospitals already face.

For the primary prevention of ‘lifestyle disease,’ Super Clinics are designed to offer a wellness-based model of primary care. These are the issues with which the present monograph is concerned. The plan is for Super Clinics to deliver high-intensity, multidisciplinary lifestyle interventions to high-risk patients. These interventions will address the ‘lifestyle determinants of ill health’¹⁵—particularly unhealthy diet and lack of exercise—that can lead to obesity and chronic illnesses such as heart disease and diabetes. According to the proponents of the ‘wellness’ model of ‘preventive healthcare’:

The lifestyle changes associated with obesity and physical activity can be facilitated by ongoing collaboration by a multidisciplinary workforce – most notably dietitians/nutritionists, and nurse educators working with fitness therapists/lifestyle coaches ... Some of the barriers to exercise can be addressed by fitness trainers, lifestyle coaches, counselors, and a range of complementary therapists.¹⁶

Does ‘preventive’ primary care improve health outcomes and lower health costs?

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

A wealth of international evidence shows that health systems oriented towards primary care achieve better health outcomes for a lower overall cost than systems focused on specialist or tertiary care ... For example, cross-country analyses have found that mortality rates and total health care costs are lower in countries with a strong primary care system. Other studies have found that health systems which have more primary care doctors per head of population achieve better health outcomes, including lower rates of mortality from heart disease, cancer and stroke, independent of socio-demographic factors.¹⁷

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

There is now international evidence to demonstrate that health systems focused on primary care and preventative health care achieve better health outcomes, including lower death rates from chronic diseases like heart disease and cancer, and lower overall cost than health systems which are focused on acute hospital care.¹⁸

Unpacking this, the rationale for 'investing' in GP Super Clinics is that primary care fulfils two roles at once. Traditionally, *primary care* refers to the general practice encounters sought out by patients seeking diagnosis and referral to necessary secondary care and tertiary treatments. Primary care also encompasses preventive and public health services such as vaccinations and disease screenings, while regular checkups allow for early detection and treatment of conditions. Beyond these roles, the claim made by Doggett and backed by the Rudd government to support the case for GP Super Clinics is that stronger primary care results in lower health costs and improved health outcomes due to the preventive care delivered in the primary care setting, which is, as Doggett put it, 'most suited to early interventions, such as lifestyle modifications ... to prevent chronic disease.'¹⁹

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

The advocates of stronger primary care have mistakenly attributed the effect of the traditional roles of primary care—diagnosis and referral—to preventive care.

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

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

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

In other words, this study showed that more spending on higher cost curative tertiary care, rather than less spending on lower cost 'preventive care,' appeared to have produced better health

outcomes, and that international comparisons do *not* show that countries with stronger primary care and ‘less focus on specialist/hospital care’ achieve better health outcomes at lower cost. The evidence base for GP Super Clinics achieving the promised outcomes thus fails its first test (for full details and analysis, see appendix 1).

The false promise of more spending on primary prevention

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

Preventative health care needs to be made more accessible to ordinary Australians struggling to find the time in their busy lives to look after their own health. We can’t expect people to take better care of their health if we won’t help provide the health services they need to make this a reality.²⁰

The first thing to notice about the case for more government spending on preventive healthcare is that it updates the assumption—pervasive and largely unquestioned in the health debate—that governments can intervene in and thus control the obesity and lifestyle disease ‘epidemics.’ In keeping with all forms of the argument for more spending on prevention, this misconstrues the classic meaning of *preventive medicine*. It is the latest example of the way that those who advocate more spending on prevention have inappropriately traded upon the legacy and deserved high reputation of preventive medicine since the new socio-medical discipline of ‘public health’ developed in the 1970s.

Preventive medicine and the prevention of lifestyle disease

Public health measures from industrial sewerage systems to mass vaccination programs, which brought contagious airborne and waterborne diseases such as cholera, typhoid, and polio under control, are a major reason why death rates fell and life expectancy rose so dramatically in the twentieth century. To eradicate disease and protect public health, in many cases governments regulated the noxious public activities—from smokestacks belching pollutants to putrid abattoirs—that fouled the air, water, and food supply, to the point of eliminating them by

prosecution and penalties. All people in countries where this was the case have been the passive beneficiaries of preventive interventions that have created a healthier public environment and collectively inoculated the community against the threat of *illnesses that people did not contract due to their own behaviour*.

Lifestyle modification is primarily the responsibility of the individual.

Public health education campaigns designed to inform at-risk groups about the risks of unhealthy lifestyles do not compare with the proven preventive measures that have compelled individuals and other entities

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

Fundamental differences and three reasons for failure

These fundamental differences, combined with the complexity of behavioral change, point to the three basic reasons the health lifestyle message has not always had the hoped-for impact on people's lifestyles. What they suggest is that education campaigns have not been as successful as promised because they have been expected to achieve outcomes they cannot in all cases.

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

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

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

The limits of 'prevention'

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

Public health experts and lobby groups tacitly admit what rising obesity levels amply demonstrate: that public health education campaigns have not been as universally successful as it was hoped they would be. What they tend to suggest, though—to obscure just how unsuccessful these policies have been—is that the evidence does not yet show what works. They also like to suggest that rising rates of obesity show that not enough of the health budget goes to prevention. The latest version of these diverting arguments is displayed in the government's policy document: individuals are absolved of their primary responsibility for the unhealthy lifestyle decisions they continue to make, and the lifestyle disease 'epidemic' is blamed on lack of government-funded entitlement to preventive care! Rarely considered are the real reasons—the limits of government authority over individual behaviour, and the importance of personal qualities in regulating it—why nearly forty years of health promotion has coincided with ascending rates of lifestyle disease.

Public health education campaigns have not been as universally successful as it was hoped they would be.

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

There are also huge differences between the kinds of behavioural change that anti-smoking and diet and exercise campaigns have each aimed to induce. Anti-smoking campaigns have targeted a specific behaviour and cajoled individuals to decide to quit one bad habit. A similar example of behavioural change is the campaign to encourage condom use to prevent the spread of AIDS.

Diet and exercise campaigns, by contrast, require people to actively do a series of things to change their lifestyle and to sustain those changes over the long term. The success of the anti-smoking campaign compared with the relative failure of healthy diet and exercise campaigns points to the real and demonstrated limits of the effectiveness of ‘prevention.’ It is simply very difficult to induce people to initiate and sustain a series of changes to complex and often longstanding behaviours, and to continually decide to make healthy decisions about diet and exercise.

Yet the merry-go-round goes round and round

Nevertheless, prevention lobby groups such as the Australian Chronic Disease Prevention Alliance (ACDPA)—a combination of non-government prevention organisations formed in 2005 to press the governments for greater spending on prevention²¹—continue to promise that ‘investing in promoting increased levels of physical activity and healthy eating in Australians would reduce the burden of chronic disease now and in the future.’²² Hence a recent report by the Australian Centre

There is actually slim support for the belief that preventive public health policies ... have in the past brought obesity and lifestyle disease under control.

for Health Research calls for a greater emphasis ‘on personal lifestyle and wellbeing (preventative care)’ and ‘on public health programs that keep people out of hospital,’ which the report assumes ‘should result in medium to long term reductions in overall expenditure,’ as if this process is sure and seamless.²³ It is worth pausing to consider just what is riding on this assumption: ensuring the cost of Medicare does not become an unsustainable burden on future generations, as this report puts it. Despite what is at stake, the key question—perpetually glossed over and subsumed beneath the mantra that governments should spend more on prevention—is the only one that counts: does ‘prevention’ actually work?

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

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

In the 1970s, the new socio-medical discipline of ‘public health’ developed around the idea that ignorance was the reason people made unhealthy lifestyle decisions and chose to smoke, overeat, drink too much, and fail to exercise. Over the last three decades, public health experts have promised that government spending on health promotion campaigns targeting diet and exercise would lead to behavioural change by educating the community to make healthy lifestyle choices. But despite decades of spending on preventive initiatives, sedentary habits, poor diet, and obesity have become major health issues, and the rising toll of lifestyle-related chronic disease is now set to increase the unsustainability of Medicare.

Nevertheless, the response from public health experts and the prevention lobby is to call for even more spending on ‘evidence-based’ prevention programs based on the promise that greater government spending in this direction can and will bring lifestyle disease under control.²⁴

The long-term cost-effectiveness of additional spending on prevention depends on whether the promised reductions in future cost of treating chronic disease are actually achievable.²⁵ However, the evidence from forty years of preventive policies both in Australia and overseas does not support the view that more spending on public health education and promotion campaigns will be an effective method of inducing behavioural change and lowering the incidence of lifestyle disease.

The limited success and overall failure of prevention policies

Australian governments have conducted public health campaigns promoting healthy diets and active lifestyles since the 1960s, the most memorable the long-running, national ‘Life. Be In It’ campaign begun in Victoria in 1975. Spearheaded by the work of the National Heart Foundation, there have been thirty-five coronary heart disease prevention programs alone.²⁶

Over this period, mortality rates from heart disease have fallen. In 2004, the prevention lobby group the ACDPA claimed that ‘programs to reduce coronary heart disease over the last 30 years have cost \$810 million but created benefits worth \$9.3 billion.’²⁷ The source for this claim was *Returns on Investment in Public Health*, a report prepared by Applied Economics for the Department of Health and Ageing in 2003, which attributed 70% of the decline in death from heart disease to reductions in smoking, cholesterol, and blood pressure levels.

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

The report determined that out of the \$9.3 billion figure, CHD prevention programs were responsible for benefits to the total of \$994 million, a figure that included benefits such as ‘longevity gains.’ The report estimated that CHD programs had resulted in a \$557 million saving in government health care expenditure, which was *less* than the \$810 million estimate spent by Australian governments on these programs.²⁸

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

The importance of class

How limited the effect on diet and exercise behaviour has been is the key point. The evidence strongly suggests that class and educational factors have determined the effectiveness of health promotion campaigns. Obesity levels are highest in lower-income suburbs and lowest in higher-income suburbs.²⁹ Middle-class people, it appears, have more keenly heeded the healthy lifestyle message, and have stopped smoking, improved their diets, and begun to exercise more. In a real sense, the ‘easy’ prevention has thus already been accomplished by those people who have made and continue to make the decision to change their lifestyle choices and adopt a healthy lifestyle. The best one can say is that while health promotion campaigns have spread the message about the lifestyle modifications individuals need to make to promote their own health, they have failed to induce a consistent pattern of behavioural change across all groups in the community.

This was the conclusion pointed to by the findings of the report *Returns on Investment in Public Health*. When it turned to the effect on lifestyle behaviours, the report found that overall CHD prevention programs had limited influence on diet and exercise risk factors, as ‘*there was little change in the amount of physical exercise taken and the proportion of overweight persons increased.*’³⁰ In other words, despite decades of investment in healthy diet and active lifestyle promotion, the obesity epidemic took off, and the proportion of overweight men and women in the Australian community continues to increase.

Health promotion campaigns ... have failed to induce a consistent pattern of behavioural change across all groups in the community.

Sedentary and obese, with no solutions: The UK experience

International evidence also confirms how unsuccessful efforts to change the unhealthy lifestyles of increasingly obese populations have been overall. The 2004 Wanless review of public health policy in the UK found that the preventive health policies pursued by both the Blair and earlier Tory governments (see box 3) had comprehensively failed to improve the overall health of the population.

Though report after report had set target after target for ‘population health,’ and outlined action plan after action plan for ‘health improvement,’ and though the Labour government designed specific programs to tackle lifestyle disease in lower-income communities, just as in Australia,

Box 3: The 'primary-care-led NHS' and New Labour's war on 'health inequalities'

Over the last thirty years, the UK government has implemented a wide range of preventive policies, various aspects of which public health experts recommend as ideal for Australia. These include 'fundholding' primary care trusts, which now control 80% of the NHS budget and have broad remits that stretch from the provision of primary care to the commissioning and planning of adequate tertiary services for local populations, operating preventive programs, and managing population health.

The 1977 Black Report concluded that the hospital-care-oriented National Health Service was ill-equipped to deal with the variety of health problems caused by social and economic factors, and that a broader public health strategy should be implemented. After failing to act on the report for over a decade, in the early 1990s the Tory government—in keen pursuit of prophesied savings on health costs in return for cheaper spending on prevention—took action to reorient the strategic direction of the National Health Service and create what became termed a 'primary-care-led NHS.'

In 1990, new GP contracts were introduced that made doctors accountable to local Health Authorities and included annual reporting provisions and a requirement to meet targets for preventive services. Following the release in 1992 of the report *Health of the Nation*, Health Authorities were required to play an expanded role in health maintenance and improvement. Five disease prevention priority areas were established—cardiovascular diseases, cancer, mental illness, sexual health, and accidents—with targets set for reducing mortality and morbidity.

In 1997, the new Labour government led by Tony Blair appointed the first minister of state responsible for overseeing public health policy and monitoring and promoting population health. As well as setting revised targets for the five priority areas, the Labour government also required Health Authorities to draw up Health Improvement Programs (HIMPs) to bring together a range of health and other community organisations to improve public health. In 1998, new national NHS guidelines and priorities further stressed the role of Health Authorities in tackling causes of ill health, and set new targets to reduce deaths from heart disease by improving prevention and treatment services. The government also commissioned the 1998 Acheson Report on inequalities in health, which again highlighted the NHS's lack of focus on improving population health, especially in disadvantaged areas. The government has subsequently reaffirmed a commitment to shifting the NHS's focus from clinical services delivery to health promotion and prevention in the 1998 green paper *Our Healthier Nation*, in the 1999 white paper *Saving Lives: Our Healthier Nation*, in *Tackling Health Inequalities: A Programme for Action* of 2003, and again in the 2004 white paper *Choosing Health*.

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

The key finding of the 2003 national evaluation was that compared to non-HAZ areas, 'HAZs made little impact in terms of measurable improvements in health outcomes.'³³

'levels of physical activity have remained relatively stable over the last decade, [and] obesity levels have been rising.'³¹

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

The slim evidence base

Does the patchy record of prevention policies show the real problem is inadequate funding of 'evidence-based' strategies? Even though Australian spending on prevention is above the OECD average,³⁴ it is frequently pointed out that under 2% of total government health expenditure goes to prevention—which means, so the slogan goes, that we have an 'illness' system, not a 'health' system.³⁵

The problem remains the lack of evidence that the prophesied benefits of dedicating a higher proportion of the health budget to 'public health activities' are realisable.³⁶ Overall, the 'evidence-base' suggests that government spending on 'prevention' has proven to be an ineffective method of controlling lifestyle disease. Even the ACDPA had to admit that the evidence that lifestyle interventions are an effective and cost-effective means of changing unhealthy diet and exercise behaviours is 'limited' and 'scarce.'³⁷

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

critical gaps in the evidence relating to lifestyle interventions across all these areas ... In general, evidence from which to assess community-wide interventions is incomplete and what is available is of poor quality ... Least satisfactory is the evidence concerning physical activity and multiple risk factor interventions, particularly in relation to retention of behaviour change.³⁸

In other words, so slim is the evidence that prevention works that, as one candid public health academic has truly said, what we really have with regard to calls for more spending on prevention is a 'policy looking for an evidence base.'³⁹

Anti-smoking campaigns: The exception, not the rule

Nevertheless, unwarranted encouragement is often taken from the success of campaigns against tobacco smoking.⁴⁰

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

Properly categorised, the anti-smoking campaign is an example of public health regulation rather than health promotion. It is more like traditional public health measures and the way governments

So slim is the evidence that prevention works ... what we really have with regard to calls for more spending on prevention is a 'policy looking for an evidence base.'

have compelled seatbelt use and attacked drink-driving, through legislation and enforcement. Governments have employed a series of highly interventionist methods to discourage smoking. Along with making cigarette advertising illegal and warnings on cigarette packaging mandatory, governments have also directly harassed smokers by imposing legislative bans on smoking in workplaces and other public areas. Constant increases in the price of cigarettes as governments have levied higher and higher tobacco taxes have been an additional deterrent.⁴¹

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

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

By contrast, obesity has not attracted the same stigma as smoking because the community continues to see obesity as harming only the obese. The impact on the community—the extra imposts on taxpayers and the additional strain on the health system—are not as obvious, and, crucially, other people's obesity does not directly affect the health of their fellow citizens. In the fight against obesity, governments are therefore unlikely to be able to rely on the same social stigmas, punitive levers, and society-

wide sanctions. For one thing, politicians will probably be reluctant to single out the expanding constituency of overweight voters for their 'antisocial' lifestyle. What health minister will want to be seen reinforcing 'negative stereotypes' about 'fat people'? For the same reasons, it is unlikely that the disease consequences of obesity will be brought home as starkly as in government-funded advertisements against smoking.

To combat obesity, could governments apply the more interventionist approach used against smoking? The problem is that it is difficult to conceive how governments could *fairly* regulate diet and exercise habits. When governments banned smoking in public, they acted on the principle that every cigarette damaged smokers' health, and penalised smokers only for the behaviour believed to harm non-smokers. Tobacco is also an easy-to-define, noxious substance. But it is difficult to define 'junk food' so that taxes could be imposed or its advertising could be banned. In addition, the 'fat taxes' proposed in emulation of the taxes on cigarettes, as well as new (far-fetched) proposals to employ urban design strategies to curtail car use and compel public transport use, would not just target the unhealthy behaviour of the overweight and obese. Such measures would also penalize people who, for instance, can consume fast foods in moderation and do no harm to themselves, let alone to others. For these reasons, any government that attempts to regulate lifestyle behaviours is liable to face legitimate and justified opposition against unwarranted intrusions upon individual liberty.

Why prevention polices have not prevented lifestyle disease

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

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

The different kind of behaviour change that each sets out to achieve would explain the success of the anti-smoking campaign and the relative failure of healthy diet and exercise campaigns. While both have sought to educate people about the behaviour they need to change to protect their health, it is (demonstrably) much harder to get people to promote their own health and

Any government that attempts to regulate lifestyle behaviours is liable to face ... justified opposition against unwarranted intrusions upon individual liberty.

initiate and sustain a series of changes to complex and often longstanding behaviours by continually deciding to make healthy dietary and exercise decisions.

This is the significance of the studies that point to the difficulties encountered in sustaining long-term behavioural change. The 'stickiness' of lifestyle behaviours means that people are prone to maintain the lifelong unhealthy but often pleasurable habits that cause obesity and can lead to chronic illness, no matter how strongly the health promotion message is pushed.⁴² Appreciating this makes sense of the evidence and the story it tells, and directs attention to the principal reason for the limited impact of lifestyle interventions. Since individuals are principally responsible for deciding to modify their unhealthy habits, success (long-term behavioural change) ultimately depends upon on personal qualities (will, self-discipline, and impulse control) that many people at risk of contracting lifestyle disease may not possess.

A new model of preventive care?

Wellness

Could the failure of health education campaigns to change entrenched lifestyle behaviours mean we do need a new approach to preventive care? According to the 'father' of the 'wellness' model of 'preventive healthcare' that is at the heart of the Rudd government's Super Clinics plan, John Stafford, the 'lifestyle changes associated with obesity and physical activity can be facilitated by ongoing collaboration by a multidisciplinary workforce.'⁴³

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

Will this work?

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

Unfortunately, it is the same story here as in the case of 'community-wide' interventions. Once again, studies report that even high-intensity professionally-guided lifestyle interventions have had low impact on behaviour, particularly with regard to the long-term retention of behavioural changes.⁴⁴

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

First, the 'fair to good' finding applied only to high-intensity behavioural interventions that targeted patients categorised as obese. Otherwise, the USPSTF 'found limited data that addressed the efficacy of counselling-based interventions in overweight adults.' Second, most of the relevant studies were judged only fair in quality, due to small samples and high dropout rates. Third, the studies were marred by 'selection bias,' which highlighted the importance of cultural and individual factors, since the data supporting the (questionable) effectiveness of high-intensity interventions was derived mostly from white women, with very little data regarding obese men or the elderly.

Fourth, the studies generally reported only average group weight change, not 'frequency of response to the interventions': the percentage of patients for whom the intervention was unsuccessful was not recorded. Finally, the studies 'showed mixed results.' Of the eleven studies, only four showed significant average weight reductions. Several studies showed modest, sustained weight loss over a two- to three-year period, but overall 'trials with follow-up beyond 1 year tended to show a loss of effect.'⁴⁵

The evidence ... seems to confirm that obesity and lifestyle disease remain difficult to prevent so long as the risk of harm remains relatively remote.

Again, the evidence does *not* show that prevention works; rather, it seems to confirm that obesity and lifestyle disease remain difficult to prevent so long as the risk of harm remains relatively remote,⁴⁶ because lifestyle modification is difficult to induce and sustain no matter the form of intervention. Promises that new models of preventive care will more effectively control lifestyle disease should be treated with caution.

From enlightenment to paternalism: The muddled public health discourse

The role of government and 'ordinary Australians'

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

Though loath to admit that 'community-wide' prevention measures have not succeeded, public health experts no longer attribute the persistence of unhealthy behaviour to ignorance. Instead, reasonably enough, some say that health education campaigns have been successful to a point, as most people now are at least aware of the lifestyle modifications they need to make to protect their health and reduce the risk of chronic illness.⁴⁷

This is the position explicitly endorsed by the prime minister and the health minister ... 'ordinary Australians' cannot ... protect their own health without government help.

'But,' as the Australian Labor Party's 'Fresh Ideas' preventive healthcare discussion paper released in June 2007 put it, 'recent history demonstrates that even while most of us already know this, we sometimes need motivation, resources, support and help from the system to turn this knowledge into practice.'⁴⁸ Note, as we have seen, there is no evidence that 'help' from the 'system' does 'turn knowledge into practice.' But what this analysis of 'recent history' reveals about the thinking and motivations behind the Rudd government's plan to unfurl a whole new stream of preventive policy is even more alarming.

The government's preventive health policy implies that while the incidence of lifestyle disease has increased because many people have not heeded the healthy lifestyle message despite public health campaign

after campaign, the real issue, as the government's GP Super Clinics policy document put it, is that 'Preventative health care needs to be made more accessible to ordinary Australians.' As the policy document continues to argue—and this is the position explicitly endorsed by the prime minister and the health minister—in 2008 'ordinary Australians' cannot be expected to fulfil the basic individual and social duty to protect their own health without government help and without taxpayer-funded entitlements to 'wellness' services.

How has it come to this?

The government's preventive health policy accurately captures (or apes) the remarkable shift that has occurred in the public health discourse as obesity has emerged as a key health issue in recent years. To explain away the failure of education campaigns to eradicate lifestyle disease as promised, public health experts are now in an absurd muddle as they try to justify their continued calls for more 'investment' in prevention.

Rather than accept the real and demonstrated limits to the effectiveness of prevention, the contemporary public health discourse has instead absolved individuals of their responsibility for unhealthy lifestyle decisions they continue to make. In a blatant misuse of the term, obesity has now been redefined as an 'epidemic,' as if it is a contagious disease that somehow people passively contract due to wicked multinational fast-food advertising. Public health experts have also developed the concept of 'health inequality,' which, properly understood, would recognise that the incidence of lifestyle disease is concentrated among lower-income groups that have failed to heed the healthy lifestyle message. But as employed in the health debate, 'health inequality' has redefined the persistence of unhealthy lifestyles as a 'social problem'—lest one 'blame the victims'—that governments have failed to intervene to control. As a result, rising levels of obesity are not attributed to individual choice and personal behaviour, but to 'a catastrophic failure of government and public health authorities to devise and implement concerted, effective evidence-based action.'⁴⁹

So absurd is the shift away from personal responsibility and towards government responsibility for the cause and cure of lifestyle disease, that it is now commonplace to blame the lifestyle disease ‘epidemic’ on lack of entitlement to preventive care. According to this remarkable and paternalistic thinking—and the government’s preventive healthcare policy documents amply demonstrate this—the reason health outcomes are lower and the incidence of lifestyle disease is highest in lower-income areas is because governments have failed to provide the relevant communities with access to preventive health services.⁵⁰

A crisis accentuated, not averted: Five conclusions

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

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

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

Unless we look beyond the false promise of more spending on prevention ... Medicare is going to impose unsustainable burdens on future generations.

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

Four. The Rudd government’s Super Clinics plan to expand Medicare-funded access to a wider range of wellness-promoting allied health services will more than likely increase the challenges Medicare faces. It will build a new structural feature into the commonwealth health budget, which will prove a very expensive, open-ended commitment, given the evidence that many recipients of these ‘preventive health services’ will find it difficult to modify and sustain changes to their unhealthy lifestyles. Rather than save on health costs, the danger is that future governments and taxpayers will have to fund the additional recurrent cost of ineffective ‘preventive’ care that yields negligible health and cost benefits. Again, this suggests that in the long-term, Super Clinics threaten to accentuate, not alleviate, Medicare’s unsustainability.

Five. On top of the costs of ageing and new technology, future generations of taxpayers will face pressure to pay an increasingly large bill for treatment of lifestyle disease—particularly in the event that improved chronic disease care increases demand for hospital care, a possibility my next monograph explores. The issue this raises is how best to reorganise the provision of healthcare, particularly hospital care, to ensure efficiency and cost-effectiveness.

The bottom line is that despite all the talk about the ‘long-term’ benefits of prevention, in reality we cannot afford to continue to avoid adequately addressing the profound long-term challenges Medicare faces. Unless we look beyond the false promise of more spending on prevention, and start to address how to move beyond relying on taxpayers to finance the accelerating cost of healthcare into the twenty-first century,⁵¹ Medicare is going to impose unsustainable burdens on future generations.

Appendix 1: The international evidence—Does ‘preventive’ primary care prevent lifestyle disease?

The international evidence consists of a number of studies, mainly from the US, that purportedly show ‘health is better in areas with more primary care physicians’ because stronger primary care ‘helps prevent illness.’⁵² What these studies have identified is a statistical relationship between regions with higher ratios of primary care provision to population and ‘improved health outcomes’: lower rates of all-cause mortality and cause-specific mortality from heart disease, stroke, and cancer.⁵³

While it makes sense that GPs would tell patients to lose weight, improve their diet, and exercise to improve their health, what these studies fail to provide is direct evidence of cause and effect—evidence demonstrating that access to and receipt of primary care reduced obesity (modified individual behaviour) and lowered the incidence of (actually prevented) chronic disease.⁵⁴ Instead, it is implied that this the process that occurred, as the association between primary care and lower mortality has been attributed, without proof, to the ‘health promotion’ activities purportedly delivered in primary care settings. In other words, there is no actual evidence to support the assertion that the ‘preventive care’ aspects of primary care reduce lifestyle disease.

What the evidence does suggest, though, is that when primary care fulfils its traditional role of detection and referral, more primary care resources do improve health outcomes. But the reason mortality is found to be lower in communities better endowed with primary care—it is lower in urban than in rural areas, for example⁵⁵—is that it permits more timely diagnosis of serious conditions and faster access to appropriate pharmaceutical and tertiary treatments.⁵⁶ As far as primary care—let alone ‘preventive care’—being the key factor goes, even these studies acknowledge their limitations and admit that improved health outcomes depend on an ‘appropriate balance’ between primary and tertiary care, and that ‘international comparisons and studies within the United States point to this conclusion.’⁵⁷ Moreover, what the international evidence actually shows is that access to higher-costing tertiary care, rather than stronger primary care alone, has produced better health outcomes.

Does lower-costing primary care alone improve health outcomes?

The most recent cross-country analysis cited by Doggett as linking stronger primary care and improved population health outcomes is a 2003 study comparing primary care across eighteen OECD countries.⁵⁸ Each country’s primary care system was scored using subjective criteria that heavily weighted ‘free and universal,’ taxpayer-financed provision, and the health outcomes were assessed. The authors concluded that the ‘stronger the country’s primary care orientation,’ the

lower the rates of all-cause mortality, premature mortality, and cause-specific mortality from emphysema, cardiovascular and heart disease, even after controlling for socio-demographic factors like smoking and income.⁵⁹

According to a major review article published in 2005 in the US medical journal the *Milbank Quarterly*, this confirmed the findings of a 2002 cross-country analysis of primary care in thirteen OECD countries, which also found that ‘countries with low primary care scores as a group had poorer health outcomes’ and ‘performed less well on most major aspects of health.’⁶⁰ If you compare health outcomes for

countries with strong primary care regimes to those with weaker primary care, this is certainly what the results indicate (see table 1). However, a closer look at the evidence is more revealing.

While both studies used the same criteria to score primary care systems, the 2002 study ranked weaker and stronger primary care countries into ‘low,’ ‘intermediate,’ and ‘high’ groups, and then assessed health outcomes for each group. The countries ranked ‘low’ did not perform as well on certain health outcomes (particularly in areas sensitive to primary care provision, such as neonatal and infant mortality and birth weight). But for life expectancy, the differences between ‘high’ and ‘low’ countries by age forty were slight, and ‘low’ countries outperformed ‘high’ countries at ages sixty-five and eighty. More importantly, the ‘intermediate’ countries outperformed the ‘high’ countries across all age categories (see table 2). Health outcomes for the intermediate group were

There is no actual evidence to support the assertion that the ‘preventive care’ aspects of primary care reduce lifestyle disease.

not ‘generally at least as good as those with high levels of primary care,’ but far better.⁶¹

The results forced the disappointed authors—the leading US primary care scholars Barbara Starfield and Leiyu Shi—to make a major concession. ‘It is apparent that the health data for the middle group of countries are better for several indicators of health than in countries with the best primary care scores,’ a result they noted was consistent with the ‘rankings for indicators past childhood (DALES) in the World Health Report.’⁶²

Table 1: Primary care: weaker versus stronger (‘intermediate’ and ‘high’ combined)

‘Average rankings# for life expectancy at ages 40, 65, and 80 for countries by grouped primary care orientation.’

	Age 40		Age 65		Age 80	
	Female	Male	Female	Male	Female	Male
Weaker Primary Care*	7.8	9.5	8.0	8.0	7.4	6.9
Stronger Primary Care†	6.7	5.9	6.6	6.6	6.8	7.1

*Belgium, France, Germany United States

† Australian, Canada, Japan, Sweden, Denmark, Netherlands, Finland, United Kingdom

#‘Best level of health indicator is ranked 1: worst is ranked 13. Thus, lower average rank indicated better performance. The ranks for each of the countries in each group represent the average rank for the countries in the groups.’

Source: B. Starfield and L. Shi⁶³

Table 2: ‘Intermediate’ primary care versus ‘high’ primary care

‘Average rankings# for life expectancy at ages 40, 65, and 80 for countries by grouped primary care orientation.’

	Age 40		Age 65		Age 80	
	Female	Male	Female	Male	Female	Male
Intermediate Primary Care*	4.0	2.5	3.8	3.5	3.6	4.3
High Primary Care†	8.8	8.6	8.8	9.0	9.5	9.3

*Australia, Canada, Japan, Sweden

† Denmark, Netherlands, Finland, United Kingdom

#‘Best level of health indicator is ranked 1: worst is ranked 13. Thus, lower average rank indicated better performance. The ranks for each of the countries in each group represent the average rank for the countries in the groups.’

Source: B. Starfield and L. Shi⁶⁴

As significant was the very poor performance of the two best scoring high-primary-care countries—Denmark and the United Kingdom (see box 4). Stronger primary care had *not* produced better health outcomes independent of socio-demographic factors, given the prevalence in these two countries of chronic conditions such as heart disease that are purportedly so amenable to the preventive interventions delivered in primary care settings.

Does higher spending on tertiary care improve health outcomes?

Overall health spending in the intermediate countries (Australia, Canada, Japan, and Sweden) was also considerably higher than the high group (Denmark, Finland, Netherlands, United Kingdom). To this extent, ‘international comparisons of primary care showed that those countries with weaker primary care had significantly higher costs.’⁶⁵ But, as Starfield and Shi again had to concede, the difference in spending between ‘intermediate’ and ‘high’ countries appeared to account for the difference in health outcomes:

Since health is influenced not only by primary care but also by appropriate referral care, it is possible that underspending accounts for suboptimal performance later in life in the countries with the best primary care systems ... chronic underspending may be associated with poor health later in life, when consultations with specialists for patients with greater morbidity may be salutary.⁶⁶

Box 4: Primary care up, cost down, health outcomes down

Barbara Starfield and Leiyu Shi:

Denmark's poor performance on health indicators, despite a relatively high level of primary care and access to health services, has been a matter of concern ... A wide range of diseases contributed to the slower improvement in life expectancy in Denmark, but it has mainly been associated with poor progress with respiratory cancer, cirrhosis, and cardiovascular diseases ... Smoking rates are high, with rates in females (41%) higher by far than in the Netherlands (33%) and double that in most other countries. One analysis indicated that the Danish government has avoided regulatory approaches such as controls on access to alcohol and tobacco that are used in other parts of Scandinavia, relying primarily on health education and taxation.

The relatively poor position of the United Kingdom was also noted in the earlier study, which postulated that the relatively low proportion contributed by central government expenditures for both social welfare and education (but NOT for health services) made the country unique among the European countries and perhaps were part of the explanation for poorer health than would be expected considering its excellent primary care infrastructures ...

France, like Japan, has relatively good health statistics despite its relatively poor primary care system. Part of the explanation may be its Mediterranean diet (at least in the southern parts of the country).⁶⁷

In other words, cross-country analyses do not bear out the claims advocates of 'stronger' primary care have made. Higher cost tertiary care, rather than lower cost 'preventive care' appears to have produced better health outcomes. International comparisons actually show that mortality is lower in countries with (relatively) weaker primary care that spent more to provide better access to tertiary treatment,⁶⁸ *not* that countries with stronger primary care, and 'less focus on specialist/hospital care' achieve better health outcomes at lower cost.⁶⁹

This was particularly true of Australia. Australia was one of the 'intermediate' countries that had better health outcomes than the 'best' primary care countries. But, as Starfield and Shi pointed out, most health indicators had improved in tandem with 'increased costs relative to other countries.'⁷⁰

Endnotes

- 1 *Western Journal of Medicine* 125:3 (September 1976), 236.
- 2 Jeremy Sammut, *The Coming Crisis of Medicare: What the Intergenerational Reports Should Say, But Don't, About Health and Ageing*, CIS Policy Monograph 79 (Sydney: CIS, 2007).
- 3 The appropriate policy response is to establish a dedicated national stream of self-funded 'health savings' in parallel with the compulsory superannuation system. See the Allen Consulting Group's report to Medicines Australia, *Medical Savings Accounts: A Discussion Paper* (September 2004). One path to creating a more efficient and sustainable health system is a voluntary national system of Medicare opt-outs, whereby entitlement to publicly funded healthcare could be cashed out in the form of a tax credit and used to fund a Health Savings Account and to pay for day-to-day medical expenses and private catastrophic health insurance. See Peter Saunders, *A Welfare State for Those Who Want One, and Opt-outs for Those Who Don't*, CIS Issue Analysis 79 (Sydney: CIS, 2007).
- 4 Commonwealth of Australia, *Intergenerational Report 2007—Overview*, (Canberra: Commonwealth of Australia, 2007), www.treasury.gov.au/igr/overview/pdf/IGR2_Overview_Web.pdf, 12.
- 5 Obesity or diabetes can increase the cost of treating hospitalised patients with comorbidities by three to four times. John Breusch, 'Costs Drive Up Health Premiums,' *Australian Financial Review* (16 January 2008).
- 6 The Productivity Commission has warned that many new drugs and procedures in the pipeline are the result of research and development specifically undertaken to discover treatments for the major chronic diseases associated with ageing and poor lifestyle. It is these diseases that will impose the greatest disease burdens in Western countries as the population ages. Productivity Commission, *Impact of Advances in Medical Technology* (Melbourne: Commonwealth of Australia, 2005), xlix–lii.
- 7 S. Willcox, V. Lin, R. Watson, and B. Oldenburg, *Revitalising Health Reform—Time to Act* (Melbourne: Australian Institute of Health Policy Studies, 2007), 22.
- 8 Doggett has acknowledged and claimed credit for this. See Jennifer Doggett, 'What's Super about Labor's New GP Super Clinics?' *Insight* (15 January 2008), cpd.org.au/article/case-primary-care.
- 9 Jennifer Doggett, *A New Approach to Primary Care for Australia*, Centre for Policy Development Occasional Paper 1 (Sydney: Centre for Policy Development, 2007), 2.
- 10 'Labor's GP Super Clinics In The Community,' *Kevin07.com.au* (26 August 2007) www.kevin07.com.au/news/health/labors-gp-super-clinics-in-the-community.html.
- 11 Doggett, 'What's Super about Labor's New GP Super Clinics?'
- 12 Mark Metherell, 'Prescription to End the Blame Game and Costly Divisions,' *Sydney Morning Herald* (24 August 2007).
- 13 Recognising this, the former federal government introduced the Enhanced Primary Care package in 1999, which established a Medicare Benefits Schedule (MBS) item covering chronic illness and enabled GPs to undertake health assessment, multidisciplinary care planning, and monitoring. Since 2005, patients with complex needs have been able to access Medicare-funded 'GP Management Plans' and 'Team Care' from up to five allied health providers and three dental services per year.
- 14 Nicola Roxon, 'ALP Offers the Healthier Option,' *The Australian* (28 August 2007).
- 15 CPD (Centre for Policy Development), 'Fact Sheet: Preventative Health,' cpd.org.au/sites/cpd/files/u2/CPDFACTSHEET_Preventative_Health.pdf.
- 16 John Stafford, *Wellness Centres Revisited: A New Model of Primary Health Care for North Lakes and Surrounding Suburbs*, submission to the Standing Committee on Health and Ageing of the Commonwealth House of Representatives (February 2005), www.aph.gov.au/house/committee/haal/healthfunding/subs/sub081.pdf, 10.
- 17 Jennifer Doggett, 'A New Approach to Primary Care for Australia,' 8. The discussion that follows draws on the studies cited by Doggett as demonstrating that stronger primary care produces better health and lower costs.
- 18 Kevin Rudd and Nicola Roxon, *New Directions for Australia's Health: Delivering GP Super Clinics to Local Communities* (August 2007), www.alp.org.au/download/now/new_directions_for_australias_health_gp_super_clinics_final.pdf, 17.
- 19 Jennifer Doggett, 'A New Approach to Primary Care for Australia,' 9.
- 20 Kevin Rudd and Nicola Roxon, *New Directions for Australia's Health*, 12.
- 21 Its members are Diabetes Australia, Kidney Health Australia, the National Heart Foundation of Australia, the National Stroke Foundation, and the Cancer Council Australia.
- 22 ACDPA (Australian Chronic Disease Prevention Alliance), *Chronic Illness: Australia's Health Challenge—The Economic Case for Physical Activity and Nutrition in the Prevention of Chronic Disease*, (January 2004), www.goforyourlife.vic.gov.au/hav/articles.nsf/pracpages/The_Economic_Case_for_Physical_Activity_and_Nutrition?open, 6.

- 23 ACHR (Australian Centre for Health Research), *Report into the Operation and Future of the Australian Health Care Agreements and the Funding of Public Hospitals* (Melbourne: ACHR, 2008), 6, 24, 74.
- 24 ACDPA, *Chronic Illness*, 6.
- 25 Productivity Commission, *Potential Benefits of the National Reform Agenda* (Canberra: Productivity Commission, 2006), 208.
- 26 As above, 207.
- 27 ACDPA, *Chronic Illness*.
- 28 Applied Economics, *Returns on Investment in Public Health: An Epidemiological and Economic Analysis prepared for the Department of Health and Ageing* (Canberra: Department of Health and Ageing, 2003), 48–49.
- 29 As was confirmed by the recent NSW Health study that found obesity was highest in the socioeconomically disadvantaged areas of the state. ‘Driven to Be Fat,’ *Sydney Morning Herald* (29 January 2008).
- 30 Applied Economics, *Returns on Investment in Public Health*, 3, emphasis added.
- 31 Derek Wanless, *Securing Good Health for the Whole Population* (London: HM Treasury, 2004), 77.
- 32 As above, 5, 7.
- 33 K. Judge and L. Bauld, ‘Learning from Policy Failure? Health Action Zones in England,’ *European Journal of Public Health* 16:4 (2006), 341.
- 34 ‘Using a different definition, [the OECD] found that Australia directed about 3.1 per cent of health spending to public and preventive health, above the OECD average of 2.9 per cent.’ John Breusch, ‘Funding Focus Shifts to Preventive Care,’ *Australian Financial Review* (13 February 2008).
- 35 John Menadue, ‘Obstacles to Health Reform,’ *Insight* (25 July 2007), cpd.org.au/article/obstacles-to-health-reform.
- 36 CPD, ‘Fact Sheet: Preventative Health.’ The prevention lobby always stresses the scope for prevention to have a positive impact—for example, that a 1% increase in the proportion of the population that is sufficiently active would result in estimated saving of \$8 million per annum. ACDPA, *Chronic Illness*.
- 37 ACDPA, *Chronic Illness*, 9, 14. In addition, methods of measuring population health outcomes and monitoring risk factors like obesity, blood pressure, cholesterol, and physical activity are underdeveloped, making it difficult to assess the performance of public health campaigns or estimate the returns on spending. NHPAC (National Health Priority Action Council), *National Chronic Disease Strategy* (Canberra: Australian Government Department of Health and Ageing, 2006), 28, 45–46.
- 38 Monash University Centre for Health Economics, *Risk Factor Study: How to Reduce the Burden of Harm from Poor Nutrition, Tobacco Smoking, Physical Inactivity and Alcohol Misuse: Cost Utility Analysis of 29 Interventions*, Research Paper 2005(1), 7–8.
- 39 ‘It is laudable to think that research findings will help to inform the evidence base for policy but often there is a sense that we have policy looking for an evidence base.’ Annie S. Anderson, ‘Obesity Prevention and Management—Evidence and Policy,’ *Journal of Human Nutrition and Dietetics* 18:1 (February 2005), 1–2.
- 40 Between 1991 and 2004, smoking rates in Australia fell by almost 30%. Presently, 17% of the population aged over fourteen smoke, down from 45% of the adult population thirty years ago.
- 41 The evidence is contested about the effect of higher taxes, though: see Applied Economics, *Returns on Investment in Public Health*, 21–22. However, in Britain, for example, the effectiveness of anti-smoking initiatives has been lower because the effect of tax rises on tobacco consumption has been muted due to the proliferation of cigarette smuggling. Derek Wanless, *Securing Good Health for the Whole Population*, 86.
- 42 For a notably sober assessment of these issues, see Productivity Commission, *Potential Benefits of the National Reform Agenda*, 218–220.
- 43 John Stafford, *Wellness Centres Revisited*, 10.
- 44 See M. Hillsdon, C. Foster, and M. Thorogood, ‘Interventions for Promoting Physical Activity,’ *Cochrane Database of Systematic Reviews* 2008:2 (2008), www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003180/frame.html.
- 45 USPSTF (United States Preventive Services Task Force), *Screening for Obesity in Adults: Recommendations and Rationale*, AHRQ Pub. No. 04-0528A, December (Rockville, MD: USPSTF, 2003).
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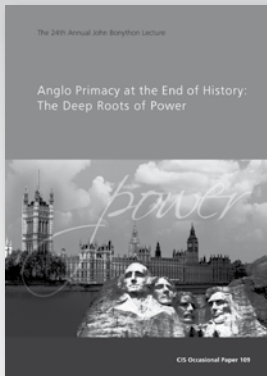
- Journal of Medicine* 344:18 (May 2001), 1343–1350. Note, however, when such trial programs have been replicated in the ‘real world’ of general practice—as in the Greater Green Triangle program in Victoria and South Australia—the dropout rate has blown out to 23%. Greg Johnson and James Dunbar, ‘Working to Fight Obesity,’ *Herald Sun* (7 April 2008). Note that this is also more of an example of secondary chronic disease prevention, rather than of primary obesity prevention.
- 47 These are ‘mostly within the power of people to provide for themselves.’ Peter Baume, ‘It’s All About Health,’ *On Line Opinion* (5 October 2007) www.onlineopinion.com.au/view.asp?article=6441.
- 48 Kevin Rudd and Nicola Roxon, *Fresh Ideas, Future Economy*, 8.
- 49 Stephen J. Corbett, ‘A Ministry for the Public’s Health: An Imperative for Disease Prevention in the 21st Century?’ *Medical Journal of Australia* 183:5 (2005), 254. Note the Rudd government has virtually decided to establish the equivalent of a Ministry of Public Health, having flagged support for new taxes on cigarettes, alcohol and fast food to fund a new national preventive health agency. Jessica Irvine and Yuko Narushima, ‘Extend Alcohol Tax to Tobacco,’ *Sydney Morning Herald* (28 April 2008).
- 50 Australian Health Care Reform Alliance, ‘Position Papers’ (July 2007), www.healthreform.org.au/content/upload/files/Microsoft_Word_-_Position_papers_July_2007_Summit.pdf, 15.
- 51 See note 2.
- 52 B. Starfield, L. Shi, and J. Macinko, ‘Contribution of Primary Care to Health Systems and Health,’ *The Milbank Quarterly* 83:3 (2005), 457, 459.
- 53 As above, 463.
- 54 On the ‘ecological fallacy’—the fact that a ‘direct relationship cannot be found between exposure to primary care and better health,’ despite arguments to the contrary—or the absence of ‘empirical evidence that appropriate receipt of primary care is associated with better health outcomes,’ which the authors of these studies admit severely qualifies their findings, see L. Shi and others, ‘Income Inequality, Primary Care, and Health Indicators,’ *Journal of Family Practice* 48:4 (April 1999), 280–1; and L. Shi and others, ‘The Relationship Between Primary Care, Income Inequality, and Mortality in US States, 1980–1995,’ *The Journal of the American Board of Family Practice* 16 (2003), 419.
- 55 The US research, as might be expected, revealed that non-urban areas ‘with a greater number of primary care physicians experienced 2 percent lower all-cause mortality, 4 percent lower heart disease mortality, and 3 percent lower cancer mortality than did non-urban counties with a smaller number of primary care physicians.’ B. Starfield, L. Shi, and J. Macinko, ‘Contribution of Primary Care to Health Systems and Health,’ 461–462.
- 56 The fall in US mortality from stroke, for example, is likely to have substantially resulted from ‘improvements in surgical and emergency room practice (e.g., treating stroke as a medical emergency)’ and use of new drugs to reduce blood pressure. L. Shi and others, ‘Primary Care, Income Inequality, and Stroke Mortality in the United States: A Longitudinal Analysis, 1985–1995,’ *Stroke* 34 (2003), 1961.
- 57 L. Shi and others, ‘Income Inequality, Primary Care, and Health Indicators,’ 283.
- 58 It is worth pointing out that much of the US primary care scholarship has a strong ideological component. It is interested in shaping US debates about health reform with the goal of making the US health system more closely resemble the health systems of European countries.
- 59 B. Starfield, L. Shi, and J. Macinko, ‘Contribution of Primary Care to Health Systems and Health,’ 468.
- 60 As above, 467.
- 61 The results hardly justified Starfield and Shi’s assertion, in the abstract to the study, that stronger primary care ‘distinguishes countries with overall good health from those with poor health at all ages.’ B. Starfield and L. Shi, ‘Policy Relevant Determinants of Health: An International Perspective,’ *Health Policy* 60 (2002), 201.
- 62 B. Starfield and L. Shi, ‘Policy Relevant Determinants of Health,’ 208–9.
- 63 As above, table 4, 208.
- 64 As above.
- 65 B. Starfield, L. Shi, and J. Macinko, ‘Contribution of Primary Care to Health Systems and Health,’ 473.
- 66 B. Starfield and L. Shi, ‘Policy Relevant Determinants of Health,’ 209, 213.
- 67 As above, 211–2.
- 68 As above, 212.
- 69 Darren Carr, ‘Out-of-date Formula Risks Creating a Health Divide,’ *Sydney Morning Herald* (19 September 2007).
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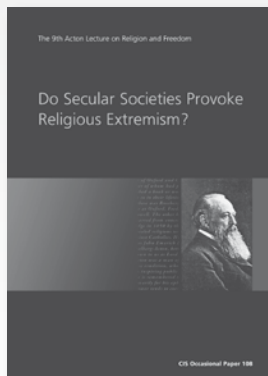
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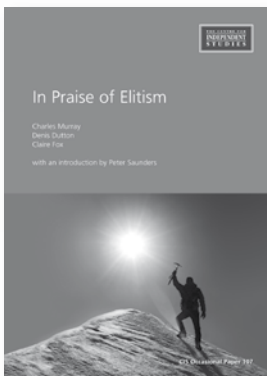
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About the Author

Jeremy Sammut is a research fellow at the Centre for Independent Studies. He has a PhD in history. This is his second contribution to the Papers in Health and Ageing series, which addresses the long-term challenges facing Medicare.

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