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Re-thinking the blame game: liberty, personal responsibility, and challenge of "lifestyle diseases"

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[SLIDE – title – 1]

[SLIDE – New York pictorial – 2]

On a crisp autumn day in late November 2003, the well-known British expat journalist and political commentator **Christopher Hitchens** went on a crime spree in New York City.

Fed up with the "capricious" and "petty" laws of Mayor Michael Bloomberg, he set out on a mission to break as many as he could, for the purposes of a tell-all account in *Vanity Fair* magazine.[1]

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During the course of the day, he sat on an upturned milk crate, he took his feet off the pedals while riding a bicycle, and he engaged in some loitering by sitting down on the subway steps.

As a smoker, Hitchens took special care to flout the smoke-free laws that, together with sharp tax increases, reduced smoking prevalence in New York City by 19% between 2002 and 2006 (240,000 people quit during that time).[2]

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In his article, Hitchens bemoans the over-reach of law, including laws that have deprived restaurant owners of the choice of allowing their customers to smoke.

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[1] Christopher Hitchens, "I Fought the Law" *Vanity Fair* February 2004, pp 74-79.
[2] Anthony Ramirez, "City Smokers' Ranks Drop 19%, Study Says" *New York Times* 22 June 2007; "Decline in Smoking Prevalence – New York City, 2002-2006", *MMWR* 2007 (June 22); **56(24):** 604-608.

Hitchens also repeats a story about Professor Sidney Morgenbesser, an American philosopher and pipe-smoker, who on one occasion put his pipe in his mouth as he ascended the New York subway steps. A policeman saw this and told him there was no smoking in the subway.

To which Morgenbesser replied "that he was leaving the subway, not entering it, and had not yet lit up".

This didn't satisfy the policeman, who then resorted to: "If I let you do it, I'd have to let everyone do it".

To which Morgenbesser replied, "Who do you think you are – Kant?"

This attempt to entice the policeman into conversation about the categorical imperative was misconstrued, and the conversation had to be continued down at the precinct.[3]

Michael Bloomberg comes in for ceaseless abuse throughout Hitchens' article. Hitchens end withs with this assessment of the man who may yet run for US President:

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> "Who knows what goes on in the tiny, constipated chambers of his mind? All we know for certain is that one of the world's most broad-minded and open cities is now in the hands of a picknose control freak."[4]

When I read this story I decided to dig a bit deeper. It turns out that the editor of *Vanity Fair,* Graydon Carter **[SLIDE – 6]** had been reported to the Health Department by his own staff – and fined - for having a cigarette in his office – with Hitchens.

[SLIDE – 7]

Here's a picture of the on-line complaint form that this unknown member of staff probably used.

Not long after, while Carter was on holidays, he was fined again, this time for having an empty ashtray in his office.[5]

New York City's Smoke Free Air Act makes it an offence to have an ashtray in a non-smoking area. By legislation, *Vanity Fair's* offices are non-smoking areas.[6]

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[3] Hitchens, above note 1, at p 76.
[4] Hitchens, above note 1, at p 79.
[5] "Tobacco, Smoking, and Insider Trading", *Cato Policy Report*, March/April 2005, pp 8-10, at 9.

"Not having ashtrays and putting up no-smoking signs are two of the strongest ways to discourage smoking and to let people know what the law is", says a New York City Health Department spokesperson.[7]

Reflecting on the laws that eliminated smoking carriages on trains, Hitchens remembers thinking:

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> "Now we've crossed a small but important line. It's the difference between protecting non-smokers and state-sponsored behavior modification for smokers".[8]

Mediating the tension between individual freedom and personal responsibility, and state interventions taken in support of collective interests – including but not limited to public health – is the grand challenge of public health law. Some scholars define the field largely in terms of government's response to this challenge.[9]

In liberal societies, public health regulation is least controversial when it targets contagious diseases, pollution and toxins, and other "external" threats that pose a risk to society collectively (such as bioterrorism).

Lifestyle diseases, on the other hand, are seen to be the consequences of private choices, and invite the response that people should be left to live their private lives as they choose. No one wants a nanny state.

American society is said to be exceptional for its "predisposition to venerate the individual and his or her rights and responsibilities" over the wellbeing of society as a whole.[10]

It is an attitude that translates into strong support for economic freedom, voluntarism, and a latent mistrust towards the motives and merits of government interventions.

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[6] Smoke-free Air Act of 2002, New York City Administrative Code, Title 17, Chapter 5, at: http://www.nyc.gov/html/doh/html/smoke/tc1.shtml; http://public.leginfo.state.ny.us/menugetf.cgi (accessed 31 March 2007).

[7] "Bloomberg's Tobacco Stormtroopers Raid Vanity Fair Office for 'Ashtray Violation'", 6 December 2003, at: http://www.prisonplanet.com/120603ashtrayviolation.html (accessed 16 August 2007).

[8] "Tobacco, Smoking, and Insider Trading", *Cato Policy Report*, March/April 2005, pp 8-10, at 9.

[9] See Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint*, Berkeley: University of California Press, 2000 pp 3-22; Mark A. Rothstein, "Rethinking the Meaning of Public Health" *Journal of Law, Medicine & Ethics* 2002; **30:** 144-149.

[10] Howard M. Leichter, "'Evil Habits' and 'Personal Choices': Assigning Responsibility for Health in the 20th Century" *The Milbank Quarterly* 2003; **81:** 603-626, at 622.

But ordinary Australians are also sensitive to being told what to do. Many an Australian, if I can borrow from an editorial published in *The Times* newspaper in 1854 when the Board of Health was abolished "would prefer to take the chance of Cholera, rather than be bullied into health".[11]

Here in Sydney, for example, on 31 January 2003, a commuter train traveling to Wollongong was derailed when the driver suffered a heart attack and slumped, unconscious, at the controls. Seven people were killed.[12] The driver was, in fact, grossly overweight and had a cholesterol problem.[13]

One might have thought that monitoring the cardiovascular health of train drivers by means of health checks, was a *not unreasonable* response to a fatal train disaster.

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Instead, it prompted an industrial dispute, with angry railway drivers vowing to "fight to the last kebab" over newly introduced drug, alcohol and fitness tests.[14]

Before moving on, let me give you a British example. In July 2006, the actor Mel Smith vowed to defy a Scottish smoking ban by smoking a cigar during a play at the Edinburgh Fringe Festival in which he was playing no other than Winston Churchill.

The play calls for Churchill to offer a cigar to the visiting Irish revolutionary leader Michael Collins and to say:

> "You have a long way to come if you have never enjoyed a Romeo y Julieta. [They] are rolled on the thigh of a Cuban maiden".[15]

In the end Smith didn't light up, following advice from environmental officers who warned that the venue would lose its licence if he did.[16]

[SLIDE – 10]

An enthusiastic cigar smoker off-stage, Smith said:

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[11] Cited in G. Rosen, *A History of Public Health* (Baltimore: Johns Hopkins Press, expanded ed, 1993): at 199-200.
[12] AAP, "Driver's Heart Attack Sparked Rail Disaseter" *Sydney Morning Herald*, 15 January 2004.
[13] Malcolm Brown, "Waterfall Crash Driver Would Have Passed Heart Test" *Sydney Morning Herald* 25 March 2004.
[14] Matthew Denholm, Malcolm Farr, "Fight to the Last Kebab" *Daily Telegraph* 19 February 2004, pp 1, 4.
[15] Jack Malvern, "Mel Smith Surrenders to the Smoking Police" *The Times*, 8 August 2006.
[16] Paul Kelbie, "Mel Smith Stubs Out Plan to Defy Scottish Smoking Ban" *The Independent* (London), 8 August 2006; Jack Malvern, "Mel Smith Surrenders to the Smoking Police" *The Times*, 8 August 2006.

> I will not have people protecting me from myself. That's the whole problem with this country....[This ban] would have delighted Adolph Hitler. Adolf Hitler, as you know, was anti-smoking. You couldn't smoke at Adolph Hitler's dining table, so he'd be pleased, wouldn't he? Congratulations Scotland!"[17]

The Chief Executive of Ash Scotland took a slightly different view. She said:

> The theatre is a workplace. This law was brought in to protect people in the workplace....When actors take drugs on stage they don't really inject. And when they have sex on stage they don't really have sex. So why use real smoke when there's a real health risk on actors and the audience?[18]

Smoking is perhaps an easy example, but the protestations of Hitchens and Smith illustrate an important truth.

Despite intense interest in the media and in the community about how we might live longer and healthier lives, the fact is that not everyone shares the goals of eliminating smoking, exercising more, and moving towards diets that are lower in sugar and saturated fats.

Public health advocates tend to think of themselves as "progressives" (whatever that means), and yet perhaps *the most important challenge* to a more expansive role for public health policies and law come from old-style liberals and others who regard economic and personal freedom, personal responsibility, and small government, as paramount virtues.

Suddenly thrust into the role of "nannies", do-gooders, wowsers, and "picknose control freaks", the public health movement is struggling to come to terms with the challenges that lifestyle diseases impose on policy-makers.

Responding to the "libertarian critique" of public health interventions in the area of chronic disease is therefore an important task, and that is what I want to talk to you about this afternoon.

[SLIDE – 11]

Over the past few hundred years, the liberal impulse has become part of the bedrock of our society. It has two parts:

- Liberty, or freedom to make choices in one's life;
- And personal responsibility for the choices thus made.

The liberal impulse translates into a populist view which disapproves of regulation and frames personal lifestyles in terms of the internal preferences of

[17] Anna Millar, "Mel Smith Flicks V at Smoking Ban", *Scotland on Sunday*, 16 July 2006.
[18] Ibid.

each individual. If individuals insist on smoking, eating a poor diet, and living a sedentary lifestyle, what can governments do?

Public health advocates, on the other hand, typically think of lifestyle risks as part of a broader system of determinants, many of which are beyond the control of individuals.

A public health approach asserts that responsibility for lifestyle diseases is shared more widely, and that in view of *their responsibility* for the public's health, governments should act assertively to make healthy lifestyle choices easier.

This debate isn't going away soon. How it is resolved will be central to the likely effectiveness of future efforts to reduce death and disability in Australia.

In my time this afternoon I would like to address this debate from several perspectives.

First of all, let's briefly consider what's at stake by looking at some of the determinants of the burden of disease in Australia.

Secondly, I want to outline a simple model for understanding different approaches to the regulation of lifestyle diseases.

And thirdly, I will consider the libertarian critique of chronic diseases regulation and defend a population health approach to policy in this area.

1. Chronic diseases and risk factors in Australia

[SLIDE – 12: Chronic diseases and risk factors in Australia]

A quick tour of statistics provided by the Australian Institute of Health and Welfare confirms what many of us know already.

[SLIDE – 13]

A significant proportion of the burden of disease in Australia can be attributable to a select number of proximate, lifestyle-related risk factors.

These include *behavioural risk factors* relating to diet, smoking and physical inactivity. As well as *physiological risk factors* that are at least partly modifiable through a healthy lifestyle, such as overweight and obesity, high blood pressure, and high blood cholesterol.

If health policy-makers could influence people's lifestyles effectively, they could make a sizeable impact on mortality from preventable conditions, and the accompanying disability that typically leads up to death.

The diseases we could do most about include:

[SLIDE – 14: Cardiovascular disease]

- cardiovascular disease, which is still the largest single cause of death in Australia, and a leading cause of disability.

SLIDE: **Cardiovascular disease (CVD)**

- CVD includes coronary heart disease and stroke
- Leading cause of disability: 6.9% of population have CVD-related disability
- Largest single cause of death in Australia: 47,637 deaths in 2004 (36% of total
- 17% of overall disease burden in 2003
- $5.5 billion in direct health care expenditures

- Preventable risk factors:
- smoking,
- high blood pressure,
- high blood cholesterol,
- insufficient physical activity,
- overweight and obesity,
- poor nutrition,
- Diabetes

See further: AIHW, *Australia's Health 2006*, pp 60-61

It is not for nothing that scholars in the field of public health law have begun to debate how law helps to facilitate cardiovascular disease, and how it might help to inhibit it.[19]

[SLIDE – 15: Diabetes]

- Secondly, diabetes – up to 950,000 adults have diabetes in Australia, up to half of them aren't aware of it. And again, healthy lifestyles can reduce the risk for Type 2 diabetes.

SLIDE: **Diabetes**

- An estimated 950,000 Australians adults (25+) had diabetes (1999-2000), 7.5% of population; up to half are unaware of it
- 11,735 deaths in 2004 related to diabetes

[19] Wendy C. Perdue, George A. Mensah, Richard A. Goodman, Anthony D. Moulton, "A Legal Framework for Preventing Cardiovascular Diseases" *American Journal of Preventive Medicine* 2005; **29(5)(Suppl 1):** 139-145; Wendy E Parmet, "The Impact of Law on Coronary Heart Disease: Some Preliminary Observations on the Relationship of Law to 'Normalized' Conditions" *Journal of Law, Medicine & Ethics* 2002; **30:** 608-621.

- Diabetes also a major cause of disability
- 5.8% of overall disease burden in 2003
- $812 million in health care expenditures

- Preventable risk factors for Type 2 diabetes:
- Obesity;
- Physical inactivity;
- Poor nutrition – inadequate fruit and vegetable consumption

See further: AIHW, *Australia's Health 2006*, pp 68-74

[SLIDE – 16: Tobacco related diseases]

- There are also several other conditions, including chronic obstructive pulmonary disease and lung cancer, that are almost exclusively caused by tobacco smoking, and almost completely preventable through smoking cessation.

SLIDE: **Tobacco-related diseases**

- **Chronic obstructive pulmonary disease** affects at least ~3% of population, potentially affects all smokers (and others exposed to ETS);
- leading cause of death: 5,200 deaths in 2004 (3.9%);
- 54,000 hospital separations;
- $432 million in health system expenditure;
- 3.6% of overall disease burden in 2004.
- Almost completely preventable through smoking cessation

- **Lung cancer**: 9,200 cases (projected) in 2006;
- leading cause of death: ~7,300 in 2004 (5.5%);
- 17,700 hospital separations;
- mortality to incidence ration remains high (0.82)
- Almost completely preventable through smoking cessation

See further: AIHW, *Australia's Health 2006;* AIHW, *Chronic Diseases and Associated Risk Factors in Australia, 2006*

2. A conceptual model for thinking about law, regulation and chronic diseases

[SLIDE – 17: A conceptual model for thinking about public health responses to obesity and chronic diseases]

I've now reached my second theme.

To put the debate about personal responsibility and lifestyle diseases in better perspective we need a conceptual framework for understanding the implications of different approaches to regulation.

Epidemiologists have developed a variety of models to illustrate the hierarchy of health determinants and to demonstrate particular pathways.[20]

[SLIDE – 18]

As you can see in this simplified but fairly conventional model, health outcomes within and between populations are typically described in terms of a hierarchy of influences. In this slide you can see that the determinants of health begin with:

- global influences, right at the top. These include factors such as the industrialization of food production and distribution, urbanization, global competitive pressures creating the stressful urban lifestyles we know and love, the activities of multinational food and tobacco companies, and other factors.

- At the national level, the model also takes into account the impact of the economy, the environment, and culture;

- It takes account of the local environment we live our daily lives within, and this includes the built environment, the workplace, housing and transport systems;

- Of course, the model includes the impact of the lifestyles we live: our choices, habits and behaviours. But you can also see that our lives are *lived in context*, and our choices are enabled, or constrained, by the upstream factors.

- At the bottom right-hand corner of the model are health care interventions. Health care interacts with all the other determinants, and our genetic endowment and physiology, our bodies – to produce health outcomes at the individual and population level.

Within each of these coloured domains, or levels of the model, many more specific determinants exercise their influence upon health, either negatively as risk factors, or positively as protective factors.

Some determinants, of course, can't be changed, like our genes, age, sex, and basic metabolic rate.

Whereas other determinants clearly are modifiable to a greater or lesser degree: our diet, smoking status, physical activity, and even education.

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[20] See George A. Kaplan, "What's Wrong with Social Epidemiology, and How Can We Make it Better? *Epidemiologic Reviews* 2004; **26:** 124-135.

In historical terms, the twentieth century reflects a gradual broadening of the determinants that are understood to contribute to states of health and illness in the population, and a growing realisation of their complexity and inter-relationships.

If we recognize that health is a complex outcome that is the result of influences and interactions at a variety of different levels, then we can also see that each level creates opportunities for public health interventions.

[SLIDE – 19]

This slide shows the same hierarchical model of the determinants of health on the left.

While on the right is a set of corresponding set public health initiatives and policies.[21]

This model provides a kind of *geography* for understanding the intentions of various public health policies, and for locating where policy attention tends to be directed in places like Australia.

Let's take cardiovascular disease as an example. You'll remember that it is the largest single cause of death in Australia.

Clearly we need to do more than just treat disease when it manifests, because treating it does nothing to prevent new cases.

So our next strategy is to search out individuals who are likely candidates for developing chronic disease.

So, as the light blue panel on the right hand side of the model illustrates, our disease prevention strategy could target those who have already had a heart attack (secondary prevention); or it could target those with specific risk factors such as high blood pressure, cholesterol and smoking (primary prevention).

Many of you will know far more than I about the work that is being done – through the Australian General Practice Network, through the introduction of new Medicare item numbers, through Lifescripts and other initiatives – to improve the capacity of the primary care system to identify and manage patients with risk factors for chronic disease.

If you then look up to the light green panel, you'll see that we can expand our strategy into the community: targeting specific high-risk groups in the

[21] This figure was partly adapted from J. McKinlay and L. Marceau, "A Tale of 3 Tails," *American Journal of Public Health* 89 (1999): 295-298, at 296.

community, or indeed seeking to educate the society at large about risk factors and how to reduce them.

In the interventions that seek to engage with *context*, and with *place*, you'll notice something important.

Rather than engaging with people and their behaviour directly, policy is now engaging in specific settings and with places and processes and the economic and social forces that channel and create patterns of behaviour.

One of the challenges for creating policy at this level is the fact that "social and economic conditions and physical environments are [largely] created by sectors other than health".[22]

On the other hand, policies that engage with *place* and with *context* do have the capacity to influence the average health status of broad populations. Their reach is much wider.

Staying with the example of cardiovascular disease, policies at this level could potentially address many issues. These include the cost and accessibility of fresh fruit and vegetables, levels of salt, fat and sugar in the national diet, the built environment and opportunities for physical activity, and the influence of social and cultural factors including the promotion of high-fat foods, and of course tobacco control.

[SLIDE – 20]

If you'll let me take this model one step further, you can see that health policies that respond to lifestyle diseases can be grouped into three main categories.

First of all, policies that:

- support better *treatment* for individuals with chronic diseases and associated risk factors;

Secondly, policies that:

- focus on *behaviour modification,* through education and other means, whether directed at high risk groups or society generally; *and*

Thirdly, policies that:

- seek to engage with broader environmental or *ecological* determinants in order to reduce risk factors across the population.

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[22] Don Nutbeam & Marilyn Wise, "Structures and Strategies for Public Health Intervention" in Roger Detels, James McEwen, Robert Beaglehole & Heizo Tanaka (eds), *Oxford Textbook of Public Health*, 4th ed., Oxford: Oxford University Press, 2002, at 1875. Similarly, as Greenberg, Raymond and Leeder point out, "Ministries of health do not control the primary levers critical to preventing cardiovascular disease…. Sectors in government other than health will need to change emphases and portfolios-difficult in all environments-and do so in response to iss*ues usually perceived as beyond their ken":* Henry Greenberg, Susan U Raymond & Stephen R Leeder, "Cardiovascular Disease and Global Health: Threat and Opportunity" (2005) 24 *Health Affairs* 31 (published online; web exclusive).

A comprehensive approach to disease prevention might try to do all these things.

My aim in talking about the determinants of health is not to play epidemiologist, but to point out the pervasive influence of personal autonomy and personal responsibility as it affects health policy at each of these three levels.

Let me explain what I mean.

[SLIDE – 21]

The theme of liberty and personal responsibility is anchored very firmly in medical law; that is, in law's regulation of clinical care.

Personal autonomy is reflected in the American notion of "informed consent". This is the idea that, provided they act with reasonable care and tell you about the risks, health professionals can delegate the risk of a bad outcome to the individual.

Patients exercise their *personal autonomy* in deciding whether to undergo the treatment, or surgery, or medication, but they bear full responsibility for the risks of misadventure.

Personal autonomy is a central value in clinical medicine, although much of the activity of law and medical ethics is on how to honour this value in a setting where age, infirmity, intellectual disability and ill-health itself all conspire to undermine it.[23]

How, then, does the ethic of personal autonomy affect policy at other levels?

In public health policy, liberty and personal autonomy have re-constituted epidemiological theories, and the result is that the causes of health problems within a population – think of diabetes, or obesity, or poor dental health – tend to be seen narrowly in terms of their proximate, behavioural causes.

Tobacco, obesity and "lifestyle diseases" tend to be framed in reductionist terms, as the price paid for bad habits that are somehow abstracted from their surrounding context: the price, easy availability and skilful marketing of tobacco, the relentless marketing of high-fat, high-sugar, high-salt foods, the price of a basket of foods making up a healthy diet, urban lifestyles and landscapes crowding out opportunities for physical exercise, and so on.

[SLIDE – 22]

[23] Onora O'Neill, "Public Health or Clinical Ethics: Thinking Beyond Borders" *Ethics & International Affairs* 2002; **16:** 35-45, at 36.

This slide shows you the "common sense" view of the causes of chronic disease.

You can see that the wider economic and social context of individual choices is ignored. These broader factors belong to other sectors, other Ministerial portfolios, other departments, and they are all too often ignored in public health policy.

Aided and abetted by this populist view, governments have, in fact, been highly successful in delegating risk management both to the market (through voluntary self-regulation, CSR and consumer pressures) and to individuals themselves.[24]

[SLIDE – 23]

The language of the Minister for Health and Ageing, Tony Abbott, provides an illustration of this commonly held view. Notice how the Minister frames the problem of obesity in this opinion piece in the *Sydney Morning Herald*:

> Unlike cancer or bird flu, there's little mystery about obesity....If the food that people eat contains more calories than they expend in daily living, they put on weight. It's a simple equation....The only way to address habits reinforced by instinct is to tell people what their behaviour is doing to them, over and over again in crystal-clear terms. People need to know that a large Big Mac meal contains 1080 calories, a large chocolate Moove 385 calories, a Krispy Kreme doughnut 198 calories.[25]

[SLIDE – 24]

I think Australia is lucky to have a Health Minister who practices what he preaches when it comes to healthy living.

I doubt many of us would be upright, let alone smiling, after a 100km run.

I agree with the Minister that the only way for an individual to lose weight is to eat less and to exercise more. We can't assume, though, that populations will behave like motivated individuals.

A strategy of mass education and encouragement, without more, leaves government with the cost of funding treatment for chronic illness, but without the policies that could prevent new cases arising.

[SLIDE – 25]

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[24] See Robyn Martin, "The Limits of Law in the Protection of Public Health and the Role of Public Health Ethics" *Public Health* 2006; **120:** 71-80, at 73.
[25] Tony Abbott, "A Plan to Win the Battle of the Bulge" *Sydney Morning Herald* 10 May 2006.

Finally, let's turn from the behaviour of individuals to the socio-economic policy sectors and settings where laws and policies need to engage if they hope to influence patterns of behaviour across the population.

Personal autonomy has emerged as a pre-eminent value here as well. In the marketplace it is expressed as consumer choice, and freedom of contract. For-profit enterprises defend their interests vigorously, and free market principles provide a powerful ideological barrier to too much legal interference.

So to sum up. In so far as law or policy seeks to regulate individual behaviours in ways that move beyond education and advice-giving, it runs the risk of offending civil libertarians.

In so far as it moves upstream, and seeks to interact with the social and economic determinants of chronic disease, in accordance with a determinants of health approach, it risks offending the free marketeers.

Furthermore, since population health approaches aim to alter the average exposure of the population to risk of harm, individual reductions in risk exposure (due to reduced salt in the diet, for example, or reduced cholesterol, or reduced exposure to advertising of junk foods), may only be modest.[26] The famous epidemiologist Geoffrey Rose called this the prevention paradox.

And in so far as law seeks to address that share of poor health that arises from health inequalities, it rapidly attracts the controversies that surround all attempts to re-shape the political economy.

Critics fume that public health should stick to what it does best: communicable diseases control, and keeping bugs out of the food supply. And they resent public health becoming a smokescreen for interference in market economies, or for launching some ambitious social justice project.

And that's not all. From a practical and logistical perspective, many of the universal prevention policies that are required if you want to respond effectively to lifestyle diseases require policy-makers to engage with ministries and sectors outside of health.

Effective structures for facilitating a comprehensive, cross-sectoral approach, don't even exist. Agencies have their own entrenched cultures, and it is difficult to collaborate with them, difficult to usurp their turf, and difficult to route around them.[27]

And of course federalism complicates everything.

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[26] See Geoffrey Rose, "Strategy of Prevention: Lessons from Cardiovascular Disease" *British Medical Journal* 1981; **282:**1847-1851.

[27] S. Leeder, S. Raymond, H. Greenberg, H. Liu and K. Esson, *A Race Against Time: The Challenge of Cardiovascular Disease in Developing Economies,* New York: Columbia University, 2004, p 60.

Nevertheless, I put it to you that the central commitment of public health as a discipline has not changed. It is the task of promoting the health of the public at large. Preventing avoidable deaths, and the long periods of misery and incapacity that typically precede them.[28]

3. Responding to the libertarian critique of chronic diseases

[SLIDE –26: The libertarian critique of chronic diseases: the "framing" debate

I've now reached my third theme. I want to consider what I call the "libertarian critique" of public health initiatives in the area of chronic diseases and lifestyle risk factors.

Liberty and personal responsibility have been used in a powerful way (as Daniel Wikler says) to "delimit the sphere of public health",[29] both nationally and internationally. This is apparent even at the level of language, in how we frame problems like diabetes and obesity.

(A) THE DEBATE ABOUT FRAMING

[SLIDE – 27]

In a major speech in 2006, former British Prime Minister Tony Blair said that:

> Our public health problems are not, strictly speaking, public health questions at all. They are questions of individual lifestyle – obesity, smoking, alcohol abuse, diabetes, sexually transmitted disease. These are not epidemics in the epidemiological sense. They are the result of millions of individual decisions, at millions of points in time.[30]

Despite framing the problem in this way, Blair went on to emphasise that the role of the state is to "enable" and "empower" individual decisions. This leaves the way open, in Blair's view, for state interventions that empower people to "choose responsibly".[31]

Other critics – I call them "anti-statists" – will have none of this. In the United States, Richard Epstein from the University of Chicago has argued repeatedly

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[28] See also Lawrence O. Gostin & M. Gregg Bloche, "The Politics of Public Health: A Response to Epstein" *Perspectives in Biology and Medicine* 2003; **46(3)** S160-S175, at S163.
[29] Daniel Wikler, "Personal and Social Responsibility for Health" *Ethics & International Afffairs* 2002; **16:** 47-55, at 48.
[30] Former British Prime Minister Tony Blair, Speech on healthy living, 26 July 2006, at: http://www.number-10.gov.uk/output/Page9921.asp (accessed 1 August 2007).
[31] Ibid.

that "there are no non-communicable epidemics",[32] and that the state has no role interfering with non-contagious lifestyle risks like tobacco or obesity.

To the extent that obesity is framed as a public issue because governments bear the cost of treatment services through specific safety nets (Medicare and Medicaid), Epstein retorts that in an ideal world, government would vacate the role of insurer entirely, or pass the cost of poor lifestyle choices back onto individuals through higher premiums. This would return obesity and chronic disease to their rightful place: individual problems to be experienced privately.[33]

Epstein's world view raises a number of issues, not all of which I can address here.

One response is to question whether, in fact, non-communicable diseases *are* non-communicable.

In a recent paper in the *New England Journal of Medicine*, Christakis and Fowler showed that obesity spreads, through time, along social networks according to the nature of the social ties. While geographic distance is not a factor in this spread, the friendships and social connections that one has exercise an important influence on a person's chances of gaining weight, possibly through the influence that overweight friends and family have on one's own perceptions of the acceptability of being overweight.[34]

This is an interesting thesis that perhaps explains why the increasing prevalence of overweight and obesity in the United States coincides with a more relaxed attitude to what Americans consider to be their ideal weight.[35]

More generally, the possibility that obesity and other risk factors for chronic disease should be "socially transmissible" should come as no surprise.

The tobacco control movement has taught us that in order to effectively resist the tobacco epidemic we need to de-normalise smoking. The social norms that govern drinking, or smoking, or food, can be powerfully marketed, especially to those who esteem us.[36]

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[32] Richard A. Epstein, "Let the Shoemaker Stick to his Last: A Defense of the 'Old' Public Health" *Perspectives in Biology and Medicine* 2003; **46(3):** S138-S159, at S154.
[33] Richard A. Epstein, "Let the Shoemaker Stick to his Last: A Defense of the 'Old' Public Health" *Perspectives in Biology and Medicine* 2003; **46:** S138-S159, at S155; Richard A. Epstein, "In Defence of the 'Old' Public Health: the Legal Framework for the Regulation of Public Health" *Brooklyn Law Review* 2004; **69:** 1421-1470, at 1463-1464; Richard A. Epstein, "What (Not) to Do About Obesity: A Moderate Aristotelian Answer" *Georgetown Law Journal* 2005; **93:**1361-1386, at 1368-1369.
[34] Nicholas A. Christakis & James H. Fowler, "The Spread of Obesity in a large Social Network Over 32 years" *New England Journal of Medicine* 2007; **357:** 370-379.
[35] See Richard M. Eckersley, "Losing the Battle of the Bulge: Causes and Consequences of Increasing Obesity" *Medical Journal of Australia* 2001; **174:** 590-592 (discussing US Gallup polls).
[36] Geoffrey Rose, *the Strategy of Preventive Medicine*, Oxford: Oxford University Press, 1992, pp 108-110.

But so what? There may be social pathways for the spread of risk factors for chronic disease, but I don't think the case for responding to chronic disease should rely on harm to others or the analogy with infection.

Epstein's quarrel with talking about chronic disease as an epidemic fits with his view that state interventions in support of the public's health can only be justified to respond to what he calls "public bads". By this he means circumstances where harm is inflicted on others without their consent, as in the case of widespread pollution and communicable diseases.[37]

Only these, he asserts, raise serious issues of market failure that cannot be resolved through private markets.[38]

At the empirical level it seems reasonable to argue that hitherto, with the exception of tobacco, private markets have not been burdened by a comprehensive suite of laws or policies focused on obesity or chronic disease. If private markets have an inherently health maximizing effect, then why are things getting worse?

Population health advocates would argue that market forces – past and present – have contributed to patterns of eating, drinking, smoking and physical inactivity that are reflected in current rates of chronic disease. Unless we do something about it, these problems will only get worse as the population ages.

Epstein's assumptions about the circumstances in which state intervention is justified also warrant closer scrutiny.

The anti-statist view reflects a set of values that apparently sees no market failure in tobacco addiction (despite near universal levels of regret among those who have started and now perceive themselves to be addicted),[39] nor in burgeoning rates of obesity (despite broad swathes of the population trying and failing to lose weight at any one time).[40] Presumably, Epstein would see little room for any notion of "demerit goods" that the state might like to discourage or tax. Nor does he favour a role for the state as a provider of advice or information.[41]

On the other hand, Epstein believes that employers and insurers should be allowed to make distinctions on the basis of weight and other factors, on the assumption that people who are overweight only allow themselves to get that way

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[37] Epstein, above note 33, at S139-S141 (2003); at 1425-1426 (2004); at 1368 (2005).
[38] Epstein, above note 33, at 1433 (2004).
[39] Geoffrey T. Fong, David Hammond, Fritz L. Laux, Mark P. Zanna, K. Michael Cummings, Ron Borland et. al., "The Near-Universal Experience of Regret Among Smokers in Four Countries: Findings from the International Tobaco Control Policy Evaluation Survey" *Nicotine & Tobacco Research* 2004; **6:** S341-S351.
[40] Mary K. Serdula, Ali H. Mokdad, David F. Williamson, Deborah A.Galuska, James M. Mendlein, Gregory W. Health, "Prevalence of Attempting Weight Loss and Strategies for Controlling Weight" *Journal of the American Medical Association* 1999; **282:** 1353-1358.
[41] Epstein, above note 33 at 1462-1463 (2004); at S154 (2003).

because they do not bear the costs that they externalize onto thin, healthy people.[42]

(In the US context, my concern is that this would only increase the size of the health underclass who have no access to basic levels of health protection, whether because they cannot afford insurance, or are already poor insurance risks.

I find it significant that chronic disease risks like smoking and obesity are disproportionately in evidence at the lower end of the socio-economic continuum, where – if Epstein were correct – the incentives for healthy living should be highest, among those who cannot afford to self-insure.)

In Australia, of course, we have national health care coverage through Medicare, and private health insurance is community rated.[43]

Whether we should use economic policies to tax consumers themselves, rather than the products they consume, brings us back to the issue of which level in the hierarchy of determinants public health policies should focus on.

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One benefit of focusing on context and place, rather than behaviour per se, is that we can develop policies with broad reach that do not make victims of individuals who for whatever reason do not manage to live ideal, healthy lives.

Ultimately, I would suggest that what is driving Epstein's views on the role of the state in public health is a deeper and far stronger commitment to an efficient and competitive marketplace, unburdened by regulation. The liberty he cares most about is not the liberty of individuals, but economic liberty.

Epstein believes that free markets do a far better job than governments of giving individuals the resources to protect their own health.

But if we look to other areas of public health, we can see that regulation – rather than market remedies or self-protection – have played a significant role in the greatest public health achievements of the twentieth century in areas such as motor vehicle safety, health in the workplace, food safety regulation and tobacco control.[44]

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[42] Richard A. Epstein, "What (Not) to Do About Obesity: A Moderate Aristotelian Answer" *Georgetown Law Journal* 2005; **93:**1361-1386, at 1369.
[43] Private Health Insurance Act 2007 (Cth) s 55.5.
[44] Center for Diseases Control and Prevention (CDC), "Ten Great Public Health Achievements – United States, 1900-1999" *Morbidity and Mortality Weekly Report* 1999; **48:** 241-243; Michael Joffe, Mennifer Mindell, "A Tentative Step Towards Healthy Public Policy" *Journal of Epidemiology and Community Health* 2004; **58:** 966-968.

I began this talk with a tobacco example because the success of tobacco control has not come about by persecuting individuals or seeking to micro-manage their lives.

Instead, the success of tobacco legislation has come about by engaging with the social and economic and cultural factors that are capable of influencing society at large, and through engagement with the local environments in which smoking occurs. Reductions in smoking rates, such as those seen in New York City **[SLIDE – 29]** have not occurred spontaneously, but as a result of carefully planned programs addressing price, smoke-free environments, and smoking cessation assistance.[45] In other words, there has been a population health approach that engages with the context and environment of smoking, rather than with smoking behaviour itself.

Ultimately, in order to justify a comprehensive policy approach to chronic diseases, I believe that public health advocates need to drill down and take a position on the role of the state in a liberal democracy. This is the underlying issue.

Ronald Glasser has pointed out that "somewhere within the span of the last thirty years the idea of the common good has disappeared from our national consciousness, giving way to the misconception that we no longer need concern ourselves with the welfare of our fellow citizens".[46] This is a "dangerous conceit", he argues. Glasser is talking about the threat of infectious epidemics, but I believe the point goes deeper: we need to travel all the way down to the premises on which we build our model of the public health enterprise.

We can imagine a state, I would suggest to you, whose citizens not only expect their elected government to ensure minimum survival needs, and protection from infectious epidemics and contaminated food, but also to promote the health and vitality of its citizens.

Such a compact does not imply that citizens will be treated like children, nor "forced" to live puritanically wholesome lives.

Nor does it eliminate the need for collective goals, like public health, to be balanced with other public interests.

[SLIDE – 30]

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[45] Thomas R. Frieden & Michael R. Bloomberg, "How to Prevent 100 Million Deaths from Tobacco" *Lancet* 2007; **369:**1758-1761; Prabhat Jha, Frank J. Chaloupka, James Moore, Vendhan Gajalakshmi, Prakash C. Gupta, Richard Peck et al, "Tobacco Addiction" in Dean Jamison et al, eds, *Disease Control Priorities in Developing Countries*, Washington DC, The World Bank, and New York, Oxford University Press, 2nd ed, 2006, pp 869-885.

[46] Ronald J. Glasser, "We Are Not Immune" *Harper's Magazine*, July 2004, pp 35-42, at 35.

Nor does it imply the kind of socialist purgatory that critics delight in conjuring up: where private enterprise (forbidden from selling you choc tops, salted nuts and pizza) cower from the constant onslaught of those howling creatures of the far left. Such a compact is compatible with a liberal economy and it is ludicrous to suggest otherwise.

But it does recognize the importance of health both as a collective value and as a political goal, regardless of whether the diseases we get sick and die from spread quickly, or slowly – across a generation.

As my American colleague Larry Gostin has argued, a theory of public health law and regulation begins from the premise that adequate levels of health at the population level are a pre-requisite to a functioning society. These levels cannot be achieved through individual efforts or private markets: collective actions are required. In a democratic society, government has a special place in public health regulation to meet citizens' expectations of meaningful health protection. And the legitimacy of government interventions is confirmed through democratic processes.[47]

In a moment, I want to give you five reasons why I believe regulation has a place in our response to chronic disease.

But before I do, I think it is also important to ask who wins? and who loses? from the way we frame lifestyle diseases.

Since the tobacco industry did an about-face and began to publicly acknowledge the health consequences of smoking, the "informed smoker" has become a recurrent motif in industry language. As one industry executive said to me, "most people, unless they've just come from Mars, would know that smoking is risky to health".

The industry puts great stock in individuals weighing up the evidence and making rational choices about smoking, regardless of whether smoking initiation actually occurs in this way.[48]

When smokers fall sick and sue tobacco companies, industry defendants can then claim, in the words of William Ohlemeyer, associate general counsel of Altria, that "People who make informed choices about smoking should not be *rewarded* for choosing to smoke".[49]

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[47] See L. Gostin, "Legal Foundations of Public Health Law and its Role in Meeting Future Challenges," *Public Health* 120 (2006)*:* 8-15, at 8-11.

[48] Edith D. Balbach, Elizabeth A. Smith, Ruth E. Malone, "How the Health Belief Model Helps the Tobacco Industry: Individuals, Choice, and 'Information'" *Tobacco Control* 2006; **15 (Suppl. IV):** iv37-iv43, at iv41.

[49] Altria, "*Engle* Verdict Defies Common Sense, Florida Law; Philip Morris Says Court Created Runaway Jury", 14 July 2000, quoting William Ohlemeyer, Vice-President and Associate General Counsel, Altria

The food industry also emphasizes individual choice and responsibility. One prominent critic of the American food industry, Marion Nestle, argues that this emphasis serves the interests of industry because if diet is purely a matter of free will,

> "then the only appropriate remedy for poor diets is education, and nutritionists should be off teaching people to take personal responsibility for their own diet and health – not how to institute societal changes that might make it easier for everyone to do so".[50]

Lest you misunderstand me, I want to be clear that I am not saying that individuals are not responsible for their diet. To a large extent, individuals *are* responsible for what *individuals* eat.

But public health is a discipline that is concerned with how to keep populations healthy, not individuals. Populations don't behave like individuals, and the individualization of public health is a brilliant framing technique for drawing policy attention away from the upper levels of our hierarchy of determinants towards the proximate, behavioural level.

This helps to shield industry from economic and social policies that might impact on their profits.

Just as importantly, it relieves pressure on government, which simply delegates responsibility for health onto individuals.

You've already seen one model of the determinants of health-

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But there are many other ways of representing the hierarchy of influences upon our lifestyles.

[SLIDES – 32, 33]

The value of these models is that they explain how we live our lives in local places that influence us, in broader societies that shape and constrain and potentially empower our lives.

A population health approach seeks to harness this understanding in ways that could improve our collective health.

Group Inc, at: http://www.altria.com/media/press_release/03_02_pr_2000_04_14_01.asp (accessed 21 August 2007) (emphasis supplied).

[50] Marion Nestle, *Food Politics: How the Food Industry Influe12nces Nutrition and Health*, Berkeley: University of California Press, 2002, p 360.

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Individuals tend to be seen as beneficiaries in libertarian attacks on public health. Freedom-loving individuals – like Christopher Hitchens and Mel Smith – standing up on behalf of the common man against the nanny state, "do-gooders", "picknose control freaks" and sundry zealots.

Rarely, though, does one hear libertarians express satisfaction with the lifestyle that gave them diabetes.

Or gratitude for the diet that led to a heart attack.

Rarely do they give thanks for emphysema, because it was a fair price to pay for the delicious, intangible brand values of their favourite pack, and years of smoking pleasure.

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While they are hale and hearty, some are bold enough, like Christopher Hitchens, to write of "moments of conversation, perfumed with ashtrays and decent company, which I would not have exchanged for a year of ordinary existence".[51]

But when illness appears, it tends to be lived out in the private domain: at this point, the health system gets on with the (expensive) business of treating patients.

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Occasionally you do hear something. In February 2004, for example, Tasmanian Premier Jim Bacon quit politics after being diagnosed with lung cancer. A smoker for 35 years, Bacon said "I have been an idiot. I have not listened. I now accept that I am in large part paying the price for that stupidity. The message from me to everyone is please, don't be a fool like me. Don't keep smoking. And if you are young and you haven't started, don't start".[52]

It is precisely when individuals show signs of illness, however, that the "personal responsibility" side of the libertarian coin rapidly warps into blame and discrimination.

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[51] Christopher Hitchens & Simon Hoggart, "Is the Smoking Ban a Good Idea?" *The Guardian*, 14 May 2007.

[52] Andrew Darby, "The Confession of a Premier with a Death Sentence" *Sydney Morning Herald* 24 February 2004, p 1.

At the level of clinical care, the "personal responsibility" frame has come into direct conflict with the "personal autonomy" that patients have hitherto enjoyed in their dealings with the medical profession.

For example, there is a growing literature that consists of calls by:

- surgeons for the right to deny coronary bypass surgery;[53] and more recently plastic, reconstructive and orthopaedic surgery on patients who won't stop smoking.[54]
- And there are calls by surgeons to deny obese women with polycystic ovary syndrome,[55] or those who are just plain obese,[56] from having infertility treatment.

Outside of medical care, the focus on personal responsibility for lifestyle risks has led to disputes over whether employers can fire employees who refuse or fail to quit smoking.

The point at which these policies become legitimate ways of creating incentives for populations to adopt healthier lifestyles is an important and ongoing issue.

Happily, though, it is one that a population health approach can largely avoid, since its centre of gravity is not, specifically, the behaviour of individuals, but the *influencers* of that behaviour.

Over the past couple of years, I've followed the public debate on obesity.

A week ago, a group called the Obesity Policy Coalition attempted to position obesity policy as an election issue by calling for government regulation in three areas. They want:

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- "a ban on marketing unhealthy food to children and adolescents under 16 across all media, including mobile phones";[57]

[SLIDE – 38]

- A compulsory front-of-pack "traffic light" labeling system for all foods (like that developed as a voluntary measure by the UK Food Standards Agency);[58]

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[53] M.J. Underwood & J.S. Bailey, "Controversies in Treatment: Should Smokers be Offered Coronary Bypass Surgery?: Coronary Bypass Surgery Should Not be Offered to Smokers" *British Medical Journal* 2003; **306:** 1047-1048.

[54] Matthew J. Peters, "Should Smokers be Refused Surgery?" *British Medical Journal* 2007; **334:** 20-21; Matthew J. Peters, Lucy C. Morgan, Laurence Gluch, "Smoking Cessation and Elective Surgery: the Cleanest Cut" *Medical Journal of Australia* 2004; **180:** 317-318.

[55] Adam H. Balen & Martin Dresner, Eleanor M. Scott, James O. Drife, "Should Obese Women with Poliycistic Ovary Syndrome Receive Treatment for Infertility?" *British Medical Journal* 2006; **332:** 434-435.

[56] Mark Henderson, "Overweight Women May Lose Right to Free IVF" *TimesOnline*, 30 August 2006.

[57] Ben Doherty, "Tax Sweet Cereals: Obesity Group Call" *Sydney Morning Herald* 10 September 2007.

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- And the removal of the GST exemption from cereals with more than 27% sugar (on the basis that these are confectionary).

The interesting thing to notice about these policies – which are advocated by Diabetes Australia, the Cancer Council of Victoria, and the World Health Organisation's Collaborating Centre for Obesity Prevention at Deakin University – is that they engage with what I've called context: they seek to influence the economic and social context of food choices.

These policies apply across the population. Yet the liberty of anyone to eat whatever they like remains intact.

Bans on food marketing to children, and the traffic light labeling system are what I call laws or policies that alter the informational environment.

A ban on food marketing to children seeks to minimize pester power and to that extent makes it easier for harried parents to exercise their parental responsibility to ensure their children have a healthy diet.

A labeling system that can actually be seen without a magnifying glass might help consumers to make rapid and healthy choices in real time – in supermarket isles and in restaurants. This is an empowering policy that supports informed choice.

Removing the GST exemption from high-sugar cereals will make them more expensive. This is an economic policy that will dampen demand for high sugar cereals, relative to lower sugar cereals.

But unlike Epstein, here you're taxing the product, not the person.

Taken together, these are examples of policies that could, over time, alter patterns of decisions around diet.

But make no mistake: reducing chronic disease *will require* reduced average intake, across the population as a whole, of high sugar, high fat, high salt foods. It will require more fruit and veg, and more exercise.

Predictably, these policies will be framed by opponents as evidence of a nanny state.

But you'll notice that individual liberty is left intact. Clearly corporate profits are an issue, but you'll notice too how this issue has been cleverly re-framed in terms of personal responsibility.

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[58] See Food Standards Agency, "Traffic Light Labelling", at: http://www.eatwell.gov.uk/foodlabels/trafficlights/ (accessed 10 September 2007).

Critics of these policies are likely to call for more research, but we need to ensure that this call does not become "an excuse for inertia".[59]

[SLIDE – 40: The libertarian critique – why a population health approach?]

(B) WHY A POPULATION HEALTH APPROACH?

So let me give you 5 reasons then, why I believe a population health approach should be the centerpiece of how governments respond to lifestyle diseases.

First, a reality check. One particularly vigorous critic of obesity regulation in the United States, Joseph Sullum, writes that:

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> "[t]he war on fat...reflects an anti-capitalist perspective that views people as helpless automatons manipulated into consuming whatever big corporations choose to produce. The anti-fat crusaders want to manipulate us too, but for our own good".[60]

What is conveniently overlooked, however, is the extraordinary sums invested by food and drink manufacturers in order to shape and influence consumer spending patterns (a fairly good proxy indicator, surely, of their real-world impact). In 2004, for example, Pepsico and Coca Cola spent $1.7 and $2.2 billion on advertising, respectively, a total exceeding the World Health Organisation's biennial budget.[61]

We live in a world where over 77% of global food sales in 2002 were of processed foods and beverages.[62] It is quite appropriate, in this environment, to acknowledge that food manufacturers exercise significant influence over the nutrition of whole nations.

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[59] Michael Joffe, Mennifer Mindell, "A Tentative Step Towards Healthy Public Policy" *Journal of Epidemiology and Community Health* 2004; **58:** 966-968, at 966.
[60] Jacob Sullum, "The War on Fat: Is the Size of Your Butt the Government's Business?" *Reason* 2004; **8:** 20-31, at 23.
[61] Tim Lang, Geof Rayner, Elizabeth Kaelin, *The Food Industry, Diet, Physical Activity and Health: A Review of Reported Commitments and Practice of 25 of the World's Largest Food Companies*. London: Centre for Food Policy, City University; April 2006, p 12, at http://www.city.ac.uk/press/The%20Food%20Industry%20Diet%20Physical%20Activity%20and%20Health.pdf (accessed 20 August 2007).
[62] Mark Gehlhar & Anita Regmi, "Factors Shaping Global Food Markets" in Anita Regmi & Mark Gehlhar (eds) *New Directions in Global Food Markets*, United States Department of Agriculture, Agriculture Information Bulletin No. 794, February 2005, pp 5-17, at 6.

The point is not to declare war on the market economy. I applaud the initiatives that are occurring in the private sector, and the important contribution of the not for profit sector.

Nor am I suggesting that policy is only the business of government. There are opportunities for private sector and NGOs to show leadership as "policy entrepreneurs", and the Heart Foundation's tick program comes to mind.

What I am saying is that we need some basic truthfulness when it comes to recognizing real-world influences upon consumer decisions.

The second point I would make is this. Despite the tendency to see the solution to obesity, or diabetes in terms of a personalized, individual commitment to healthy living, the evidence is not encouraging that populations benefit from this approach.

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A small number of risk factors – you can see them on the screen - (smoking, physical inactivity, obesity, high blood pressure, high blood cholesterol, diabetes and inadequate fruit and vegetable intake) – are responsible for an alarming share of the burden of non-communicable disease.

The INTERHEART study found that over 90% of the risk of heart attack in men and women, young and old, across all geographical regions and ethic groups, could be predicted by the seven risk factors on the screen, together with an eighth factor, psychosocial stressors.[63]

Despite this, in a survey of over 150,000 Americans, 76% were nonsmokers, 40.1% had a healthy weight, 23.3% had the appropriate fruit and vegetable intake, and 22.2% exercised regularly.

But only 3% of the sample were following all four of the healthy lifestyle factors.[64]

One of the authors of this study said, "The effect of following these lifestyles is greater than anything else medicine has to offer. I don't know anything a doctors'

[63] Salim Yusuf, Steven Hawken, Stephanie Ôunpuu, Tony Dans, Alvaro Avenzum, Fernando Lanas et al, "Effect of Potentially Modifiable Risk Factors Associated with Myocardial Infarction in 52 Countries (the INTERHEART Study): Case-Control Study" *Lancet* 2004; **364:** 937-952. Five factors – smoking, high blood cholesterol (abnormal lipids), hypertension, diabetes and obesity – accounted for 80% of the risk of heart attack in the population: ibid, at 942.

[64] Mathew J. Reeves, Ann P. Rafferty, "Healthy Lifestyle Characteristics Among Adults in the United States, 2000" *Archives of Internal Medicine* 2005; **165:** 854-857.

office can do that would reduce your risk of diabetes or cardiovascular disease by 80% or 90%".[65]

Here in Australia, 55% eat enough fruit, but only one in four Australians are getting enough physical exercise, and only 15% eat enough vegetables. And less than 5% are doing all three.[66]

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The Commonwealth government's position, as stated by Minister Abbott, is that the role of government is "not so much to regulate, let alone to ban. I think its role is to encourage, to inform and to give good example".[67]

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Few people provide a better example of healthy living than Minister Abbott.

But what do you do if the population finds it too difficult to follow the advice?

I think the economists would be the first to tell us that education alone is not enough. If you want to change behaviour, economists say, you need to change the costs of behaviour.[68]

The literature is, in fact, full of suggestions about policy approaches to obesity and other chronic diseases – that address the broader environment in which lifestyles are lived.[69] Here are some of them:

[SLIDE – 45]

My role this afternoon is not to push or defend any of these policies, but to advocate a population health approach.

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[65] Janice Hopkins, "Only 3% of US Citizens Follow Good Health Advice" *British Medical Journal* 2005; **330:** 1044.

[66] "95 Percent of Australians Do Not Meet National Health Guidelines", 30 August 2007, at: http://www.usyd.edu.au/news/84.html?newsstoryid=1909 (referring to study by Atlantis et al to be published in the *International Journal of Obesity*).

[67] Hon Tony Abbott MHR, Minister for Health and Ageing, Address to the Queensland Obesity Summit, 3 May 2006, at: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2006-ta-abbsp030506.htm?OpenDocument&yr=2006&mth=5 (accessed 12 September 2007).

[68] Michael McCarthy, "The Economics of Obesity" *Lancet* 2004; **364:** 2169-2170, at 2169.

[69] For example: Mike Lean, Laurence Gruer, George Alberti, Naveed Sattar, "Obesity – Can We Turn the Tide?" *British Medical Journal* 2006; **333:** 1261-1264; Paul Z. Zimmet, W. Philipa T. James, "The Unstoppable Australian Obesity and Diabetes Juggernaut: What Should Politicians Do?" *Medical Journal of Australia* 2006; **185:** 187-188; S. French, M. Story, R. Jeffery, "Environmental Influences on Eating and Physical Activity" *Annual Review of Public Health* 2001, **22:**309-335; M. Nestle, M. Jacobson, **"**Halting the Obesity Epidemic: A Public Health Policy Approach" *Public Health Reports* 2000, **115:**12-24. R. Brownson, D. Haire-Joshu, D. Luke, "Shaping the Context of Health: A Review of Environmental and Policy Approaches in the Prevention of Chronic Diseases" *Annual Review of Public Health* 2006, **27:**341-370.

As Geoffrey Rose has argued, a population health approach "attempts to remove the underlying causes that make the disease common".[70]

Unless we take this approach, there is nothing to prevent the occurrence of new cases.[71]

And if we can change the environment to better support healthy behaviours, it will be "less necessary to keep on persuading individuals".[72]

This brings us to the status quo in many societies today. On the one hand, we have food and tobacco companies pouring vast sums into promotions and advertising, suggesting a high degree of confidence that these efforts increase sales.

But individuals themselves are seen as isolated units who are expected to live wisely and eat healthily, drawing on personal resources wholly within themselves.

When they fail, it is their own fault, and any effort to criticize the status quo is framed as a dangerous attack on market freedom, and on the liberty of individuals.

The third point I would make is that the personal responsibility critique does not apply to other systemic issues that government is serious about tackling.

We do not fight corruption only by urging individuals to be honest. We take a whole of system approach: we don't put all our eggs in the basket labeled "private morality of individuals".

We do not reduce traffic accidents and road-related deaths only by telling individuals to drive safely.

I mention this example because opponents of regulation are quick to seize on the metaphor of the "food police". One of the most absurd suggestions I ever heard, was the warning of a food industry lobbyist that the war on obesity could lead to "laws that would let a waiter decide if a patron could order dessert".[73]

[SLIDE – 46]

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[70] Geoffrey Rose, "Sick Individuals and Sick Populations" *international Journal of Epidemiology* 1985; **14:** 32-38, at 37.
[71] World Health Organisation (WHO), *Obesity: Preventing and Managing the Global Epidemic*, WHO Technical Report Series 894, Geneva: WHO, 2000, p 178.
[72] Geoffrey Rose, "Sick Individuals and Sick Populations" *international Journal of Epidemiology* 1985; **14:** 32-38, at 37.
[73] D. Griffith, "Industry Puts its Weight into Food Fight" *The Sacramento Bee*, 2 May 2004.

Now I want to make one thing crystal clear.

[SLIDE – 47]

None of you out there are going to start messing with my right to dessert.

Corruption and traffic accidents are different, of course in many ways from personal intemperance. But the common factor is that you regulate most effectively by looking at the wider environment, not only by seeking to directly change individual behaviour.

My fourth point is that if we want to alter the prevalence of lifestyle diseases, we need to reach the entire population. This requires policies that engage broadly across the nation, and make a difference in the daily lives of just about everyone.

Geoffrey Rose argued that lifestyle risk factors, such as overweight, and high blood pressure, form a continuum of risk in the population. New cases of chronic disease don't only come from those whose lifestyle risk factors place them on the extreme right of some distribution, but also "from the many people in the middle part of the distribution who are exposed to a small risk".[74] At the population level, large numbers of people exposed to a small risk may generate more cases than the small number exposed to a high risk. So we need to reduce what Rose called the "widespread inconspicuous risks".[75]

We also need to recognize that the distribution of risk factors vary from population to population. In Australia, for example, as the statisticians keep telling us, the weight curve is shifting to the right as we – on average – gain weight. In circumstances where "nearly everyone carries an avoidable excess risk", then "nearly everyone needs to take preventive action".[76] This requires a population-wide approach that understands the determinants of average weight, average blood pressure,[77] and the same applies to other risk factors.

This is a very different approach to trying to capture those who make it into the local GP, or trying to encourage people to eat five fruit and two veg (or is it five veg and two fruit)?

The payoff, Rose argues, is that reducing the avoidable risk of the population as a whole will also dramatically reduce the right-hand tail of the distribution of preventable risk factors; that is, those who are at "highest risk".[78]

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[74] Geoffrey Rose, "Strategy of Prevention: Lessons from Cardiovascular Disease" *British Medical Journal* 1981; **282:**1847-1851, at 1849.
[75] Geoffrey Rose, "Population distributions of Risk and Disease" *Nutrition, Metabolism and Cardiovascular Diseases* 1991; **1:**37-40, at 38.
[76] Ibid, at 38.
[77] Ibid, at 39.
[78]Ibid, at 38.

My fifth point is that there is a great deal of evidence showing that chronic disease, and its risk factors, vary according to socioeconomic position.[79] Rates of obesity have risen for all socioeconomic groups, but a socioeconomic gradient remains. It is particularly pronounced when measured by level of education, income quintile, and occupation.[80]

In rural Australia, rates of overweight and obesity for men and women are particularly high.[81] This casts doubt on the hypothesis that features of the urban environment are driving the obesity epidemic, to the exclusion of energy intake issues.

Studies also confirm that those with low levels of education and in low-income households are less likely to purchase foods high in fibre and lower in sugar, fat and salt.[82]

All of this evidence suggests that, if policies are to seek to redress health inequalities, they must be broadly based, and also engage with local environments.

Conclusion

In conclusion, I would say that a population health approach is a difficult sell because it offers what is really rather a sophisticated explanation **[SLIDE – 48]** that often finds it hard to compete with the over-simplification of the populist, "common sense" approach **[SLIDE – 49]** which matches the dominant narrative of individualism.

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[79] Australian Institute of Health and Welfare, *Chronic Diseases and Associated Risk Factors in Australia, 2006.* Canberra: AIHW, November 2006. AIHW Cat. No. PHE 81; G. Turrell, L. Stanley, M. de Looper, B. Oldenburg, *Health Inequalities in Australia: Morbidity, Health Behaviours, Risk Factors and Health Service Use*. Health Inequalities Monitoring Series No. 2. AIHW Cat. No. PHE 72. Canberra: Queensland University of Technology & AIHW, 2006; J. Glover, D. Hetzel, S. Tennant, "The Socioeconomic Gradient and Chronic Illness and Associated Risk Factors in Australia" *Australia and New Zealand Health Policy*, 2004, 1:8, available at: http://www.anzhealthpolicy.com/content/1/1/8 (accessed 28 August 2007).

[80] G. Turrell, L. Stanley, M. de Looper, B. Oldenburg, *Health Inequalities in Australia: Morbidity, Health Behaviours, Risk Factors and Health Service Use*. Health Inequalities Monitoring Series No. 2. AIHW Cat. No. PHE 72. Canberra: Queensland University of Technology & AIHW, 2006, pp 73, 95, 120.

[81] Australian Institute of Health and Welfare, *Chronic Diseases and Associated Risk Factors in Australia, 2006.* Canberra: AIHW, November 2006. AIHW Cat. No. PHE 81, pp 45-40; E. Janus, T. Laatikainen, J. Dunbar, A. Kilkkinen, S. Bunker, B. Philpot et. al., "Overweight, Obesity and Metabolic Syndrome in Rural Southeastern Australia" *Medical Journal of Australia* 2007, **187:**147-152.

[82] G. Turrell, A. Kavanagh, "Socio-Economic Pathways to Diet: Modelling the Association Between Socio-Economic Position and Food Purchasing Behaviour" *Public Health Nutrition* 2005, 9:375-383; K. Ball, D. Crawford, G. Mishra, "Socio-Economic Inequalities in Women's Fruit and Vegetable Intakes: A Multilevel Study of Individual, Social and Environmental Mediators" *Public Health Nutrition* 2005, 9:623-630.

The irony, of course, is that by focusing on the influences upon behaviour, rather than the behaviour itself, a population health approach can minimize the need to micro-manage individual lifestyles.

It leaves us free to treat ourselves to dessert.

I'd like to conclude by remembering that public health policy will always be, as my colleague Professor Leeder has pointed out, about the raw exercise of political power. It's war.[83]

It's partly a war of ideas and language, and if you can look through the clouds of smoke in this slide **[SLIDE – 50]** you will see some of the verbal missiles hurled by Christopher Hitchens in the direction of Michael Bloomberg.

One can only imagine what Hitchens said when he learned in August last year that Bloomberg was donating US$125 million to global tobacco control efforts.

And with that, I will close. Thank you very much.

[83] S. R. Leeder, "Ethics and Public Health" *Internal Medicine Journal* 2004; **34:** 435-439, at 436-7.