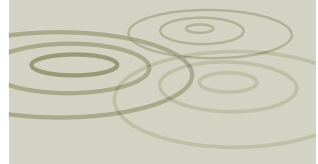


The Oxford  
Health Alliance



Confronting the Epidemic  
of Chronic Disease

# The strike back on chronic diseases: it's happening!

March 2006

For more information: [www.oxha.org](http://www.oxha.org)

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## Purpose of the document

The purpose of this document is to provoke thought and discussion about broader political and socioeconomic determinants of global health, specifically those aspects of the way the world is now that promote chronic diseases; and how we might change them.

To this end we explored the growing call for action to address barriers to health and the resurgence of community and civil society, the groundswell of influence being brought to bear on government, industry and big business to protect health, and the signs that this is having an impact.

The burden of chronic diseases is well described elsewhere. The economic argument for intervening, although incomplete, is also increasingly well described. These issues are not revisited here.

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### **Abbreviations**

CHD	Coronary heart disease	HMO	Health maintenance organisation
CSO	Civil society organisation	HPGs	Health Prosperity Goals
CVD	Cardiovascular disease	IDF	International Diabetes Federation
DALYs	Disability-adjusted life years	MDGs	Millennium Development Goals
DEHKO	Finnish acronym: Development Program for the Prevention and Care of Diabetes in Finland 2000–2010	NCQA	National Committee for Quality Assurance, The
EU	European Union	NGO	Non-governmental organisation
FDA	Finnish Diabetes Association	NHS	National Health Service (particular to the UK)
FIN-D2D	Finnish Prevention Implementation Program 2003–2007	PHM	People's Health Movement
GDP	Gross domestic product	RCT	Randomised controlled trial
GEGA	Global Equity Gauge Alliance	SARS	Severe Acute Respiratory Syndrome
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome	WHO	World Health Organisation
		WTO	World Trade Organisation

# Executive summary

This document explores issues around current political, macroeconomic and societal trends that have created, and continue to create, environments that encourage chronic diseases to flourish. Specifically, it tells a story about where we are now; some of the influences that led us there; a 'revolution' in the form of a resurgence of civil society; a counterattack from the food industry; and insights, approaches and possibilities for ameliorating the global impact of chronic diseases. We have structured our story into four parts:

## Introduction

We start with *the world we live in*, which overviews some aspects of the changes that have occurred over the past generation or so and their impact on our lives and health. We argue that *old solutions are not meeting new challenges*, noting confounders such as 'risk factor-ology', and the global failure to act on the mounting evidence about the future consequences of chronic diseases. We raise some questions with regard to current dilemmas and outline what we did in 2004 to gain an understanding of the state of evidence and thinking about the likelihood of successfully addressing chronic diseases and how this might be done. These investigations took the form of reviews of the relevant literature and websites, interviews and Oxford Dialogue meetings with key opinion leaders from Australia, Finland, Canada, New Zealand, and the Pacific Islands – Samoa and Tonga, the United States and the United Kingdom.

## What we found

*What the experts said* summarises discussions with some 45 key opinion leaders from public health, academia, clinical care, planning and administration, research and industry from eight countries.

There was considerable congruence about the problem, barriers to addressing it, and what needs to be done. All agreed that health is different and should not be 'commodified'. Many felt that burgeoning health care costs were artificially inflated due to the private health sector draining public funds, primarily through cost shifting. And the majority believed that most countries had a reasonable capacity to provide a good standard of basic health care to their populations.

It was unanimously agreed that, notwithstanding some knowledge deficits, there is more than adequate

evidence available to justify comprehensive anti-chronic disease action now. Another strong point of agreement was the need to fund prevention and disease care from the same 'bucket' and move from fee-for-service to a cohort model to increase the focus on keeping people well, and to contain costs. Other suggestions for positively influencing the environment to inhibit chronic diseases centred on creating strong alliances, particularly between disease-specific NGOs; building a compelling economic argument to encourage governments to intervene; whole-of-government and business engagement; and rethinking and reframing the way we communicate chronic disease messages to the public. Overall, there was a strong feeling that there is a good and growing capacity for positive change and that the time is ripe for it.

*What the literature said* presents four landmark reports selected from our review of the relevant literature. The first is an Australian report, *Returns on Investment in Public Health* (Abelson, 2003), which moves the case for prevention forward by analysing five public health programmes – for HIV/AIDS, tobacco, road trauma, immunisation and coronary heart disease (CHD). We cite the substantial savings estimated from lowering CHD risk factors and from public health programmes.

The Wanless reports (2002 and 2004) urge for greater investment in public health programmes, evaluation, and research, and clearly state the case for making health everybody's business. The author urges an upstream macroeconomic approach that addresses disease determinants such as poverty, employment and education through a broad intersectoral effort. To support his argument, Wanless demonstrates that 'a fully engaged scenario', although more costly than the status quo initially, will reap economic benefits in the long term. Finally we cite *A Race Against Time: The Challenge of Cardiovascular Disease in Developing Economies* (Leeder et al., 2004). This report estimates the potential costs of not intervening to prevent cardiovascular disease (CVD) by analysing changing disease and dependency patterns in low- to middle-income countries compared to two high-income countries. The authors provide examples of successful population interventions.

In this section we also look at *promising models* for chronic disease prevention. The first case provides an overview of the rapidly growing corporate interest in employee health which is being driven by steep rises

in the cost of employee ill health and absenteeism. The United States has been leading this trend and it appears that a new industry – for advising, monitoring and supporting employers on employee health programmes – is about to be born.

Two very different but both innovative examples of *national action* on chronic disease prevention focus on Finland and the Pacific Island of Tonga. In each case innovation, intersectoral collaboration, and the engagement of a wide range of stakeholders are building strong structures for combating chronic diseases in both primary prevention and disease management.

### It's happening

This section asks the question 'are the above examples unrelated phenomena or is a more pervasive trend emerging?' To answer this we provide *further evidence of government action* on three continents, notably in the area of food and anti-childhood obesity legislation. We note the new WHO chronic disease prevention policy report and applaud the conditional cash payments to poor families being used by some governments in Latin America to reduce poverty by improving health and education.

With some excitement, we also note *the resurgence of civil society*, as evidenced by the proliferation of large and small civil society organisations (CSOs) that are working to ensure transparency and accountability of governments and business for the impact of their policies and products on health. The degree to which some of these CSOs are organised is exemplified by the People's Health Movement, which now operates in 100 countries and recently produced *Global Health Watch*, a comprehensive alternative to the WHO global health reports.

In *how do we know it's happening? – the counterattack*, we point out that a sure sign of impact is opposition. The pressure civil society is putting on governments and which governments are passing on to the food industry has elicited a discrete, organised response under the guise of the Center for Consumer Freedom. The Center is said to be funded by the food and tobacco industries, and exhorts consumers to ignore the 'food police' claiming that 'violent radicals ... are pushing against our freedoms'.

### Where to next?

In this last section we advocate for a new approach, which still utilises proven public health tools but which recognises the complexity of chronic disease determinants and, accordingly, takes a comprehensive, macroeconomic 'engage-all' approach. In support of this we quote the insights and ideas of several leading authors:

- Leeder (2005), who calls for the development of Health Prosperity Goals to complement the UN Millennium Development Goals by focusing on the four-fifths of the world not caught in the poverty trap.
- Allin et al. (2005), who propose that public health decision-making can be improved by better communication between research and policy; political commitment and robust legal frameworks for health; removal of restrictions on public health employees to speak freely; and debate around the tensions between individual freedoms and government actions on health.
- Greenburg et al. (2005), who argue for a balanced framework composed equally of effective primary care; political and economic commitment to prevention based on public education and social structural reform; and changing the environment to favour health through macroeconomic policies.

Finally, we agree with Saul (2005) that times of uncertainty are also times of great opportunity and suggest that we have enough knowledge and insight to intervene successfully in chronic diseases now. We urge that, for long-term sustainable change, *the coalition of the committed* must focus on the macro-socioeconomic level, and propose that it just might be possible to bring the food industry into the coalition rather than repeat the tobacco confrontation.

# Introduction

## The world we live in

While countless children do not have sufficient nutrient or caloric intake for normal growth and development and are dying as a result of poverty, millions of us are getting fatter than ever before. We move our bodies progressively less but increasingly fill them with energy-dense diets of ever-growing serving sizes. As a result, diseases such as diabetes and cardiovascular diseases (CVD) are not only increasing but exploding, causing fears that, unless this trend is reversed, future health costs will be unsustainable. We are living longer but having fewer children, and new research suggests that childhood obesity may cause a significant shortening of life spans by the middle of this century (Olshansky et al., 2005). Who, indeed, will fund the care we will need to service our diseases of old age and chronicity? And how did we get this way?

### ***Not everything can be counted, and not everything that can be counted counts.***

*Albert Einstein*

In one generation the world has changed so fast and so radically that the rules of engagement handed down from previous generations are applicable only loosely, if at all. We travel distances beyond the wildest dreams of our grandparents and can communicate instantly with almost anyone almost anywhere. We personally know many more people than our parents and grandparents did, but we are less connected with the people we know (Tanner, 2003). We are more urbanised but lonelier. Many of the things we hold dear – peace, dignity, freedom – have no monetary value, yet we try to measure everything, even quality of life, in economic terms as if such things have no value in their own right.

Globalisation, technology and free trade have transformed us and the world we live in forever – in many ways for the better but, nonetheless, leaving a trail of seemingly insoluble health and social problems in their wake. In this context chronic diseases are running wild and narrowing the window of opportunity for developing countries to capitalise on any potential health gains which might result from an increase in affluence and concomitant downturn in infectious diseases. New and re-emerging health threats such as SARS, avian flu, HIV/AIDS, antibiotic resistant tuberculosis, terrorism and bio-terrorism, and climate change, are dramatic and emotive. But it is the quieter epidemic of obesity, diabetes, cardiovascular disease and hypertension, and the

recreational folly of all time – smoking – that threaten to cripple our bodies and our economies.

Whether born into the first or the third world, we are increasingly susceptible to these conditions, but health messages about them, and their causes, are mixed and often conflicting. And there is ambivalence about just what constitutes good health. Risk factor-ology is rampant. Cut points for physical and biochemical assessments, originally designed to distinguish between normal physiology and deviations from it, are constantly being lowered. Blood pressure targets are a prime example, with nearly half of the world's population now classified as hypertensive or pre-hypertensive. Pre-diabetes and the lowering of criteria for impaired fasting glucose is another case in point.

Community unease about health and the state of health care is reflected in polls from several countries, which show that health is high on the general list of public concerns. 'Patients' are no longer patient. In the western world, dissatisfaction with health care and healthcare providers has reached an all-time high as has the social, psychological and financial cost of the resultant 'epidemic' of medical litigation. In the midst of this, the 'worried well' are constantly utilising health services for new 'manufactured' health risks which once would have been considered normal. At the same time, the less empowered and less affluent unworried unwell, and the poor, are left in relative ignorance of their need for health interventions, and how to access and use them effectively.

## **Old solutions are not meeting the new challenges**

The chronic disease epidemic has not come upon us without warning. Although the recent increase in its prevalence and costs has been exponential, it has long been documented in epidemiological projections. But we have not heeded the warning. While epidemiologists, economists and others have been measuring, modelling, and admiring the resulting statistics, we have failed to intervene cohesively or effectively.

The biomedical model of health has been skilful at treating chronic conditions once they manifest as diseases but has never seen primary prevention, population risk reduction or addressing societal disease determinants as part of its brief. Neither has public health attempted to address determinants of chronic diseases with anything like the missionary zeal it has applied to sanitation, vaccination, and tipping stagnant

water out of discarded tin cans to destroy breeding grounds for disease-carrying mosquitoes. Government sectors have long worked in portfolio silos, each making policy decisions for its own 'patch' with little awareness or regard for their impact on other sectors or on population health. International aid agencies have continued to concentrate their health programmes on infectious diseases, despite the decline of these diseases and in the face of the mounting magnitude of chronic diseases. The World Health Organisation (WHO) is said to spend only around 5% of its programme budget on the cluster of (chronic) diseases that is responsible for 60% of the world's mortality (Yach et al., 2004). And disease-specific NGOs are only just discovering primary prevention.

As we grapple with how best to approach these problems, healthcare costs continue to rise while neglected capital infrastructure crumbles. Despite this, expectations of what health systems should deliver have never been higher. Yet we still do not publicly debate just what we are striving for. We have no agreed goals. Nor have we come to terms with what we should pay for health. We are equally shocked by 16–18% of GDP spent by the United States on a health system that leaves over 40 million of its population unfunded for care as we are by India spending only 1% of its GDP on health, but we still do not know what is the 'right' average amount to spend on health per country.

How will these issues be resolved? What will convince the WHO, ministries of health, international donor agencies and NGOs to invest more equitably in the fight against chronic diseases? How do we achieve whole-of-government involvement and engage big business to bring about the macroeconomic policy changes needed? How do we persuade local government that designing the built environment to promote community interaction and healthy lifestyles is as important as enacting building regulations to maximise safety from trauma and minimise the risk and repercussions of fire and flood? Even if we can convince them, do we know what to do?

### What we did

To better understand these questions and their possible answers, in 2004 Novo Nordisk Denmark undertook a project entitled *Investigating Models and Trends in the Prevention and Care of Chronic Diseases*. The aim was to explore the current state of knowledge and thinking about these issues, and identify emerging ideas, trends and models that might illuminate a

way forward. The investigations took the form of consultation with key opinion leaders and literature and web searches on issues such as:

- What kinds of models and interventions are known to be effective now?
- Why are healthcare costs spinning out of control? Can/how can this be reversed?
- What would have to happen across government and private sectors to stem the tide of obesity and physical inactivity? Is this feasible?
- Can/how can health systems be refocused to address the priorities? Who can influence this? How can other players be brought on board?
- What are the most influential socio-political and economic trends and drivers that will shape the future of health protection/ disease prevention and health care?

Consultation to identify the current status of chronic disease prevention and care and to build a profile of how this might change in the next 5–20 years, took two forms – individual key opinion leader interviews and Oxford Dialogue meetings.

Interviews were held with ten opinion leaders from four countries – the United States, the United Kingdom, Finland and Australia. The interviewees were senior public health academics and researchers, specialist clinicians and health authorities, and included a former health minister. All were well known internationally for their contribution to health. In addition, five Oxford Dialogues – small interactive focus-group discussions – were held with 35 senior academics, researchers, clinicians, health bureaucrats, technocrats and health administrators in four countries:

- United Kingdom (with representation from Scandinavia)
- New Zealand (with representation from the Pacific Islands – Tonga and Samoa)
- Australia
- Canada

# What we found

## What the experts said

There was considerable convergence and congruence of opinion within and among the key opinion leader interviews and Oxford Dialogues. Both forms of consultation were open to discussion about primary prevention and systems of care for people already diagnosed with chronic diseases. However, participants tended to focus primarily on prevention. While many negative issues were raised during the interviews, there was a sense that there is currently a good capacity for positive change and a convergence of opinion and ideas about the need for healthcare reform and what size and shape such reform should take. The following themes are representative of the discussion.

### Health is different

The argument that health is different from 'business' revolved around issues such as:

- the provision of health services having a potential for moral hazard due to there usually being a third-party payer;
- short-term political cycles impeding support for long-term planning;
- very long feedback loops: have to wait 10–15 years to reap rewards in overall public-sector budget or socioeconomic terms;
- provider dominance: supply-side control and 'information asymmetry';
- price inelasticity, as normal price signals do not apply;
- being an emotional issue not a business transaction;
- the need for public debate about the interface between personal responsibility and state responsibility for health;
- reluctance on all sides to debate and determine priorities – for example, should we refuse bypass surgery to 85-year-olds?

### Healthcare costs are not as out of control as we may think

Many participants believed there is enough money in most countries to provide basic infrastructure and services for health. Cost blow-out was thought to be a function of cost shifting and private enterprise draining funds from the public system\*. In the United States, this includes health maintenance organisations (HMOs) shifting costs on to Medicare. Inefficiencies resulting from structural barriers, the mismatch between policy and practice, and the failure of health to adopt and utilise information and communication technology were also cited:

- 'healthcare costs are not spinning out of control', 'the money has been siphoned off by private enterprise: a lot of people have made a lot of money out of health';
- 'it's not technology that is the greatest cost driver, it's structural barriers to efficiency';
- 'fee-for-service promotes over-servicing and emphasises "sick care": there is a need to move to a cohort management model'.

Some participants proposed that costs could be contained by compressing morbidity into the last few years of life. Others argued that approximately 80% of healthcare costs are already incurred in this period.

It was agreed that cost containment is a 'must', but that the focus should change from reducing services, hospital beds and staff numbers to a model of:

- integration and coordination through single funding streams that cover both community and acute services;
- funding prevention and care from the same bucket, and increasing the proportion of funding for prevention by reducing inefficiencies in the care system;
- removing structural, policy, and institutional barriers that foster waste, duplication and fragmentation;
- cohort care instead of the current fee-for-service, which promotes over-provision and under-quality of services;

\***Authors' note:** At the time of reviewing this summary, Australia's leading national newspaper published excerpts from and comments on a newly released government report on healthcare expenditure. This included the statement that 'Government spending on private hospitals grew by 21 per cent a year between 1997 and 2003 while non-government funding for private hospitals declined 2.4 per cent a year'.

**Source:** 'Out of pocket health costs have doubled', *The Australian*, 30 September 2005.

- de-emphasising disease silos and building workforce capacity across a range of chronic diseases;
- overall health-sector reform and longer-than-political-cycle strategic planning and financial commitment: ‘20-year planning cycles rather than 20-minute cycles’;
- governments acting like HMOs and constantly working to predict and reduce risk.

And accountability:

- focusing on outcomes not just processes;
- making providers and administrations responsible for outcomes;
- looking at what happens to people rather than just what was done to them. For example, monitoring hospital stays, mortality, disability-adjusted life years (DALYs) and creating incentives and disincentives to support an outcomes focus.

Fee-for-service health systems were unanimously agreed to be a recipe for increasing costs and decreasing quality. The need to move towards funding on a population cohort basis was seen as central to achieving health gain within affordable resources.

### **Primary prevention is complex and under funded**

The view that primary prevention of chronic diseases is under funded and faces an uphill battle in gaining political attention in the face of more emotive and dramatic conditions such as HIV/AIDS was universal. However, there was also a feeling that we are on the brink of a breakthrough with prevention. Reasons given for this included:

- the growing political and societal recognition of the economic threat of the disease burden of obesity and chronic diseases;
- the increasing volume of good quality evidence about chronic disease prevention, particularly in the case of diabetes;
- the growing international advocacy platform for chronic disease prevention.

The need to concentrate money, effort and innovation to reduce the impact of obesity and chronic diseases was seen as best being achieved by:

- creating alliances and partnerships between the big national and international NGOs to strengthen lobbying;
- building a compelling economic case for governments to invest in prevention;
- an intersectoral approach that engages government and non-government sectors in creating and maintaining healthier, less diabetogenic and obesogenic environments where healthy options are built in;
- putting health activities on the workforce agenda of employers;
- bringing the food industry on side to turn its talents to produce healthy fast foods rather than fatty fast foods;
- emulating the international anti-smoking lobby and using taxation, regulation and legislation to align the social environment with healthier options in everyday life;
- de-medicalising the problem and putting the money into gym subscriptions and health-promoting community activities.

The view was also voiced that, according to medical sociologists and specialists in human development, the early childhood environment is critical to health over the course of life. Therefore, investing in child health would most likely bring the greatest future gains. However, it was noted that there is little evidence about which part of the life cycle to invest in to achieve the greatest gains.

### **Research and evaluation**

It was agreed that up-scaling the effort to address lifestyle determinants of chronic diseases would need to be supported by:

- expanding and improving the quality of the evidence base about nutrition and physical activity for example, exploring the relative contribution of diet versus exercise in preventing obesity, diabetes and CVD;

- improving understanding of population prevention and implementation of the evidence for prevention of diabetes in high-risk groups;
- investing in public health/health services research, and behavioural and educational research to find out what works best with mass communication and develop a more appropriate research paradigm to take account of issues where the dominant randomised controlled trial (RCT) model is not appropriate.

### Communicating about health

There is a need for a shared vision and common understanding and language around primary prevention. There are disparities in understanding between clinicians and public health practitioners. Public messages about research, nutrition and physical activity are often contradictory. The public only gets sensationalised news – for example, about adverse events – and has no normative data to set this in context. The theme ‘Innovation Urgently Required’ in communicating about chronic disease issues and health in general ran through all the Dialogues and most of the key opinion leader interviews, but was most forcefully and graphically expressed by one Dialogue participant who, among other innovations, suggested:

- a Dow-Jones-type health index to inform the public about the relative status of disease and health risks;
- escaping the tyranny of acute diseases by adopting and promulgating a ‘fire alarm’ approach to communicating about chronic diseases – for example, they get you in the prime of life through ‘death by comfort’.

### Whole-of-government and public-private effort required

‘Must have the health minister at the cabinet table.’ This point was emphasised repeatedly, the rationale being that the cabinet is where the financial decisions are made. If the health minister is not at the same table as the treasurer to argue the economic case for health funding, health is often overlooked in favour of other sectors, and the link between health and its social determinants is lost. In addition to the need for a whole-of government approach it was agreed that, for sustainable change, governments must involve big business in finding solutions.

### What the literature said

The literature searches focused on the peer-reviewed medical literature, government, NGO and corporate websites, and selected texts from the general press about global socioeconomic trends of particular relevance to health and its determinants – globalisation, ethics and the corporatisation of democracy. The large body of peer-reviewed evidence about the burden of chronic diseases will not be repeated here. Nor will the evidence about the feasibility of intervening except to say that the possibility of preventing diabetes, obesity and cardiovascular disease is clear and unequivocal. That is, these disorders can be prevented or delayed until their impact is compressed into fewer years later in the life cycle. The approximately 50% reduction in deaths from heart disease among 45–65 year old men that has occurred in developed countries since the 1960s is a case in point. And recent RCT evidence shows that diabetes can be prevented or significantly delayed in high risk individuals through lifestyle programmes (58%) and medication (33%) with lifestyle interventions proving the most cost effective and demonstrating that only a modest weight loss (5-7% of total body weight) can prevent progression to diabetes (Knowler et al., 2002; Tuomilehto et al., 2001).

From the literature, we selected four landmark reports, for presentation here, which illustrate the issues, the imperatives, and the potential to intervene successfully.

### Prevention is better than cure

An Australian publication, *Returns on Investment in Public Health Report* (Abelson, 2003), moves the case for prevention forward by analysing five public health programmes – for HIV/AIDS, tobacco, road trauma, immunisation and CVD – by estimating:

- the costs of the programmes;
- the reduction in cases of disease attributable to public health interventions since the commencement of programmes and up to 2010;
- the benefits of reductions in disease with regard to increased longevity, improved quality of life and reduced healthcare expenditure;
- the total return to society of investment in public health interventions and savings to the government.

The results of the analysis for coronary heart disease (CHD) showed that over the last 30 years mortality rates from CHD fell significantly in males aged 35 to 74 years from nearly 400 per 100,000 in 1968 to under 100 per 100,000 in 1998 and in females from 118 to 23 per 100,000 in Australia. Significant declines in major CHD risk factors – smoking, cholesterol and hypertension – accounted for an estimated 70% of the decline in mortality. The estimated benefit of reduced CHD in 1996 due to the lowering of three risk factors was \$8.9 billion. The estimated benefits attributable to public health campaigns were \$994 million in 1998. This included longevity gains (in Australian dollars) of \$828 million, \$100 million from improved health status, and \$66 million in lower healthcare costs.

### Health care is everybody's business

In an unprecedented move, the UK Chancellor of the Exchequer appointed a former banker to review the National Health Service (NHS) and offer insights, options and advice on what would be required to refocus the NHS in the short and long term, and to estimate what this might cost. The 2002 Wanless report, *Securing our Future Health: Taking a Long Term View* (Wanless, 2002), set out three futures scenarios as options for turning the sickness system into a health system:

- *The fully engaged scenario* – requires transformational change in public attitudes, government cohesion and cooperation, and the quality and level of services provided. The health system is responsive in treating disease and proactive in preventing it and health outcomes improve significantly.
- *Solid progress* – incremental improvements occur in the quality of care and prevention services and in public attitudes to health. There is a concomitant but not marked improvement in health outcomes.
- *Slow uptake* – no deviation from the present approach and virtually no improvement in health outcomes or community and individual engagement in health.

As a result of modelling the financial implications of the three scenarios, Wanless demonstrated that although the short-term costs of the fully engaged scenario were higher than the other two options, in the long term they were substantially less. A

further report, *Securing Good Health for the Whole Population* (Wanless, 2004), centres on primary prevention and an intersectoral approach to bring about the full engagement of all levels of the health system, all sectors of government, business and the public to address determinants of disease. The report also called for meaningful provider and community consultation on health, and for breaking down and refocusing disease silos and professional territorialism to build a new and responsive capacity to prevent and control disease and disability. As in the first report but perhaps even more strongly, Wanless presents a compelling and entirely sensible argument for investing in prevention.

### Investment in intervening now is more sustainable than the cost of not intervening

*A Race Against Time: The Challenge of Cardiovascular Disease in Developing Economies* (Leeder et al., 2004) cites CVD as responsible for 30% of the world's current burden of mortality and estimates that by 2020 it will be the leading cause of death globally.

This report mounts the argument for combating CVD as an economic imperative for developing countries, estimating that in China alone more than 6 million life years are potentially lost annually as a result of heart disease and stroke. It synthesises the available epidemiological and costing data from a number of index countries to model the future social and macroeconomic impact of CVD to illustrate that, regardless of the cost of intervening, ultimately the cost of intervening will be cheaper than the cost of not intervening.

To demonstrate this, Leeder and his team studied five developing countries from low or medium resource settings (China, Brazil, India, Russia and South Africa) and compared them to two high income countries (Portugal and the United States) and explored the:

- current prevalence of CVD;
- current and projected long-term costs over 40 years;
- cost benefits of various prevention and control strategies.

The first notable trend is the significant increase in CVD rates among 35–64 year olds in the study countries as opposed to the wealthier comparator

countries. The second is that the impact of CVD on women in this age group in the low and medium resource settings far outstrips that found in women from developed countries. Using Brazil to illustrate these points, the report demonstrates three possible scenarios for the future:

- increased rates;
- steady increase;
- decreased rates.

The ‘increased rate’ scenario predicts that by 2030 there will be an increase of 84% of CVD in the Brazilian workforce, while an investment in prevention activities that led to decreased rates would result in a reduction in CVD in the same age group of 39%.

The societal implications and costs of CVD are explored in terms of the impact on dependants. The authors propose that for a child under two the death of the breadwinner in the family puts the child at a 12-fold increased risk of death. The changing nature and shape of dependency is also explored with regard to the decreasing number of dependent children compared to the increasing number of older people. For example, children under five will soon be outnumbered by adults over 65 years who, when ill, incur costs and require care by the family at a much greater rate than the young.

These predictions assume no increase in risk factors for CVD and are based solely on projections about increasing population size and ageing. However, the authors estimate that, if considerations such as increasing urbanisation were taken into account, CVD in China would increase by 215% in the 30 years from 1995 to 2025.

The report illustrates the feasibility of intervening successfully through references to Australia, the United Kingdom, the United States and others where the incidence and impact of CVD has fallen. Using the North Karelia study, the report cites the combined community, agriculture and food industry engagement, which resulted in a reduction of CVD as an example of successful health promotion. In another example from Poland, Leeder et al. cite a combination of food legislation resulting in higher taxes on animal fat, combined with health promotion as resulting in a 25% reduction in CVD. In yet another example, but this time

from modelling rather than real life, the report cites a study where it was claimed that a 1–3% reduction in dietary fat would result in a decrease in the cost burden of CVD of between \$4–12 billion annually.

### Promising models – a glimmer of hope

Notwithstanding deficiencies in the scientific literature and the hitherto poor investment in public health research, there is ample evidence about what needs to be done. The burning question is not so much about what to do but about how to get it done. As shown in the following two very different examples – health-promoting workplace initiatives and national action – there are glimmers of hope.

### Workplace initiatives – rising healthcare costs spur boardroom action

Tackling runaway healthcare spending has become a key priority in boardrooms across the United States. McKinsey predicts that by 2008 a typical Fortune 500 company will spend as much on healthcare benefits for its employees as it earns in profits (McKinsey, 2004).

Driven by the rising costs of healthcare spending, a growing number of US companies’ health and safety programmes are evolving to focus on health promotion and wellness. They do not just provide benefits for treatment, but aim to keep employees healthy and out of hospital. This strategy brings additional benefits including productivity increases and enhanced reputation to the employer (Edington 2005) in the way of:

- improved staff recruitment and retention;
- increased company visibility;
- enhanced social responsibility profile.

A key focus area for the new approach is potentially preventable diseases. About 80% of healthcare costs met by companies relate to chronic diseases such as cancer, CVD, diabetes, HIV/AIDS and arthritis. But most traditional healthcare schemes reward hospitals and doctors for treating symptoms rather than preventing chronic conditions. There are huge benefits to be gained for both the employees and their companies by better disease management. For example, the US National Committee for Quality Assurance estimates that, on average, total medical expenditures incurred by people with diabetes were five times higher than for

people without diabetes. If blood glucose levels were better controlled in 95% of diabetes patients, more than 4,000 lives could be saved each year and at least 4 million sick days avoided (NCQA, 2002 and 2005). Such potential gains are contributing to the growth of the market for disease-management firms who may be hired directly by companies or by insurance or managed-care organisations.

GE, AT&T and Lockheed Martin are among the large companies that have introduced market-driven incentives for preventive medicine that keep employees with chronic conditions healthy and out of hospital. In more general models:

- Xerox sponsors yoga and salsa classes for employees. The company's website gives information for employees on relaxation techniques, breathing exercises and tips for relieving tension. Employees can have a health-assessment coach aiming to keep them fit.
- The Johnson & Johnson employee health and wellness programme integrates disabilities management, employee assistance, occupational health, wellness/fitness and work-life services to promote prevention, education and self-responsibility. The Health & Wellness programme covers more than 47,000 domestic employees. Due to its health programmes, health risk among employees declined for 8 out of 13 categories examined. Savings from the programmes are about US\$9 million per year from reduced medical expenses and lower administration costs.
- The Union Pacific Railroad Health Track programme works to identify at-risk employees and provides them with intervention programmes, company-sponsored exercise opportunities, general health education and disease management. Recently, Union Pacific identified health and welfare as one of eight major business initiatives receiving special focus for improvement. The continued integration of health promotion with the company's safety culture has resulted in development of a Health Index for field-operating personnel. The Health Index allows work units to set goals related to health promotion activities. By establishing measurable goals, each work unit is then able to develop plans to meet these goals.

Workplace wellness programmes are also gaining momentum in other countries. These tend to cover fitness, well being and risk-reduction programmes; smoking and alcohol cessation; healthy canteens; direct health care and disease management services; and environmental design. Recent evidence suggests that multi-factorial, comprehensive programmes that focus on both health promotion and disease-management around multiple risk factors are most likely to reduce chronic disease risk. Further, although more expensive, it can be expected that improved health outcomes will be achieved through programmes that have a periodic individual counselling and support component (Pelletier, 2001).

The factors that mediate economic returns on investment in workplace health programmes are multiple and include programme scope and goals, initial health state of the target population, program related costs, and benefit calculation categories. In the United States, returns of 1:2 up to more than 1:10 are reported (Chapman, 2005). Further, cost-effectiveness research and translation of new insights into practice is likely to increase the return on investment (Anderson, 2005).

The increasing corporate interest in health is indeed welcome and has good potential to impact on chronic diseases. Already there are a large number of consultancies and service providers positioned to assist organisations seeking to implement or upgrade workplace health promotion and wellness initiatives, internationally (see Appendix 1 for examples). The next step of this evolution is the consolidation of a workplace health promotion industry, including the formation of international industry associations and certification bodies.

### **National action**

The following two examples demonstrate serious national commitment to preventing and ameliorating the effects of chronic diseases in two geographically distant and demographically and culturally very different countries and healthcare contexts – one in first world Europe, the other in a developing country, Pacific Island, setting.

### ***The Finnish Diabetes Prevention Program***

In Finland, a requirement for disease prevention has been specified in the Occupational Health Care Act

(since 2001) and large companies pay for employee health care. This has sparked a huge interest in prevention of diabetes and associated CHD.

The Development Program for the Prevention and Care of Diabetes in Finland 2000–2010 (Finnish acronym – DEHKO) exemplifies a ‘new’, nationally coordinated and integrated, comprehensive approach to chronic disease prevention – specifically to addressing lifestyle determinants and skilling the workforce to provide an enhanced quality of service. This large-scale diabetes prevention programme represents the Finnish government’s response and commitment to preventing or delaying the onset of diabetes in the 30–50% of Finns who are genetically predisposed to type 2 diabetes.

DEHKO ([www.diabetes.fi](http://www.diabetes.fi)) is financed by the Finnish Slot Machine Association (project grants), company sponsors and the Finnish Diabetes Association (FDA). Establishing DEHKO led to an acceleration of collaboration and, today, the FDA leads DEHKO in close collaboration with the Finnish Heart Association, the Ministry of Social Affairs and Health, the National Public Health Institute and the Social Insurance Institute, municipalities, hospital districts, health professionals, pharmaceutical companies and others. DEHKO was evaluated very positively in 2003 by an independent panel of academics including project management and communications experts from the FDA. And, the evidence base for local preventative action is indeed strong, for example, the North Karelia Project that reduced CVD mortality rates by 75% in the working population in 20 years, and the recent Prevention Study that showed how simple lifestyle interventions can significantly prevent or delay the onset of type 2 diabetes (Tuomilehto et al., 2001).

The Prevention Implementation Programme 2003–2007 (aka FIN-D2D) combines a primary and secondary prevention approach. It is predominantly government funded but is led by the FDA. The programme has a €6 million budget, but expects to save society some €75 million annually for many years if it succeeds in reducing diabetes incidence by 25% over five years. The key activity is a primary care and occupational health pilot project covering 1.5 million people – more than a quarter of the country’s population – to reduce the incidence and prevalence of type 2 diabetes and explore the feasibility and cost-effectiveness of various interventions (Finnish Diabetes Association, 2004). This programme pursues three simultaneous strategies:

- a population approach: prevention of obesity focusing on community awareness of nutrition and physical activity;
- a high-risk approach: screening, education and monitoring;
- an individual approach: early diagnosis and intensive treatment and lifestyle management.

In spite of DEHKO and FIN-D2D, resources in Finnish primary health care are generally insufficient for delivering effective prevention. Interventions aimed at high-risk individuals are increasingly being carried out outside the healthcare sector by private companies.

To evaluate the effects of lifestyle intervention, high-risk subjects found in the screening process will be followed by annual health examinations. A control group has been formed, consisting of high-risk subjects found in national health surveys in areas that are not part of the prevention programme. FIN-D2D baseline data are expected in the near future.

### ***Prevention and control of diabetes and related chronic diseases in Tonga***

Despite a population of only around 100,000, inadequate critical mass to support a specialised medical, scientific and technical capacity, a chronic ‘brain drain’, and lack of financial resources, the Kingdom of Tonga is setting an example to the world. Under the leadership of its Minister of Health, the Honourable Dr Viliami Tangi, this tiny Pacific Island nation is addressing the threat of chronic diseases using intersectoral collaboration and action, generating and applying evidence, legislation and taxation, and capacity-building as its primary tools.

Combining legislation and intersectoral cooperation, the Health Minister is using data from a national nutrition survey to attempt to change legislation to restrict the import of fatty foods (mutton flaps and turkey tails). While this initiative has not yet translated into a change in policy, it represents a seminal attempt which, if pursued, will ultimately succeed in ameliorating first world exploitation and its impact on obesity and related chronic diseases. The Ministry of Health is also working with other government sectors to improve the environment for physical activity in the capital city by laying paved footpaths. The first 11 km of footpath were laid in March 2003 during the Pacific

Health Ministers Conference (WHO, 2003) and funding has been assured for further extensions.

Since 1997 Tonga has conducted two major health programmes – one on health-sector reform and another national programme for the prevention and control of diabetes and related chronic diseases. The latter included a national diabetes and CVD risk factor and prevalence survey (Colagiuri et al., 2002) which demonstrated that, over 20 years, age-matched women had increased their body weight by 19 to 20kgs – presumably as a direct result of urbanisation and westernisation. Unpublished data from a repeat of this prevalence survey showed that the trend of increasing weight gain has slowed, and that hypertension has declined significantly in the intervening five years since the initial survey (Colagiuri et al., 2005). Further, despite a visible concentration of tobacco companies on developing Pacific nations, the 2004 survey also showed a small but significant decline of 1% in smoking rates. This is no doubt due to a combination of awareness campaigns, increases in tobacco taxes, and the introduction of smoke-free zones in restaurants.

Tonga has steadfastly refused to allow fast-food chains into the country. Nonetheless, unhealthy foods are abundant and their vendors target schoolchildren by setting up at or near schools. A recent risk-factor survey of approximately 600 schoolchildren aged 13–15 (Palu et al., 2004) demonstrated low levels of physical activity and high consumption of unhealthy foods – mostly purchased at or on the way to and from school.

Despite the results, this is a good-news story on several fronts. First, because the School Childrens' survey was conceived and organised locally – something Tonga did not have the capacity to do four or five years ago. Secondly, it was done in collaboration – with school authorities, the Ministry of Education, school principals and teachers, and the community of parents whose children attend the schools. Thirdly, having generated this evidence and measured the problem, Tonga is acting on the results. Already a healthy eating policy for schools has been drawn up under a collaboration of the health, education and other sectors. This policy aims to improve the quality of food available through schools and curb the incursion of 'junk food' vendors. Likewise, dedicated exercise programmes are being reintroduced to schools to promote physical activity.

Tonga's response to the School Childrens' survey is being mounted under the umbrella of the National NCD (Non-Communicable Disease) Committee established by the Minister of Health three years ago. There are four NCD subcommittees, all with an intersectoral composition – one for physical activity (P), one for alcohol (A), one for tobacco (T) and one for healthy eating (H). All are focused on promoting the public PATH to good health.

Finally, as a signal of his strong commitment to combat chronic diseases, the Minister for Health has dedicated 60% of the WHO routine country budget for Tonga to the prevention of chronic diseases, to support the national chronic disease strategy developed and launched in 2003.

## It's happening!

### Further evidence of government action

Are these promising models isolated cases, or is there a deeper thread of change? From our investigations in 2004 and since, we believe there are systematic processes driving a growing awareness among governments of the magnitude and implications of the problem.

The UK government is responding to the Wanless reports (2002 and 2004) with its 'Choosing Health' and 'Delivering Choosing Health' initiatives (UK Dept of Health, 2004 and 2005) and has recently announced the allocation of substantial funding to train health professionals in strategies to reduce obesity. Likewise in 2004, the Australian government dedicated several million dollars to combat childhood obesity. Canada too, well recognised for action on chronic diseases, has announced an additional injection of government funding for a new research effort against childhood obesity ([www.cihr-irsc.gc.ca/](http://www.cihr-irsc.gc.ca/)). And a 'walk' through the US government website ([www.healthierus.gov](http://www.healthierus.gov)) reveals an array of primary preventative strategies and plans aimed at addressing chronic diseases.

Europe is also on the move. The European Union has included health as the primary theme in its seventh framework programme of research. Most importantly, it is determining that a sizeable proportion of the health research budget should not be spent on traditional biomedical and biochemical research alone but should be allocated to health services and population research of an adequate time frame to allow 'for life course investigation of disease development'. It also calls for a serious investment in training and education – both formal and informal – to increase competence and capacity for all population health sciences (Saracci et al., 2005).

And if the food industry in Europe is not prepared to self-regulate, it is on very clear notice from the EU Health and Consumer Affairs Commissioner to phase out 'junk food' advertising targeting young children, or face regulatory restrictions. This is being reinforced at the national level with several European countries introducing legislation aimed at curbing the advertising of 'junk food'.

On a global scale, the WHO is targeting the governments of its member states with a new publication entitled *Preventing Chronic Diseases: A Vital Investment* (WHO, 2005). The WHO website ([www.who.int](http://www.who.int)) profiles the purpose of this report as 'making the case for urgent action on chronic disease

prevention and control'. But, perhaps the best news story of government action is that of Latin America, where governments are using what appear to be potentially effective measures for reducing poverty in the form of cash payments to the poor. Payments are conditional on meeting specified requirements such as keeping children in school, vaccinated and having regular health checks. Brazil and Mexico are cited as successful examples with programmes covering millions of the poorest families (*The Economist*, 17 September 2005).

### The resurgence of civil society

***If there's no light at the end of the tunnel,  
you just have to march down there  
and turn the bloody thing on yourself..***

*Sarah Henderson*

Why are governments acting this way? Is it due to a growing appreciation of the potential magnitude of the cost of not acting? More likely, since the political cycle is short, it is largely due to pressure from the tsunami of like-minded organisations and groups that are marching down the tunnel and flicking the light switch to signal that they have 'had enough' and it is time for change.

Daily, in the news media there are items about action aimed at reversing the abundant availability of so-called 'junk food', oversized food servings, misleading food industry advertising and practices, unhealthy school canteens and the over-consumption of energy-dense foods generally. Calls to combat obesity – particularly childhood obesity – are everywhere. Governments are increasingly banning or restricting the sale of soft drinks and high-fat foods in schools, and some 17 states in the United States now have legislation around childhood obesity.

Such changes are undoubtedly due to mounting pressure from voluntary associations of concerned parents, other community groups, and leaders of medical and public health professional organisations. The writing is not only on the wall but is in large and bold. This is not unheeded by the food industry, which is rapidly changing its approach by looking for healthier fast foods to replace the fatty, vitamin- and mineral-deficient fodder we saw turn Morgan Spurlock from a trim-figured young man into a bloated mess. While McDonald's was the 'fall guy' in Spurlock's

experiment, recent consumer lobbying has led to the state of California filing a complaint in the Los Angeles Superior Court to prevent fast-food chains generally from selling french fries without warning customers of the potential carcinogenic effect of frying potatoes at high temperatures (*The Australian*, 30 August 2005). This test case paves the way for a court case forcing the provision of warnings to consumers about the weight-related health dangers of eating fast food and/or large food servings.

The groundswell that is laying the foundations for such action is enabled and facilitated by that high-speed, easy-access, low-cost communication tool-without-borders, the internet. Over the past few years myriads of web-based associations of 'people with a purpose' have sprung to life. This is nowhere more apparent than in health, and includes organisations such as Parents Jury ([www.parentsjury.org.au](http://www.parentsjury.org.au)), a web-based initiative that seeks to give parents a collective voice in societal issues that impact on their children's nutrition and physical activity. Likewise, organisations such as Patient View/HCNews ([www.patient-view.com](http://www.patient-view.com)) are using the internet to simultaneously target, engage, represent and canvass the opinions of consumers, healthcare workers and campaigners to lobby for health system and health-related policy reform.

On a broader scale the People's Health Movement – a global grassroots collaboration of health activists and organisations – is gaining momentum. The PHM wants 'health for all now'. To this end, along with Medact and Global Equity Gauge Alliance (GEGA), it has recently published *Global Health Watch* as an alternative to WHO health reports. This venture assumed that civil society needs a global health report which is unencumbered by political constraints. *The Watch*, as it is fondly known, is available at [www.ghwatch.org](http://www.ghwatch.org) and is self-described as 'an evidence-based assessment of the political economy of health and health care ... aimed at challenging the major institutions that influence health'. And indeed it does so. But, rather than denigrate traditional health-system structures, Global Health Action – the campaign tool derived from *The Watch* – calls for a strengthening of the WHO and the public health sector. Other key priority areas focus on addressing militarism, climate change, pharma and big business.

The PHM, Medact and GEGA are about a fairer world which removes socioeconomic and political barriers to opportunity for good health for everyone. What

is perhaps most interesting about the PHM and its activities is that, although born in and of the desperate plight of some parts of the developing world, its message is being heard and acted upon in more affluent societies – over 100 countries in all – with countries such as Italy, the United States and Australia now having active PHM chapters. Most importantly, the PHM represents a rational and comprehensive global advocacy and action response to the negative forces that are acting against health.

This is civil society – defined (by Raymond et al., 2004) as the 'free association of the totality of law abiding individuals and institutions present in open societies and open economies' – in action. This movement is exemplified by the recent rise of civil society organisations (CSOs) such as the PHM, which have possibly developed as an antidote to the previous failure of disease-specific NGOs to join forces to integrate their actions and amplify their advocacy power. And, happily, perhaps inspired by the new CSOs, disease-specific NGOs are increasingly forming national alliances across the major chronic diseases.

Globally, an even more recent phenomenon that is strengthening civil action is the emergence of a new class of CSO anti-chronic disease 'think-and-action tank'. The Oxford Health Alliance is one example of an increasing number of groups which are providing an umbrella 'superstructure' to encourage the alignment of like-minded individuals and organisations to focus their thoughts and efforts on where they will count most. Academia, too, is fostering the rise of civil society, with universities in many countries initiating and hosting chapters of the PHM, and establishing departments and chairs of citizenship and relationship.

Another truly curious but much to be welcomed model is the emergence of hybrid, semi-civil, semi-government advocacy groups within the political arena. Australia, Canada and, more recently, the United Kingdom are among countries that have discrete Parliamentary Diabetes Support Groups. Neither government nor non-government, these groups are non-partisan and are composed of parliamentarians who collaborate to raise awareness of diabetes within and outside the parliament, and to attempt to influence government policy to favour action against chronic diseases.

## How do we know it's happening? – the counterattack

For whatever reason, the pressure is on and many fast-food companies have responded by offering healthier options such as salads alongside their standard fare. Still, it is hard for leopards to change their spots and there is anecdotal evidence that at least one fast-food company is paying rap singers to write the name of its product into songs. This kind of tactic is reminiscent of the battle with tobacco companies. Chopra and Darnton-Hill (2004) draw many similarities and cite the food industry's promulgation of misleading information and hiding of negative results. Rather than be alarmed by this, we should recognise it as a signal that the public and government pressure on these companies is making its mark.

Even more telling is the organised counterattack on the current effort to curb energy-dense diets and unhealthy lifestyles. For example, the Center for Consumer Freedom (CCF) ([www.consumerfreedom.com](http://www.consumerfreedom.com)) describes itself as a 'non profit coalition of restaurants, food companies, and consumers working together to promote personal responsibility and protect consumer choices'. However, Sourcewatch ([www.sourcewatch.org](http://www.sourcewatch.org)), a tool of the non-profit Center for Media and Democracy, which claims to investigate and expose manipulation of the public mind and agenda, profiles the Center for Consumer Freedom quite differently. Sourcewatch claims that CCF is a 'front' for the tobacco, alcohol and food industry and is specifically designed to counter efforts to impose bans on tobacco, unhealthy foods and so on. A visit to the CCF website confirms a high degree of 'attitude' as evidenced by references to the 'so-called obesity epidemic' and the statement that:

'the growing cabal of food cops, health care enforcers, militant activists, meddling bureaucrats, and violent radicals who think they know what's best for you are pushing against our basic freedoms. We're here to push back.'

It is widely reported that the CCF is run by controversial Washington food-industry lobbyist, Rick Berman, having been established in 1995 with funding from the tobacco giant, Philip Morris.

# Where to next?

## Towards a coalition of the committed

***...in the foreseeable future victory will go to those who have learned the habit of co-operation.***

*Jonathan Sacks*

From our investigations it appears that, although a little shaky and tentative at times, there is evidence that we are learning to cooperate. But cooperation and collaboration are a means not an end. To be truly successful, we will need not only to coalesce our commitment but to be very clear about exactly what it is we are committed to doing.

We are unlikely to revert to the way we were. Traditional hunter-gather lifestyles hold little appeal to most of us and, whatever economic paradigm follows free trade, the globalisation of communication and technology is unlikely to recede. We will have to find new ways of modulating our social environment and economic policies to reduce risk and protect and promote health. And clearly, unless a more cooperative solution can be found, the food industry counterattack will have to be dealt with.

The stock-in-trade public health tools of legislation, regulation and taxation remain effective, especially in specific circumstances such as tobacco control, and will be useful in better aligning nutrition with recommendations for health if the food industry fails to self-regulate. However, these tools alone are not adequate to take account of the bewildering variety and complexity of chronic disease determinants, or the need for truly comprehensive interdisciplinary and intersectoral effort to reverse the current trend. Even assuming their efficacy, a broader strategy is needed. But how far upstream do we need to aim?

The UN Millennium Development Goals (MDGs) call for universal access to basic education, the eradication of extreme poverty, and 'a global partnership for development'. Their object is the relief of extreme poverty, much of which (though by no means all) is concentrated in the least-developed nations. These nations, including all those in sub-Saharan Africa, are also the ones that are most deeply afflicted by the major infectious diseases, including HIV/AIDS, tuberculosis and malaria, and where child and maternal mortality remain high. MDG strategies include objectives of assisting developing countries by cancelling bilateral debt; improving access to 'decent and productive' employment opportunities for young

people; sharing the benefits of new technologies; and providing access to essential medications.

These aspirations are worthy and should be wholeheartedly supported and rigorously pursued. However, there is, at present, no countervailing set of goals for the four-fifths of the world not caught in a poverty trap. Here the health issues are different, and the agenda for health gain must be set around the major non-communicable disorders and injury (Leeder, 2005). To ameliorate the potentially devastating social and economic impact of chronic diseases on middle-income industrialising countries and in the economically advanced nations over the next 20–30 years, Leeder suggests setting Health Prosperity Goals (HPGs) targeting chronic conditions, especially CVD, the world's number one killer, by:

- focusing us on addressing the problem and acting on what we know is effective;
- establishing accountability to the community;
- providing an evidence-based, overarching framework for adaption at the national level with numerical goals – specific expected reductions in both mortality and morbidity over, say, ten years.

Finally, and most importantly, Leeder points out that HPGs could facilitate the engagement of those who are central to producing prosperity in ameliorating its unwanted effects, citing the possibility that employers, unions, town planners and representatives of organised society may well come up with more effective solutions than the health sector has done so far.

Specifically, we need more targeted approaches to address structural barriers, improve allocative efficiency, and re-skill and refocus the health workforce. Entrenched, obstructive professional demarcations and practices, in public health as well as among the clinical disciplines, need to be removed. We need to reduce waste and duplication through transparency and control of vested interests, and make our politicians and health bureaucracies more accountable, and we need to sharpen and align decision-making with real needs and real priorities.

In response to the Wanless Report, Allin et al. (2005) reviewed public health decision-making processes in eight first world countries, warning that, even where there is a robust scientific and economic

evidence base, it should not be assumed that this will necessarily lead to better policies. These authors saw improvements as hinging on:

- policy-makers specifying and communicating their needs to researchers more clearly and researchers attending to these needs;
- political commitment to public health accompanied by clearly articulated legal frameworks for health;
- removal of potential disincentives and punishments that might restrain public health employees from speaking freely about limitations of the systems they work in;
- acknowledgement and public debate around the tension between individual freedoms and government action, including the 'nanny-state' approach;
- a dual approach of discouraging unhealthy behaviours while simultaneously 'directing policy to the broader socio-economic determinants of health'.

Not dissimilarly, Greenburg et al. (2005) conceptualise a 'three-legged stool' approach to the prevention and care of chronic diseases in which the three legs are equally necessary for the stool to remain upright. They are, first, an effective primary-care system and programmes that are worthy of consumer confidence in the treatment and long-term follow-up of disease and individual disease risks and precursors. Secondly, 'strong political and economic commitment to nation-wide prevention based on public education and social structural change'. Thirdly, macroeconomic policies designed and enacted across government sectors to favour and entrench environments and lifetime behaviours that promote health.

John Ralston Saul (2005) tells us that globalism as we know it is dead or dying and that the world is up for reinvention, urging that times of upheaval and uncertainty are also times of great opportunity.

While we should by no means stop measuring and monitoring the magnitude of the chronic disease burden, we must balance the cost and benefits of this against the need to invest in doing something about the problem. We already have enough information and insight about what needs to be done. Let's grasp the opportunity offered by the present uncertainty and act on our current knowledge now.

There is still a long way to go. We should not forget about community education, individual motivation and personal responsibility, but for these approaches to realise their potential the coalition of the committed must concentrate on changing the health environment at the macro-socioeconomic level. And, who knows? If we are inventive enough we may even be able to avoid a repeat of the 'battle of the tobacco industry versus the rest of the world', and engage the food industry in promoting health without a head-on confrontation.

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## Appendix

### Organisations supporting workplace wellness

Examples of the growing number of organisations and networks supporting workplace health promotion and wellness, particularly in the United States and the United Kingdom include:

- The Wellness Councils of America, WELCOA ([www.welcoa.org](http://www.welcoa.org)), is a US non-profit membership organisation dedicated to promoting healthier lifestyles for all Americans, especially through health-promotion initiatives in the workplace. WELCOA rewards member organisations that forge new ground by linking health-promotion objectives to business outcomes.
- Partnership for Prevention ([www.prevent.org](http://www.prevent.org)) is a US non-profit, non-partisan organisation dedicated to offering evidence-based recommendations to shape health-promotion and disease-prevention policy decisions. One initiative is the 'Leading by Example' programme, where CEOs leading best-practice approaches make the case for integrating health promotion and disease prevention in business strategy.
- Health Promotion Advocates ([www.healthpromotionadvocates.org](http://www.healthpromotionadvocates.org)) is a broad coalition of professional associations, healthcare organisations, advocacy groups, educational organisations, employers, federal/state/county departments and individuals. The aim is to make health promotion an integral part of all elements of society, including workplaces.
- Corporate Health and Performance (CHAP), a UK charity, funds research demonstrating that it is profitable for businesses to provide their employees with health-promotion services. Members include BP, GlaxoSmithKline, Bristol University, King's

College Hospital, London Underground, Hewlett Packard, PriceWaterhouseCoopers and Unilever.

- Business Action on Health, a UK programme initiated by Business in the Community ([www.bitc.org.uk](http://www.bitc.org.uk)), aims to support business in improving their impact on employee health and well-being, and to establish reporting on health.