

The law and chronic disease prevention: possibilities and politics

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Legislation has the potential to reduce chronic disease, but political will and leadership are essential

If the law required restaurants to tell you the total calories and the grams of saturated fat, *trans* fat, carbohydrates and salt in the food you order, would it make a difference to your food choices?

The California legislature thought so. In September 2007, it passed a law requiring food facilities with 15 or more outlets to prominently display nutritional information for all fixed-menu food items, together with the statement: "Recommended limits for a 2000 calorie daily diet are 20 grams of saturated fat and 2300 milligrams of sodium".¹ The Bill was hotly contested by the food industry and subsequently vetoed by Governor Schwarzenegger.² New York City, meanwhile, recently reintroduced its own restaurant labelling law, which requires calorie information to be displayed in a typeface as large as the price.³

Although governments are increasingly using legislation in innovative ways to support the prevention of chronic disease, the law's role remains controversial. The food, tobacco and alcohol industries have lucrative markets to protect, and there is a pervasive assumption that the solution to galloping rates of obesity, diabetes and other lifestyle diseases lies in individuals exercising greater self-control. But preaching self-control will not work if healthy choices are constantly being undermined by other, more powerful influences. While the law is not a complete answer, it can help to create supportive environments for changing the average behaviour of populations.

Successful tobacco control programs illustrate this point. Success has not come by merely insisting that smokers exercise more will-power. Nor have laws been drafted with the aim of persecuting smokers or seeking to micromanage their lives. Instead, tobacco control laws have taken a population focus: addressing the price of tobacco through taxation and regulating businesses through laws that dictate smoke-free environments, point-of-sale controls, advertising restrictions and warning labels. This has resulted in conditions that discourage people from starting smoking and better support of individual attempts to quit (eg, the Quitline).

The law and behavioural risk factors

Laws can influence the behavioural risk factors for chronic disease at three distinct levels:

1. First, by better supporting interventions led by health care providers. Although Medicare now covers a range of allied health services aimed at improving care for chronic diseases,⁴ the challenge remains to design incentives for preventing such diseases in primary care,⁵ building on Lifescripts (tools for general practitioners to use when providing lifestyle advice to patients)⁶ and the new Medicare item for a health check for chronic disease risk factors at age 45 years (Medicare Benefits Schedule item 717).⁷
2. Laws can seek to change behaviour directly. In the United States, federal regulations permit health insurance premium discounts for people who control their weight and other lifestyle risks.⁸⁻¹¹ In Australia, this approach would have the risk of creating disincentives to private health coverage and increasing the burden on Medicare.

3. Laws can influence risk factors by addressing the social, economic and environmental influences on lifestyle choices (Box 1).^{12,13} While this is where we see the best opportunities for the law, the combined weight of multiple legal interventions will be needed if our aim is to slowly reverse broad population trends.

Information policies

Information is a powerful tool for fighting chronic disease. Laws can mandate the provision of information to consumers and, more controversially, can restrict advertising to consumers. Consumers have difficulty understanding the significance of nutrition information. Despite this, we still lack nationally agreed and standardised criteria for a front-of-pack, readily understandable labelling scheme to flag products that are high in saturated fat, salt and sugar. The United Kingdom's "traffic-light" labelling system uses visual signposts (red, amber and green) to flag these levels in food (Box 2).¹⁴ This approach is simple to use, in real time, in supermarket aisles. Food labels can also support healthy choices by showing the amount of fat, sugar and salt as a proportion of the daily recommended intake for a normal adult. In takeaway food outlets, appropriate labelling might alert customers that the "large meal deal" delivers 52% and 77%, respectively, of the average daily energy intake for men and women.¹⁵

A "child protection" model is evident in the UK, where the Office for Communications has banned the advertising and promotion of foods with high levels of salt, sugar and fat in television programs likely to appeal to children. Some states in the US are using the law to improve the nutritional quality of food sold in schools. Any serious attempt at regulation in this area must also confront the increasing complexity of food advertising, encompassing television, the Internet, mobile phones and print media.¹⁶

The built environment

While improvements in the built environment could facilitate and encourage physical activity, the legal processes for making these

1 How the law can improve the health of populations^{10,11}

The law can influence behavioural risk factors for chronic disease through:

- **health infrastructure and governance:** improving the quality and implementation of public health policies and programs through agencies that have a clear mandate to follow the evidence and to engage with stakeholders across all sectors;
- shaping the **information environment** and creating "information assets";
- taxing, spending, making grants, **subsidising and creating economic incentives;**
- designing and altering the **physical and built environment;**
- **economic policies** addressing the socioeconomic gradient: confronting and addressing health inequalities; and
- **command and control regulation:** directly regulating persons, professionals, businesses and other organisations. ◆

changes are not well understood.¹⁷⁻¹⁹ Many aspects of the built environment are shaped by zoning and planning policies and laws, and all levels of government have a role to play. The possibilities go well beyond using the law to create mixed-use neighbourhoods that encourage walking and cycling and that are well integrated with public transport. For example, in the US, zoning laws have been used to “thin out” the density of fast food outlets.

Economic policies

The workplace is an important setting for interventions to reduce lifestyle risks. In the US, employer-funded health insurance coverage, which includes chronic disease prevention, is seen as central to reducing rising care costs.²⁰ There are proposals before Congress to deepen this trend by partial tax relief for companies offering prevention programs that meet specified criteria.²¹ While Australian employers do not have the same responsibility for employees' health insurance, the opportunity remains for Australian companies to improve productivity and reduce absenteeism by investing in workplace health promotion and disease prevention programs.²² Tax relief for companies that invest in employee wellbeing could encourage this. Other economic policies include taxing unhealthy foods to raise revenue for health promotion initiatives or to create price disincentives for overconsumption of these foods.

How can this come about?

Successfully addressing the broader influences on lifestyle will require policies that engage with the food production system, address public health nutrition, the built environment, transport and urban development, key settings such as schools and the workplace, and issues like food advertising and taxation. No health department, state or federal, is currently mandated to begin doing this. Successful coordination of policies across multiple sectors requires governance structures that can rise above the boundaries and entrenched cultures of existing bureaucracies and agencies, and a clear legal mandate to get things done. The central choice is between politically owned structures with cabinet-level leadership and independent-of-government agencies with clear powers and cross-sectoral reach. Either could work, but the point is that current structures are failing.^{23,24}

Australia has a brand new federal government with a clear mandate for policy change. Will it maintain the reactive model of its predecessors — directing all its resources to disease treatment by the health care sector — or opt for a more preventive approach that engages with the socioeconomic and environmental determinants of health and illness? Most importantly, will it grasp the nettle and establish a national overarching structure — with adequate funding, support and leadership from the highest levels — to make effective intersectoral and interagency action a reality? Or will we be left, yet again, with only the rhetoric?

Competing interests

None identified.

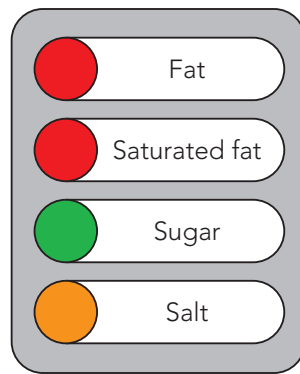
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2 Traffic-light food labelling¹⁴



This traffic-light label shows the shopper, at a glance, that the labelled food is high in fat (> 20%), particularly saturated fat (> 5%), but low in sugar (< 5%) and moderate in salt (0.3–1.5%). ◆

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