Health at all costs?

How health-first paternalism is promoted by government to corrode choice

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December 2013

Institute of Public Affairs
THE VOICE FOR FREEDOM
70 YEARS: 1943-2013

Executive summary

- Public health policy has broadened from traditionally indiscriminate and/or communicable risks to the health of the population toward discriminate and/or non-communicable risks to the health of the population.

- The broadened definition has created a 'health-first paternalist' approach to public policy that prioritises health above traditional public policy considerations, including the rights of individuals and human rights, when they are in conflict with health priorities.

- Under this model, state sponsored universal healthcare and the subsequent costs to public finances have justified government regulation of any behaviour detrimental to health.

- Approaching public policy from a 'health-first paternalist' perspective leads to freedom and human rights being expensive and dispensable when they are in conflict.

- Even when 'health-first paternalist' policy options fail, they are still advocated for because the potential for health benefits outweigh any perceived costs.

- Since 2008 the Commonwealth has funded at least $100 million of research that can be used to justify 'health-first paternalist' policies, though this paper doesn't assess the research's merit.

- Government increasingly funds research and advocacy from the 'non-government' sector to advocate for 'health-first paternalist' policies, including through grant funding criteria.

- Both the government and 'health-first paternalist' advocacy groups see the role of government funding to as helping build the public case and evidence-base for the introduction of 'health-first paternalist' policies.

- The targets of 'health-first paternalist' policies are designed to reduce consumption of alcohol, gaming, tobacco products and unhealthy foods.

- 'Health-first paternalist' policies designed to target tobacco are now being replicated on gaming, unhealthy food and alcohol with questionable evidence of their merit or efficacy.

- 'Health-first paternalist' policies justified with research is based on:
  - Questionable 'social costs' studies of individual behaviour that concludes there are significant public and private costs to people's freedom.
  - Risk inflation research that shows that behaviours lead to increased risks of cancer, or that they have equivalent addiction rates to illicit substances (This paper does not seek to dispute whether they are accurate, only identify the intention to highlight these risks).

- Some research is showing poorly designed 'health-first paternalist' policies are driving consumers to consider or engage in substitution, such as higher volumes of cheaper products and illicit drugs.

- As outlined in Figure 1, 'health-first paternalist' policies are self-reinforcing: if a policy is effective it should be followed up with a stronger policy because it is effective, if it fails it should be followed up with a stronger policy so that it is effective.

- Public funding for 'health-first paternalist' research is its own self-reinforcing cycle with advocates arguing for policy action by government off the back of government-funded research that was introduced as part of government policy action.

Figure 1 | Self-reinforcing nature of 'health-first paternalist' approach to public policy

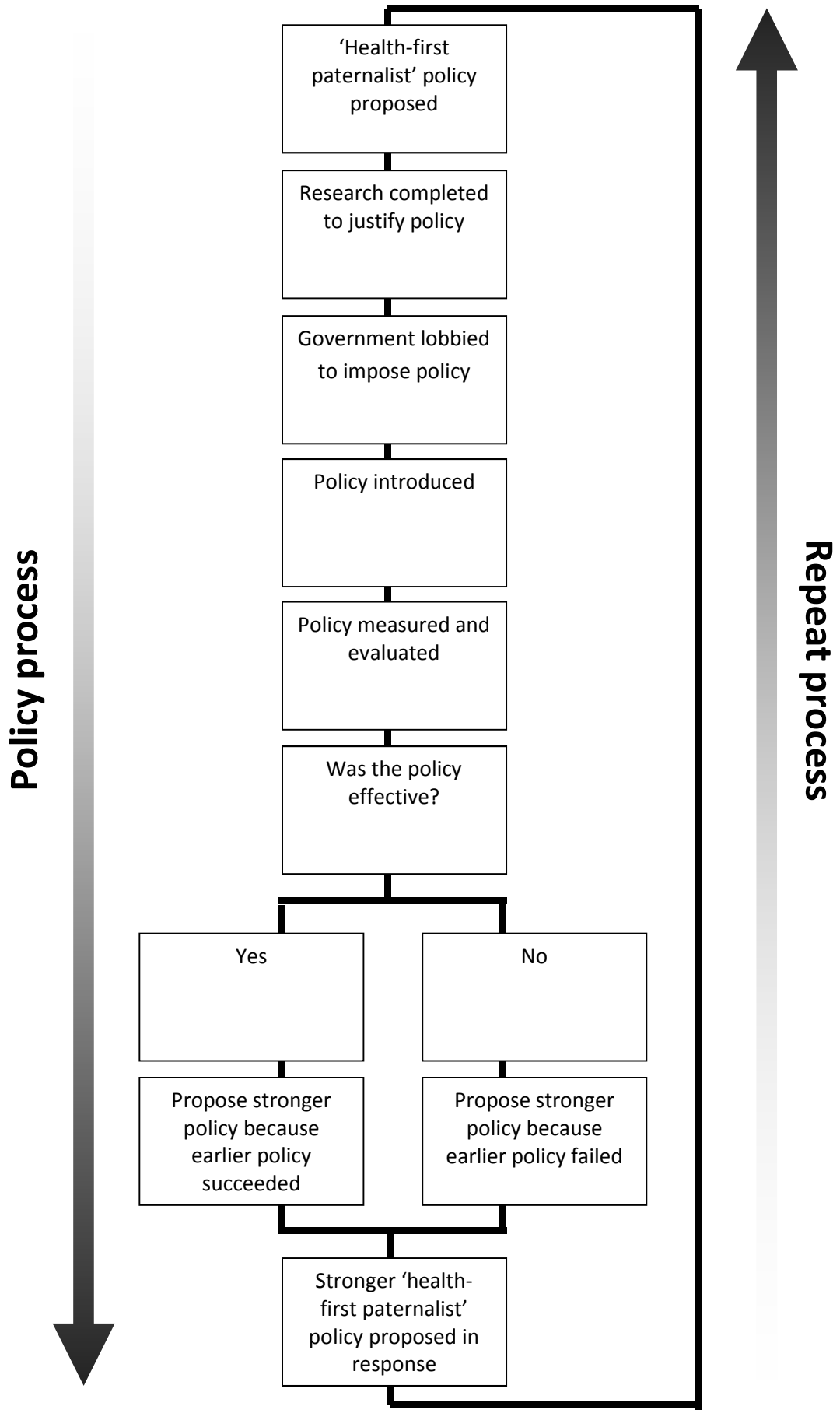


Table of contents

Abbreviations & glossary

ANPHA	Australian National Preventative Health Agency
EDNP	Energy-dense, nutrient-poor
EGMS	Electronic gaming machines
GST	Goods and services tax
NHS	National Health Service

1.0 Introduction

Rising health costs under state sponsored universal healthcare systems is placing increasing pressure on public finances. These costs are being influenced by multiple drivers, including technology, longer life expectancy, curing communicable diseases that lead to health consequences from non-communicable diseases, lifestyle factors and an ageing population.

In response governments are looking at policy action to reduce costs, notably through preventative health measures that prioritise health above other traditional freedoms.

Notably, there is a growing body of research published that is designed to inform and steer debate in favour of government action to introduce preventative health measures. This research regularly seeks to target behaviours such as eating unhealthy food, drinking alcohol and gambling. The research seeks to replicate the measures used to reduce tobacco consumption on unhealthy food, alcohol and gaming.

This research paper looks at the policy approach taken towards research that emphasises health as the most important public policy priority ahead of other, competing priorities.

In critically analysing this approach the paper will look at the nature of this research. In particular this paper will look at the inter-relationship between the principle supporters of this research – government – and the researchers and advocates who benefit from government support.

This paper will also look at how this support influences public policy and the consequences for policy making and government.

2.0 The changing health policy landscape

The perceived role of government, and consequently public policy, in Western liberal democracies has changed significantly over the past century.

In broad terms the nature of public policy debate has traditionally been between individual freedom and empowering the state to promote greater equity. Because an increase in the role of government necessarily came at the expense of individual freedom, these objectives were in contest across all areas of public policy.

Fitting within the Western liberal democratic tradition, Australia had an ongoing contest between liberal-conservatism that encouraged individual empowerment and responsibility, and social democracy that focused on limited state empowerment as both a provider and agent to promote societal and economic equity.

Communism's demise and the perceived failure of collective governance to provide the best framework for societal governance left classical liberal ideas of the primacy of individuals as dominant. Throughout the 1970s, 80s and 90s liberalism led to privatisation of previous state assets and services, the revitalisation of classical liberal economics and political philosophy.[1]

The evolution of globalisation and the more free movement of trade and capital, and the emergence of significant multinational corporations, have undermined the nature of traditional state sovereignty and local expectations of company loyalty to the country they were based in.[2]

In response the state has changed from being the dominant agent as provider to the regulator of both individuals and enterprise. This change is sometimes referred to as the regulatory state.

But the development of a regulatory state has led to the role of government being fundamentally redefined from an agent designed to secure the freedom of individuals, to one that regulates behaviour based on the collective good. This is particularly prevalent in health.

2.1 Heavy demands on public finances

Resulting from policies introduced in Australia, especially in the 1960s and 1970s, the state became the funder and provider of certain social and welfare services, particularly in health. The establishment of Medicare as a state sponsored fund to address issues of equitable access to health services has shifted much of the cost from individuals to the state. Following the intent behind Britain's National Health Service (NHS), the ideal was to ensure that every person had access to a full suite of essential health services to have a healthy population.

But with rising costs and expectations, our current mode for the delivery of universal health has become a threat to sustainable public finances.

Like with the NHS, expectations of the type and extent of service provision has continued to expand and placed higher costs on public finances. These increased costs are being driven by a range of

[1] Berg, C. 2008. "The growth of Australia's regulatory state: Ideology, Accountability and the Mega-regulators". Institute of Public Affairs. Available at http://ipa.org.au/library/publication/1207807254_document_berg_regulation.pdf.

[2] Majone, G. 1997. "From the Positive to the Regulatory State: Causes and Consequences of Changes in the Mode of Governance". Journal of Public Policy. v17. n2. May – August 1997.

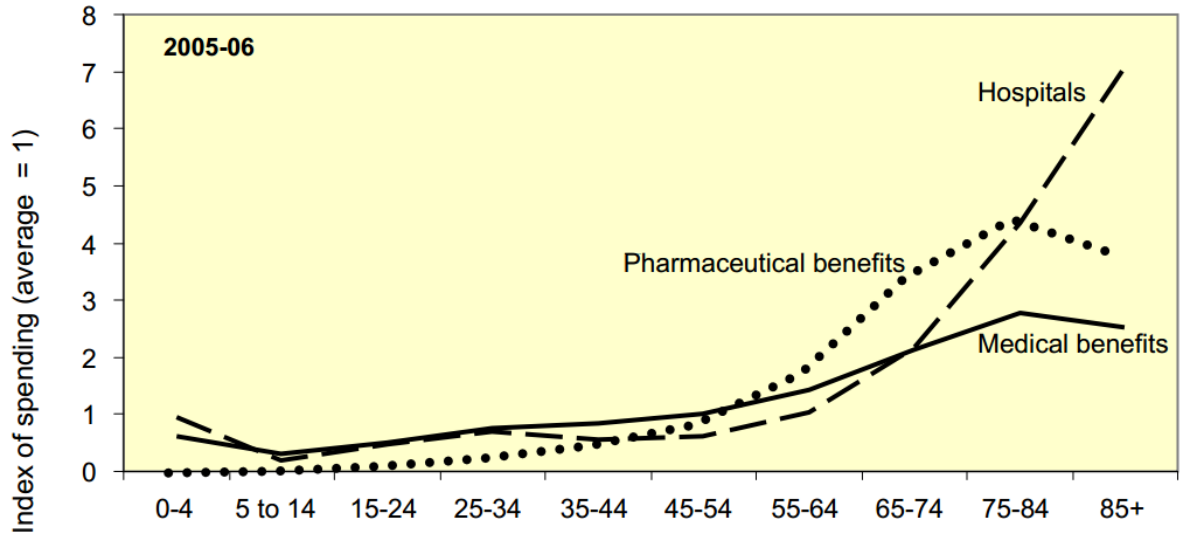
factors including technology, longer life expectancy, curing communicable diseases that lead to health consequences from non-communicable diseases, lifestyle factors and an ageing population.

Government data now shows the long-term risks to public finances based on this model. According to the Commonwealth Treasury's latest Intergenerational Report, *Australia to 2050: future challenges*, total healthcare expenditure is set to increase three and a half times by 2050.[3]

There are many factors influencing this trend, most prominently an ageing population that ensures an increasing number of people will not be workers and active taxpayers at the same time they are likely to be partially, or wholly, dependent on an aged care pension, state-funded housing and require access to the public health system during the most expensive time in their lives.

An ageing population is particularly concerning because of the disproportionate burden an ageing population puts on public expenditure. A Productivity Commission report analysis found that health expenditure for persons above the age of 65 are three times higher than persons under 65.[4] The same analysis found that the Pharmaceutical Benefits Scheme (PBS) costs for Australians aged between 65 and 74 are twenty times greater than a person aged 15 to 24.

Figure 2 | Health costs rise steeply with age



Source: Productivity Commission. 2008. "Health costs and policy in an Ageing Australia". Commonwealth of Australia. Available at http://www.pc.gov.au/__data/assets/pdf_file/0011/81758/cs20080701-agedhealthpolicy.pdf

This data provides an overall glimpse at the known risks to public finances from the health budget already. These costs are particularly concerning considering the percentage of Australia's population aged 65 and over will increase from 3 million in 2010 to 8.1 million by 2050, and as a share of the population from 11.7 per cent to 17.6 per cent.[5]

[3] Commonwealth Treasury. 2010. "Australia to 2050: future challenges". Commonwealth of Australia. January 2010. Available at http://archive.treasury.gov.au/igr/igr2010/report/pdf/IGR_2010.pdf.
[4] Productivity Commission. 2008. "Health costs and policy in an Ageing Australia". Commonwealth of Australia. Available at http://www.pc.gov.au/__data/assets/pdf_file/0011/81758/cs20080701-agedhealthpolicy.pdf.
[5] Commonwealth Treasury. 2010. "Australia to 2050: future challenges". Commonwealth of Australia. January 2010. Available at http://archive.treasury.gov.au/igr/igr2010/report/pdf/IGR_2010.pdf.

The concern, in addition to the ageing population, is the economic productivity of non-Baby Boomers. The capacity for Australians under the age of 65 to support the tax base to finance the cost of the Baby Boomers will be stretched. Concurrently it will be in the collective interest to keep Australians under the age of 65 active and healthy to reduce their health expenditure at a time when the public health system will already be under significant strain. Consequently there has been an increasing focus on national productivity and the need for skilled migration to fill the gap to increase the working and taxpayer-paying population to finance health and other costs of Baby Boomers.

Consistent with the evolution of a regulatory state model, the response from government is how to design policies and laws that seek to steer the behaviour of individuals towards healthier lifestyles.

Supported by the argument that 'prevention is better than a cure,' preventative health measures are assessing how to improve the habits of society-at-large to keep them healthier for longer and reduce expenses onto the health system. On the assumption that a dollar invested in preventative measures can reduce health expenditure by nearly six dollars, the economic benefits of promoting preventative health measures for a public health system are obvious. And while the economics of prevention may stack up, there is little doubt that people's general preference is to live longer and healthier lives.

Consequently the focus of government policy has shifted toward finding ways to reduce demands on the public health system through preventative action. Like earlier research that shows the benefits to health systems through the use of pharmaceuticals to cure, prevent or manage conditions in place of alternative, more-expensive treatments,[6] research is now focusing on preventative health to reduce costs to the health system.

2.2 The use of evidence-based policy

In responding to the risks to public finances from rising government expenses, there has also been a shift in the approach of the development of policy. Traditionally policy has assessed proposed government action, weighing competing interests between the individual and the collective ambitions of the state. The political and philosophical values of governing parties have influenced the questions asked, the solution provided and the weighting that evidence receives. The role of evidence is to inform policy, not direct its outcomes. But under the regulatory state model technocratic solutions are sought based on evidence to decide policy action.

The evidence-based policy approach to developing policy arguably achieved its heights under the former British Blair and Brown governments that championed the evidence-based approach.[7] It has also found support in the former Rudd and Gillard governments.

The problem with the evidence-based policy approach is that it has a very loose definition. As identified by Ray Pawson "there is no such thing as evidence-based policy."[8] However, as Pawson also identified the definition of it comes from Donald T. Campbell who argued in 1969:

> "The United States and other modern nations should be ready for an experimental approach to social reform, an approach in which we try out new programs designed to cure specific

[6] Kass-Bartelmes, B. & Bosco, L. 2002. "Reducing costs and improving outcomes". Agency for Healthcare Research and Quality. Available at http://www.ahrq.gov/research/findings/factsheets/pharmaceutical/rxtherapies/index.html#newexpensive.
[7] Davies, H. T. O., Nutley, S. M. & Smith, P.C. [Eds]. 2000. "What works? Evidence-based policy and practice in public services". University of Bristol. United Kingdom.
[8] Pawson, R. 2006. "Evidence-Based Policy: A realist perspective". Sage. London. United Kingdom.

problems, in which we learn whether or not these programs are effective, and in which we retain, imitate, modify or discard them on the basis of their apparent effectiveness on the multiple imperfect criteria available. Our readiness for this stage is indicated by the inclusion of specific provisions for program evaluation in the first wave of the 'Great Society' legislation and by the current congressional proposals for establishing 'social indicators' and 'data banks'".[9]

More recently, an evidence-based policy approach has been perceived as a "pragmatic, anti-ideological" to policy development. Government agencies have become a support of this model for policy development because it is technocratic and diminishes the importance of political values.[10] In the Australian context evidence-based policy is largely a fad since the election of the first Rudd government in 2007.

Kevin Rudd once outlined his approach to evidence-based policy in response to a question about raising the legal alcohol drinking age from 18 to 21 on ABC1's *Q&A*:

"[Questioner]: The Australian Medical Association in Queensland has said that 100 lives a year could be saved if we lifted the legal drinking age to 21, the same as it is in the US. Teenagers start driving when they're 18. Coincidentally, this is the same age as the legal drinking age in Australia. Mr Rudd, have you ever considered lifting the minimum legal drinking age in Australia?

…

Kevin Rudd: **I believe in something called evidence-based policy, which is if the evidence is there and it's capable of being proven that it works, then we look at these things and make a decision.** But you're asking me for a personal impression. You don't run policy that way, Tony.

…

Well, you don't. You actually - if you're doing the serious thing, how many of you are in the category of 18 to 21 here? Okay. How many of you want the drinking age raised to 21. Okay. Well, I'm just saying there's got to be a debate about this and it would be an informed debate if we had evidence in front of us which said you do this in State X of the United States and the overall car accident rate and mortality on roads goes down. But I don't have that in front of me.

Tony Jones: So it's an interesting experiment though, policy by popularity. That's - I actually haven't seen that done before.

Kevin Rudd: No what I mean is if you've got some evidence based policy, is it a uniform view in the community, point one. Point two, is it effective?"[11]

[9] Campbell, D. T. 1969. In Pawson, R. 2006. "Evidence-Based Policy: A realist perspective". Sage. London. United Kingdom.
[10] Pawson, R. 2006. "Evidence-Based Policy: A realist perspective". Sage. London. United Kingdom.
[11] Australian Broadcasting Corporation. 2010. "Q&A Episode 1: The PM on Q & A". 8 February 2010. Available at http://www.abc.net.au/tv/qanda/txt/s2811552.htm#transcript.

Like in the UK, the Australian approach to evidence-based policy is a technocratic approach to government where issues are raised and evidence is then used to justify a policy response with a general indifference to the impact it has on the foundation values of our society.

The evidence-based policy approach sits comfortably with the regulatory state model of governance. Under the model, societal harm can be identified, research can be conducted to assess different policy responses and a regulating government can then take policy action.

The evidence-based policy approach also brings with it the intent to reduce criticism of policy proposals. Essentially, by arguing that evidence is the basis of the policy decision, it allows criticism to be dismissed either as absent evidence, or with irrelevant evidence. An evidence-based policy model also assumes there is a linear relationship between evidence and policy outcomes. This assumption has rightly faced some criticism in the health policy community.[12]

Arguably the clearest statement of the comfortable fit between evidence-based policy and the regulatory state results from the idea of libertarian paternalism, or 'nudge' theory. The concept evolved from the Western liberal democratic model that government should protect the freedom of the individual, but that a technocratic, regulatory state is justified in using policy to 'nudge' individuals into preferred behaviour informed by evidence. Nudge theory loosely preserves and protects individual choice, but also uses taxes, regulations and legislation to make government-identified undesirable behaviours less attractive and more difficult than their preferred alternatives. A classic example of nudge through is taxing unhealthy food at a higher rate than healthy food, but avoiding an outright ban.[13]

[12] Black, N. 2001. "Evidence based policy: proceed with care". British Medical Journal. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1120888/.

[13] Thaler, R. H. & Sunstein, C. R. 2009. "Nudge: Improving decisions about health, wealth and happiness". Penguin Books. United States of America.

3.0 Public health and the use of evidence-based policy

Public health policy has been developed for millennia by different civilisations. In the tussle between the role of the state and the rights of individuals there is no dispute that there is some role for government action to protect the general health and wellbeing of the population against indiscriminate health risks.

In ancient civilisations this was achieved through early measures to respond to the indiscriminate health hazards to the public from environmental pollution and sanitation. In modern history it has focused on the indiscriminate spread of communicable diseases. [14] In a contemporary context public health has shifted from indiscriminate threats to health, to the sociological and non-communicable factors determining poor health outcomes amongst the general population. The broad division appears in Table 1.

Table 1 | A select, broad grouping of past and current 'public health' challenges

Traditional public health challenges	Contemporary 'public health' challenges in a developed country
Disease epidemics, particularly communicable diseases. **Environmental pollution**, particularly resulting from industrial activity. **Quarantine**, particularly the spread of disease. **Sanitation**, particularly from the lack of housing and waste disposal/sewage systems.	**Health problems**, particularly non-communicable diseases. **Alcohol consumption**, and associated consequences. **Gaming and gambling**, particularly through the use of pokie machines. **Obesity**, through the consumption of energy-dense, nutrient poor food and a lack of physical activity. **Smoking**, through the consumption of tobacco products.

In response, public health policy has shifted from addressing policy challenges that indiscriminately harm the population, such as the absence of sanitation or epidemics, towards policy challenges that impact across the population based on their own conduct and may have an impact on society-at-large. Some have taken it further to include just about any policy measure that may prevent an undesirable health outcome, such as laws against domestic violence, though such an extreme definition does not appear to be common.[15]

The adoption of a sociological approach to the inclusion of discriminate health challenges in the public health model has resulted from the use of sociology and a disease-model to justify the challenges as indiscriminate.[16] For example, while obesity is generally caused by individuals consuming more energy than their body exerts, a sociological approach is used to justify conduct based on environmental factors including that individual's socio-economic status, the operating commercial environment, their physical environment and constraints that prompt their behaviour. Doing so effectively neuters the individual as a responsible agent of their own health, and instead a

[14] Rosen, G. 1958. "A history of public health". John Hopkins Press. United States of America.
[15] Chapman, S. "One hundred and fifty ways the nanny state is good for us". The Conversation. Available at http://theconversation.com/one-hundred-and-fifty-ways-the-nanny-state-is-good-for-us-15587.
[16] Keane, M. 2011. "Should public health experts stop us from consuming products". Australian Medical Association. Available at https://ama.com.au/media/should-public-health-experts-stop-us-consuming-products.

victim of societal factors. In short, external factors are deemed to overwhelm their capacity to choose and potentially accept responsibility for their actions.

Justified in this broadened approach to public policy there has been the emergence of policy that places health as the most important factor above other traditional public policy considerations.

Sitting comfortably with the complimentary evidence-based policy approach that provides data and justification for government policy action to promote health, the approach has been dubbed 'healthist' by New Zealand academic and economist, Eric Crampton. However 'healthist' only loosely infers the paternalist nature of these policies, so in this paper the term 'health-first paternalist' or 'health-first paternalism' is used instead, but the intent is essentially the same.

Crampton is not the only one who has identified this new trend in policy development. Recently Crikey journalist, Bernard Keane, argued that:

> "The medical profession and the growing, taxpayer-funded preventive health industry are engaged in a constant campaign against basic rights in the name of forcing Australians to become healthier. Media coverage of the campaign is episodic and sporadic. But pieced together, the nature of the campaign becomes clear".[17]

Keane identifies that there is an impact on an individual's basic rights and freedoms from a 'health-first paternalist' agenda, but there is a broader problem surrounding the very nature of policy design and implementation for public health policy.

The model for 'health-first paternalist' policy is based on the idea that government action is justified to make us healthier. Once introduced a policy is either successful and consequently justifies the policy and then for further action to be taken, or it fails justifying further policy action because it is ineffective. In essence, 'health-first paternalist' policy is only about how, when and at what rate policy is imposed, not the relative merits of the perceived goal.

The problem with the evidence-based policy approach is that it ignores the role of values in informing the public policy issues considered worth tackling and how they should be addressed. Taking the example faced by Rudd, should the evidence show that raising the alcohol drinking age from 18 to 21 may save 100 lives annually, it raises a whole series of questions, including:

- Does potentially saving the lives of 100 persons outweigh the freedoms enjoyed by the remainder of adults who choose to consume alcohol?
- To what extent should we weight substitution from the legal consumption of alcohol to other legal and/or illegal products that deliver the same perceived 'benefits' of alcohol consumption?
- To what extent should we weigh the benefits of potential saved lives against making criminals of those over 18, but under 21, who decide to drink alcohol?

These are only a few example questions of potentially tens, if not hundreds, of legitimate questions surrounding welfare losses. Similar sentiments have been identified by James Whyte from the Institute of Economic Affairs, who wrote:

[17] Keane, B. 2012. "Dear preventative health wowsers: stop taking the piss". Crikey. 19/11/2012. Available at http://www.crikey.com.au/2012/11/19/dear-preventative-health-wowsers-stop-taking-the-piss/?wpmp_switcher=mobile.

> "A frequent error is to ignore the costs resulting from the policy. For example, minimum alcohol price plans do not consider the welfare losses associated with reduced consumption among recreational drinkers. The benefits of alcohol consumption, and hence the cost of reducing it, are simply ignored in the analysis".[18]

Values inform both the questions and how any evidence is weighted. From a 'health-first paternalist' perspective the assessment of these questions only comes down to how many lives are saved and/or extended. But even then challenges are faced as responsible alcohol consumption is deemed to have desirable social and health benefits – again – depending on how they are weighted against the alternatives.

In policy terms, asking the question – how many lives are saved by banning alcohol or junk food? – is as important as the answer provided. The proposed question has already made a value judgment that there will be a number that justifies limiting people's choices and freedoms for the sake of the ban. These judgements are informed by political considerations and attitudes of those who ask the question and their motivations.

A recent example that highlighted the questionable merit of arguing for "evidence-based policy" was a $463,000 research project funded by ANPHA to consider a "fat tax." Even before the research has concluded the policy measure had been ruled out by both the Liberal and Labor parties.[19] While the Danish experience showed a "fat tax" was ineffective, should the results of the Australian study show that a "fat tax" did help tackle obesity, alternative policy and political priorities already ensured it will not be introduced.

Similarly, the Australian National Preventative Health Agency released a draft report, *Exploring the Public Interest Case for a Minimum (Floor) Price for Alcohol*.[20] Following its release it attracted significant public attention and resulted in politicians ruling out the introduction of a floor price, essentially making the evidence worthless. Political parties did so because of competing concerns and political values that show deference to individual choice.

Importantly, a 'health-first paternalist' perspective changes the very nature of the individual and the state. In the broad Western democratic framework the role of the government is to provide a framework for individuals to go about their lives and enterprise freely so long as they do not unnecessarily harm others. This relationship between the individual and the state evolved out of classical liberal thinking around the role and nature of the individual and their human rights to free association, movement, property, religion and speech. The role of government is to protect and preserve these freedoms.

If Australia continues to support funding health from a universal state centric framework, a 'health-first paternalist' perspective essentially deems our freedoms and choices as too expensive.

[18] Whyte, J. 2013. "Quack policy: Abusing science in the cause of paternalism". Institute of Economic Affairs.
[19] Lewis, S. 2013. "Federal government backed study into fat tax on fast foods". News.com.au. Available at http://www.news.com.au/lifestyle/food/federal-government-backed-study-into-fat-tax-on-fast-foods/story-fneuz8wn-1226646283704.
[20] Australian National Preventative Health Agency. 2012. "Exploring the public interest case for a mimumum (floor) price for alcohol". Commonwealth of Australia. Available at http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/draft-report-minimum-price-alcohol.

4.0 A 'health-first paternalist' approach to public policy

For entirely understandable reasons, a 'health-first paternalist' approach to public policy has many attractions. Its intention to improve the health of individuals and the community-at-large.

In addition to the political concerns outlined above, there are fundamental problems with approaching public policy from a 'health-first paternalist' perspective, because:

- It becomes a self-reinforcing cycle of justified intervention by government into people's lives;
- It takes little account of alternate public policy objectives, including human rights; and
- It leads to unintended consequences that are ignored because they compromise a health-first outcome.

The self-reinforcing nature of a 'health-first paternalist' approach to public policy is particularly concerning. Public health policy research is not the same as traditional health research. In health research data is collected to support hypotheses.

Public health policy research conforms to public policy standards where evidence informs deliberations. But it ignores that values inform the issues raised and the potential framework for policy responses. Approaching public policy from a 'health-first paternalist' perspective has a structural flaw because all measures are essentially justified, irrespective of its efficacy. Rather than approaching public policy from a rational assessment of costs and benefits, essentially any measure that can improve the health of an individual is justified irrespective of whether it infringes on traditional policy priorities such as the rights of the individual or even equity. Through a 'health-first paternalist' framework, unintended consequences that emerge are also considered secondary except in the situations that they also have deleterious health impacts.

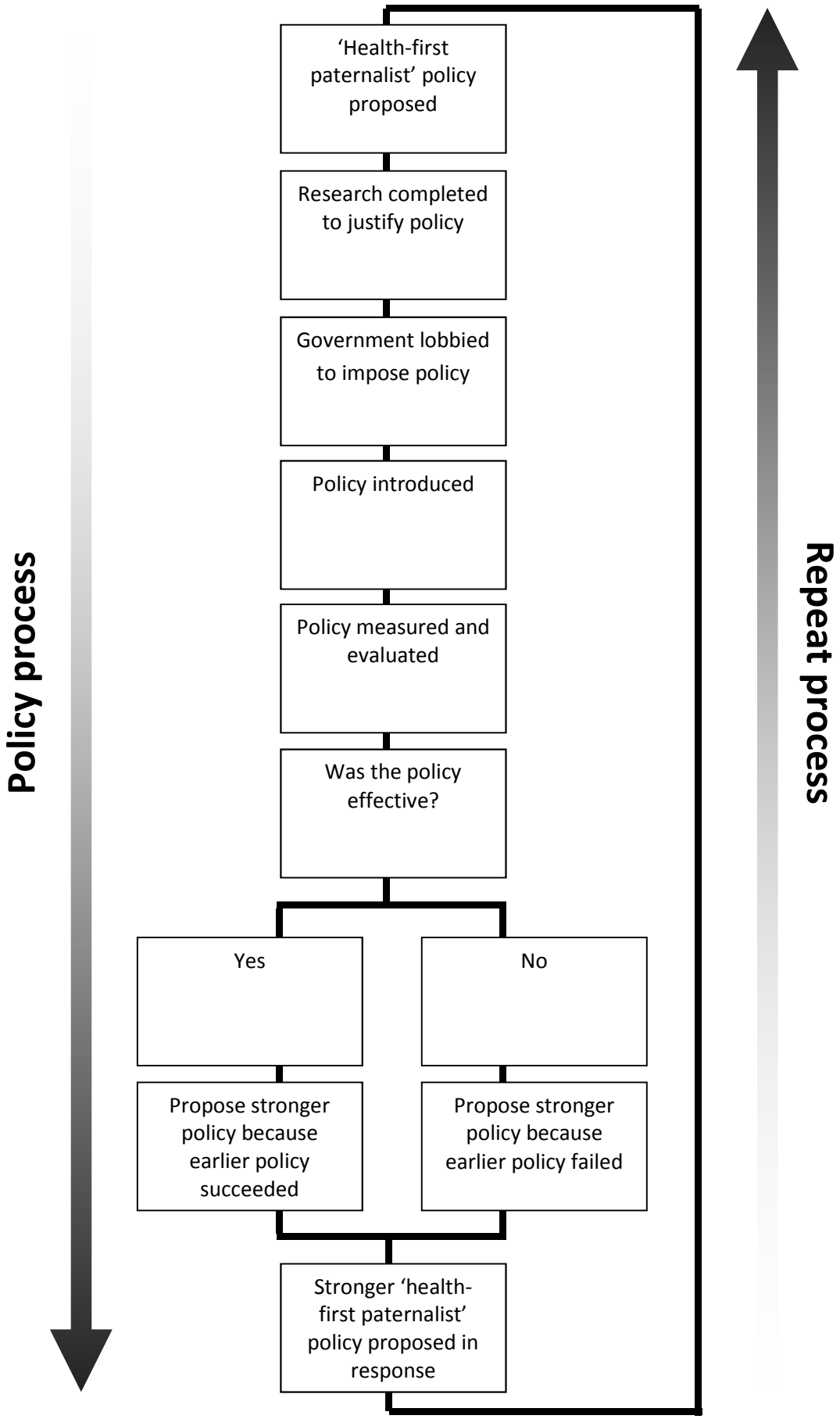
The structural flaw is outlined in Figure 3.

The basis of 'health-first paternalist' public policy is that ideas are proposed and justified with evidence-based research. Governments are then lobbied to introduce the policy, adopt it and introduce it. Following the policies' introduction its efficacy is measured and evaluated. If the policy is successful, it justifies further action. If it fails, further action is justified primarily because the existing policy is not strong enough. Regardless of the policy's efficacy stronger policy responses are then proposed and the cycle repeats itself.

The number of 'health-first paternalist' policies that are not successful, and should be repealed, but are not, are small. Despite the alcopops tax being identified as ineffective, it remains in place. The most notable example that runs contrary to the general trend was the repeal of Denmark's fat tax which was both ineffective and had considerable unintended consequences including higher prices on those least able to afford them.[21]

[21] ___. 2012. "A fat chance". The Economist. 17/11/2012. Available at http://www.economist.com/news/europe/21566664-danish-government-rescinds-its-unwieldy-fat-tax-fat-chance.

Figure 3 | Self-reinforcing nature of 'health-first paternalist' approach to public policy



Despite the failure of the Danish fat tax, it continues to be promoted as a solution to addressing issues surrounding obesity in Australia.[22] According to the Obesity Policy Coalition the introduction of a fat tax also needs to be complimented with the subsidy of health foods. These statements come in spite of Australia already having an operational 'fat tax' through the GST which taxes processed and cooked foods, while fresh food remains GST free.[23]

Table 2 | Current state of regulations surrounding consumer choice

Regulation / Measure	EDNP food	Alcohol	Gambling	Tobacco
Product-specific taxes	●	●	●	●
Advertising restrictions	●	●	●	●
Advertising bans	●	●	●	●
Sponsorship bans	●	●	●	●
Purchasing limits	●	●	●	●
Consumption restrictions	●	●	●	●
Text-based warning labels	●	●	●	●
Product placement restrictions	●	●	●	●
License retailers		●	●	●
Graphic warning / pictorial labels	●	●	●	●
Ingredient / feature restrictions	●	●	●	●
Plain packaging	●	●		●
Explicit pricing regimes (minimum prices)	●	●	●	●
Non-traditional age-access restrictions		●		●
Specific license to consume			●	●
Outright ban	●	●	●	●

Legend
- ● Legislated / Regulated / Self-regulated
- ● Considered by government
- ● Proposed in public debate or academic literature

Source: Institute of Public Affairs analysis.

The relatively linear nature of the imposition of 'health-first paternalist' policy is amply demonstrated in Table 2. Each measure – from additional taxes, advertising bans and consumption restrictions – is introduced on the grounds that it will improve people's health and deliver a benefit.

But individually no measure is a silver-bullet to deliver the objective of 'health-first paternalist' policy: it cannot ensure consumers only gamble responsibly and within their means, eat healthy,

[22] Kippist, L. 2012. "Will the fat tax for Australia work?". News.com.au. 12/11/2012. Available at http://www.news.com.au/lifestyle/health-fitness/copenhagens-out-will-the-fat-tax-work-for-australia/story-fneuzkvr-1226515115543

[23] Novak, J. 2012. "Nanny state taxes: Soaking the poor in 2012". Institute of Public Affairs. Available at http://www.ipa.org.au/library/publication/1335389416_document_novak_nannystatetaxes.pdf.

drink responsibly and give up smoking. As a consequence one measure is always followed with the advocacy of another measure designed to achieve the same broad objective as the earlier measure.

Each measure is proposed, progressively adopted and imposed through a form of self-regulation or explicit regulation.

The direction of the policy process is to essentially replicate existing proposals across all activities. In the group of the four goods and services identified (Table 2), tobacco is clearly the market leader, where regulatory proposals are developed, argued for and imposed. Out of those measures identified, only explicit minimum pricing, non-traditional age restrictions,[24] a specific license to consume and an outright ban have not been imposed on tobacco. Meanwhile many restrictions around branding and promotion and additional taxes have been. Gaming is the closest equivalent to tobacco with extensive regulations around how the public can engage with gaming, particularly the use of Electronic Gaming Machines (EGMs).

Concurrently, EDNP food and alcohol are starting to have similar measures proposed on products, before they are eventually adopted. For example, current labelling regulations are being considered by government for food products to warn consumers against the excessive consumption of fatty, sugary and salty foods – in addition to traditional health information panels.

Similarly, following the introduction of plain packaging on tobacco products, it is now regularly spruiked as a measure that could be imposed on energy dense, nutrient poor food and alcohol products, as well as ingredient restrictions such as the pre-mix of caffeinated and energy drinks with alcoholic products.

[24] Non-traditional age restrictions means increasing the age of access above the traditional age of 18. In the case of tobacco this takes the form of imposing licenses that can only be accessed by persons currently over the age of 18, and alcohol to increase the age of access to 21 or 25.

5.0 Government funding to justify government action

Advocates for 'health-first paternalist' policies are well within their rights to advocate for public policy outcomes based on their identified priorities and values. As outlined above, all public policy is informed and weighted based on the values of those who propose them. But unlike traditional non-government public policy actors that sit outside of government, 'health-first paternalist' public policy is generally heavily financed and supported by government raising questions about the conduct of government and those who advocate for government policy change.

There are numerous streams for public funding for 'health-first paternalist' research, including funding provided by the National Health and Medical Research Council, various strategy groups and the Australian National Preventative Health Agency (ANPHA). In fact, developing and financing research for obesity measures was a particular focus of the National Preventative Health Taskforce and its report *Australia: The Healthiest country by 2020*. According to the report a key measure of success for tackling its priority areas included:

> "A National Strategic Framework for preventative health research. A preventative health strategic research fund. A national preventative health research register".[25]

The influence of ANPHA is considerable. It received $58 million specifically to "driv[e] the national capacity for change and innovation around preventative health policies and programs."[26] Not all funding streams exist at the commonwealth level. There are also state based funding streams.

The grant process for securing funding from government is based on a series of identified priority areas that prompt research applications to follow government priorities. Following the establishment of ANPHA the nuance of policy priorities may change from year to year, but the focus will remain consistently on financing research on means to tackle alcohol, obesity and smoking.

By financing research exploring policy options for government action based on their priorities, the government is effectively buying conclusions from research institutes to justify their ongoing intervention.

There is no single figure that encapsulates the value of 'health-first paternalist' research being financed by the Commonwealth, or the states. However, based on publicly available commonwealth information on research that is financed principally from ANPHA and the National Health and Medical Research Council, at least $100 million has been provided for 'health-first paternalist' research since 2008. The list is provided in Annex 1.

Not all of this research will ultimately be used to conclude justifications for government action. However, they do help the government build the evidence base for action and intervention based upon the 'health-first paternalist' grounds because they are identified by government as priority areas. Meanwhile some are explicitly being used to promote 'health-first paternalist' policy agendas and explicit advocacy to build public support for government programs.

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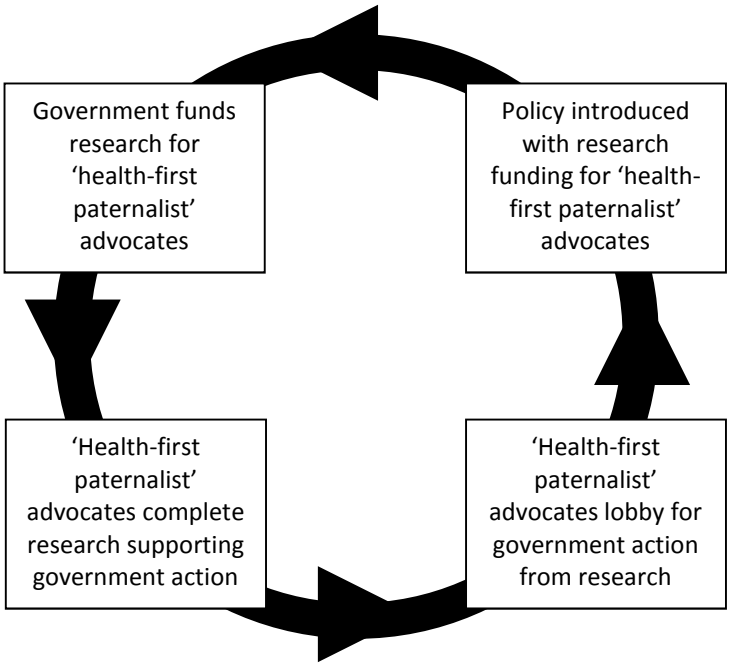
[25] National Preventative Health Taskforce. 2009. "Australia: The healthiest country by 2020: National Preventative Health Strategy – the roadmap for action". Commonwealth of Australia. Available at http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/CCD7323311E358BECA2575FD000859E1/$File/nphs-roadmap.pdf.

[26] Australian Medicare Local Alliance and Australian National Preventative Health Agency. 2012. "Joint statement on health promotion, disease prevention and Medicare locals". Available at http://www.amlalliance.com.au/policy-and-advocacy/?a=49545.

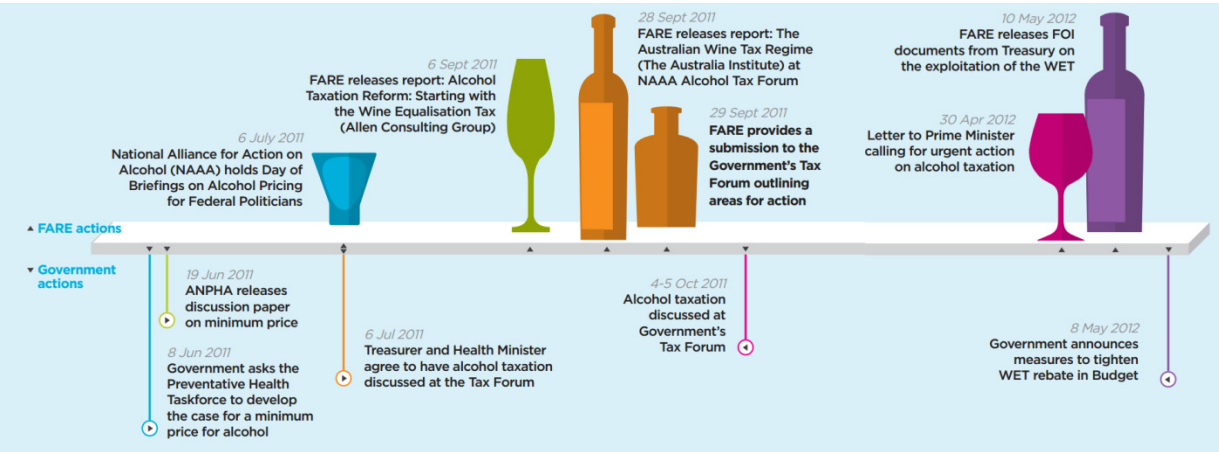
Compared to the linear design of 'health-first paternalist' policy development and implementation, the funding cycle for 'health-first paternalist' policy is similarly self-reinforcing. As outlined in Figure 4, the government funds research, that research justifies government action, the conclusions of that research are then used to lobby government for policy implementation that justifies further research and action.

Figure 4 | The cycle to support 'health-first paternalist' policy



It's important to understand that this is how advocates for 'health-first paternalist' policies see themselves. A clear example appeared in the 2011-12 Annual Report of the Foundation for Alcohol Research and Education. According to a timeline provided in the report (Figure 5), the Foundation maps its 'actions' against policy deliverables by the government drawing a direct correlation between their own activities and research, and changes in government policy consistent with the outcomes of their activities and research.

Figure 5 | FARE's measurement of organisational activities against policy changes



Source: Foundation for Alcohol Research and Education. 2012. "FARE Annual Report". Available at http://www.fare.org.au/wp-content/uploads/2011/07/47748-FARE-Annual-Report-2011-12_screenIndividual.pdf.

Equally, it is how government sees the role of research and advocacy from 'health-first paternalist' researchers. It is the intention of the government to finance 'health-first paternalist' advocates to advocate for government policy and intervention and to reinforce community perceptions about the government's approach. In the 2013/14 Federal Budget this intent was made explicitly clear. As part of the $250 million annual National Drug Strategy the *Substance Misuse Prevention and Service Improvement Grants Fund* will now directly finance advocacy for measures on consumption behaviour. According to the budget:

> "Through the Substance Misuse Prevention and Service Improvement Grants Fund, the Government will continue to invest in illicit drug and alcohol research. The non-government sector will also be supported to ensure a strong community voice on illicit drug and alcohol issues".[27]

Supporting advocacy for the government's policy objectives is confirmed in the Fund's application guidelines, which include:

> "Provide an evidence base for drug and alcohol policy through targeted data collection particularly in areas of emerging national concern; [and] support the development of national policy through providing support for national advocacy and representation of the drug and alcohol sector".[28]

The fund also lists as its priorities:

> **"Targeted data collection**
>
> Provide an evidence base for drug and alcohol policy through targeted data collection particularly in areas of emerging national concern.
> Potential activities. The Department may fund a range of activities that address this priority area, including but not limited to:
> - the conduct of data collection for specific population groups to identify trends that directly inform the government's policy priorities for alcohol and other drugs;
> - support for data collection into factors of mortality or morbidity that directly contribute to the evidence base for drug and alcohol use.
>
> **National advocacy and representation of specific groups**
>
> Support the development of national policy through providing support for national advocacy and representation of the drug and alcohol sector.
> Potential activities. The Department may fund a range of activities that address this priority area, including but not limited to:
> - support for the core funding of national bodies representing the drug and alcohol sector on matters of relevance to the government's priorities;
> - the provision of expert advice to Government on matters relating to drugs and alcohol (and their relationship to broader society).
>
> **Campaigns**

[27] Commonwealth Treasury. 2013. "2013/14 Budget: Budget Paper No 2". Commonwealth of Australia
[28] Department of Health and Ageing. 2011. "Flexible fund guidelines: Substance misuse prevention and service improvements grants fund". November 2011. Commonwealth of Australia. Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/F9E67232A04C91BDCA25794900169EDE/$File/SMPSIG%20Guidelines.pdf.

Prevent substance misuse and promote evidence based messages about alcohol and other drugs through credible and relevant information campaigns and early intervention activities. Potential activities. The Department may fund a range of activities that address this priority area, including but not limited to:

- targeted social marketing activity and development of key messages on the Government's priorities in alcohol and/or other drugs policy;
- other communications, information and/or social marketing activity to support prevailing Government priorities related to alcohol and/or other drugs".[29]

The consequence of this approach is that the government and 'health-first paternalist' researchers work constructively together using government-funded research programs to build the evidence-base to be used to lobby government for further government intervention, to advance 'health-first paternalist' priorities.

The influence of government financed organisations is not just limited to research. The role of government funded bodies now lobbying governments was outlined in an earlier IPA research paper, *The biggest vested interest of all: How government lobbies to restrict individual rights and freedom*.[30] The report specifically identified that around one-third of submissions to the National Preventative Health Taskforce that recommended the establishment of ANPHA, which subsequently received significant government funding that financed many of the groups that advocated for its creation.

[29] Department of Health and Ageing. 2011. "Flexible fund guidelines: Substance misuse prevention and service improvements grants fund". November 2011. Commonwealth of Australia. Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/F9E67232A04C91BDCA25794900169EDE/$File/SMPSIG%20Guidelines.pdf.

[30] Berg, C. 2013. "The Biggest vested interest of all: How government lobbies to restrict individual rights and freedom". Institute of Public Affairs.

6.0 The perfect marriage: evidence-based public 'health-first paternalist' policy

Providing an evidence-base to justify action under the broadened definition of public health policy provides ample opportunities for advocates for a 'health-first paternalist' agenda to advance their cause. The principle reason is that, under a universal healthcare model, any detrimental health impact automatically imposes costs on public finances, can be quantified and justifies government action.

As discussed earlier, the arguments for introducing paternalist policies are based on economic grounds and the costs of people's choices to public finances. Reinforcing the importance of the state over the individual, spokespersons from the Foundation for Alcohol Research and Education and the University of Wollongong wrote in a recent article the approach is based on "rational thinking" and that "there are social, health and economic arguments that justify acting to reduce the more than $10 billion a year cost to government".[31]

But the economic data often provided to justify these measures is often questionable through the use of "social costs". Social costs are not the same as costs to government. Costs to government generally involve the additional costs of a particular behaviour to public finances through the provision of goods and services such as the police and access to health services. Social costs include the broader cost to society and seek to quantify both public and private costs, including costs to private businesses as well as individuals.

In many cases these private costs may be accepted by the party that bears the cost and therefore it is dubious that they can be assessed as having a negative impact on society. As has been identified in research,[32] social costs often discount or ignore perceived benefits of individual choice which may rely on an entirely subjective assessment.

While deeply dubious, social cost calculations find a positive reception amongst governments seeking to justify their policy proposals. The National Preventative Health Taskforce's plans were justified on the grounds that the social cost of illicit drugs, alcohol and tobacco were $56 billion, a number the then Health Minister described as "staggering."[33] Based on social cost analyses (see Table 3) the estimated social costs of obesity, gambling, alcohol consumption and smoking is $109.5 billion annually, a number that is staggering and unbelievable.

Social cost studies are particularly useful if the objective of the modeller is to have as large a figure as possible to calculate, to exceed government revenue from taxing a particular product. For example, the social costs of alcohol are regularly promoted as $15 billion a year, but subsequent studies have found that the cost to public finances is closer to $4 billion which is closely aligned with the revenue raised from alcohol sales.[34]

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[31] Thorn, M. & Jones, S. 2012. "Alcohol control: preventative health response to alcohol problems". Crikey.21/11/2012. Available at http://www.crikey.com.au/2012/11/21/alcohol-control-no-nanny-state-conspiracy-preventive-health-lobby/.

[32] Crampton, E., Burgess, M. & Taylor, B. 2011. "The cost of cost studies". University of Canterbury. Available at http://www.econ.canterbury.ac.nz/RePEc/cbt/econwp/1129.pdf.

[33] AAP. 2008. "$56b social cost of drinking, smoking". Sydney Morning Herald. 09/04/2008. Available at http://news.smh.com.au/national/56b-social-cost-of-drinking-smoking-20080409-24pl.html.

[34] Kenny, C. 2011. "Social costs of alcohol 'are vastly inflated'". The Australian. 08/07/2011. Available at http://www.theaustralian.com.au/national-affairs/social-costs-of-alcohol-are-vastly-inflated/story-fn59niix-1226090176946.

The use of social costs also brings a broader governance question. By using social costs, and not just public costs, the choices of individuals are being interpreted through the lens of what is in the best interests of society. It is a method that essentially devalues the rights of individuals to live their own lives in favour of the community-at-large, and that the individual comes second to society overturning the foundations of the liberal democratic approach to governance.

Table 3 | Estimated annual "social costs" for Australia

Issue	Annual "social cost"
Alcohol	$15.3 billion
Gambling	$4.7 billion
Obesity	$58 billion
Tobacco	$31.5 billion

Sources: Deloitte Access Economics, Productivity Commission & Australian National Preventative Health Taskforce

The questionable nature of figures to justify evidence-based public health policy is not just limited to generous "social cost" assessments. According to Crampton, Burgess and Taylor "the 'healthiest' literature passes off headline costs as representing value … it assumes without evidence that consumption in excess of an epidemiological standard, or consumption that results in experienced probabilistic downside costs, is due to irrational decision-making … [and] cites assumed imperfections in rationality and information as reason to dismiss by assumption the existence of all economic benefits including enjoyment from such consumption."[35]

As identified by Crampton, Burgess and Taylor:

> "By presenting costs drinkers impose upon themselves as social costs to the country, [the cost of illness] measures … may help build popular support for paternalist policies. Embedding paternalism in the assumptions of the model rather than advocating paternalist policies directly appeals to voters' pocketbooks … voters take the cost measures as impartial measures of the cost they're called upon to bare due to others' actions and shift outward their demand for corrective measures." [36]

A 2011 study by the Australian National University's Harrison and Robson[37] follows on from earlier work from a 2009 Crampton study.[38] Both critiqued the general direction of public health cost-benefit analyses and drew conclusions that rigorous processes were not being followed to provide a balanced ledger of costs and benefits to assess the merits of proposed policies. Instead they argued that the reports suffered from a 'health-first paternalist' norm that prioritized their policy preferences against other weighted policy objectives. In essence a 'health-first paternalist' norm only counts the benefits of introducing desired policy objectives without a fair assessment of their costs and alternatives. In particular, Harrison and Robson, challenged the potential benefits of the 'health-first paternalist' prevention model stating:

> "But prevention might also be inefficiently *high*, especially where decision makers do not take into account the costs of the preventative effort. An obvious instance is when the

[35] Crampton, E., Burgess, M. & Taylor, B. 2011. "The cost of cost studies". University of Canterbury. Available at http://www.econ.canterbury.ac.nz/RePEc/cbt/econwp/1129.pdf.
[36] *Ibid.*
[37] Harrison, M. & Robson, A. 2011. "Prevention no cure: A critique of the Report of Australia's National Preventative Health Taskforce". Agenda. Australian National University. v18. n2. 2011.
[38] Crampton, E. 2009, "Nonsense upon stilts". Norml News. Spring.

person undertaking the prevention reaps the benefits but does not pay the costs. In some instances, this is simply because the costs are not fully priced: for example, when my purchase of a stronger bumper bar protects my vehicle, but at the expense of greater harm to the vehicles of others. Equally, if there are government subsidies that favour prevention over other health related goods and services (or if prevention is taxed relatively favourably compared to other health-related goods and services), then too much prevention may be provided and consumed. For example, if consumers have imperfect information and overestimate the probability of health risks of a certain product, then an inefficiently low amount of that good might be consumed. As the Taskforce focuses on the effects of policies on the health system, it ignores many of the costs of its policies. In particular, it does not recognise the very different policy relevance of private and external costs".[39]

Their study concluded:

> "The National Preventative Health Taskforce Report has bypassed the hard work that is needed to the make the credible cost-benefit calculations required for rigorous public policy analysis".

And the approach of the Taskforce can be digested into the following points:

1. "Certain activities create health costs — and, therefore, are judged to be automatically undesirable.
2. It automatically follows that there is a role for government to do something to discourage individuals from undertaking those activities.
3. The Taskforce then sets arbitrary targets for reductions in these particular activities.
4. The Taskforce then develops recommendations for policymakers to achieve those targets, without examining the social costs and benefits of those policies.
5. Finally, the Taskforce asserts, without evidence, that the policies that have been recommended will achieve these arbitrarily chosen targets".

6.1 Rhetorical risk inflation

What's become clear is that in recent years, as measures that can be taken against tobacco have been implemented and funding for further research has declined, researchers and activists have shifted to food, alcohol and gaming. For example, the Obesity Policy Coalition is headed by a former anti-tobacco advocate who is now seeking to translate their policy and activist experience onto food. This method was articulated by Keane who argued "the preventative health agenda for alcohol has been clear for some time: it's the remorseless demonization of the product, with the intent of doing to alcohol what was so successfully done to tobacco – to so discredit it that the community eventually supports draconian regulation to limit its use".[40]

The rhetorical amplification against products is becoming shriller. Alcohol causes cancer,[41] alcohol is now considered more harmful than illicit drugs, including heroin and crack,[42] sugar is as harmful as tobacco,[43] and sugar is as addictive as cocaine.[44]

[39] Harrison, M. & Robson, A. 2011. "Prevention no cure: A critique of the Report of Australia's National Preventative Health Taskforce". Agenda. Australian National University. v18. n2. 2011.
[40] Keane, B. 2013. "Bottoms up the non-crisis of Australia's alcohol consumption". Crikey. 08/02/2013. Available at http://www.crikey.com.au/2013/02/08/bottoms-up-the-non-crisis-of-australias-alcohol-consumption/?wpmp_switcher=mobile.
[41] Winstanley, M. H., Pratt, I. S., Chapman, K., Griffin, H. J.,Croager, E., Olver, I. N., Sinclair, C. & Slevin, T. J. 2011. "Alcohol and cancer: a position statement from Cancer Council Australia". Medical Journal of Australia.

This paper doesn't seek to assess the various health consequences associated with people's consumption behaviour, but such statements are clearly designed to inflate the population's general assessment of the ongoing voluntary consumption of products and rationalise government action. Such statements bring alarm into policy discussion when the broader context paints a different picture.

Table 4 | Frequency of Australian alcohol consumption, proportion of the population aged 14+ years

Frequency	1991	1993	1995	1998	2001	2004	2007
Daily	10.2	8.5	8.8	8.5	8.3	8.9	8.1
Weekly	41.0	39.9	35.2	40.1	39.5	41.2	41.3
Less	30.4	29.5	34.3	31.9	34.6	33.5	33.5
Ex-drinker	12.0	9.0	9.5	10.0	8.0	7.1	7.0
Never	6.5	13.0	12.2	9.4	9.6	9.3	10.1

Source: National Preventative Health Taskforce. 2009. "Technical Paper 3: Preventing Alcohol-related harm in Australia: A window of opportunity". Commonwealth of Australia.

For example, as Table 4, shows the rate of alcohol consumption is generally declining according to government statistics, particularly regular drinking behaviour.

6.2 A blind eye to unintended consequences

One of the more bizarre dimensions to a 'health-first paternalist' approach to evidence-based public health policy is the indifference of its advocates to unintended consequences, including unintended health consequences through substitution.

One of the key motivators for changing behaviour is price. As a consequence there is increasing focus on increasing taxes on junk food, alcohol and tobacco products. But what is ignored is how it leads to substitution.

A study by Canadian academics highlighted the consequences of increasing the price of alcoholic beverages and how it changed behaviour in young adults. According to the paper a 10 per cent increase in the minimum price of beer reduced its consumption by 16.1 per cent, alcoholic sodas and ciders by 13.9 per cent, wine by 8.9 per cent and spirits and liqueurs by 6.8 per cent, but overall alcohol consumption drops by only 3.4 per cent. The differences in price are highly likely to result from the financial capacity and price sensitivity of the target markets for the respective products. But the reason for such a small overall decline in alcohol consumption (3.4 per cent) is because

Available at https://www.mja.com.au/journal/2011/194/9/alcohol-and-cancer-position-statement-cancer-council-australia.

[42] Boseley, S. 2010. "Alcohol 'more harmful than heroin or crack'. The Guardian. Available at http://www.guardian.co.uk/society/2010/nov/01/alcohol-more-harmful-than-heroin-crack.

[43] AP. 2012. "Sugar as harmful as tobacco, alcohol, experts say". Sydney Morning Herald. Available at http://www.smh.com.au/lifestyle/diet-and-fitness/sugar-as-harmful-as-tobacco-alcohol-experts-say-20120202-1quat.html.

[44] AAP. 2013. "Sweetner high-fructose corn syrup tests show food addicted similar to cocaine addiction". News.com.au. Available at http://www.news.com.au/lifestyle/food/addiction-to-sweet-foods-studied/story-fneuz8wn-1226648805799.

consumers substitute from one product to another when the price rises.[45] Another study that assessed the value of alcoholic content volumetric taxation came to similar conclusions with higher alcoholic content consumption declining as consumers substituted to lower alcohol content.[46]

Recently the Director of the Centre for Alcohol Policy Research acknowledged the capacity for substitution between consumer products. In a recent interview the Centre's Director argued that marijuana should be made legal as it was a preferable substance for young Australians to consume instead of alcohol, arguing "cannabis is not without harm but it's substantially less than alcohol and tobacco in terms of social harm."[47]

The Centre's director then argued that alcohol should be treated equivalent to tobacco for regulatory purposes. Considering the proposed direction of tobacco regulation is to move towards a licensing regime as a precursor to a potential ban, the position seems strangely inconsistent.[48]

In practice, the consequences of substitution were clearly evidenced following the introduction of the Rudd government's alcopops tax. Following the 2009 tax to increase the price of pre-mixed sugary alcoholic drinks, rates of consumption of alcopops did drop, but consumers substituted to straight spirits and other alcoholic drinks. In some reported cases consumers switched to cheaper illicit drugs.[49] The risk of increasing prices to prompt substitution to illicit drugs is now being supported by research indicating that, while some consumers will never choose illicit drugs, once an alcoholic drink exceeds $14 consumers will consider switching to illicit drugs.[50]

Importantly, the alcopops tax did not achieve one of its key objectives – a reduction in the rate of health consequences. This conclusion has since been substantiated by research from the University of Queensland. Research measuring the alcohol related harm to young residents of the Gold Coast that presented to emergency departments concluded there was no change resulting from the tax compared to control groups. As outlined in Table 5, the presentations of Australians aged 15 to 29 did not change in the time following the taxes' introduction in 2008.

[45] Auld, M.C., Martin, G., Stockwell, T. & Zhao, J. 2012. "Does minimum pricing reduce alcohol consumption? The experience of a Canadian province". Addiction. May 2012.
[46] Stockwell, T., Zhao, J., Giesbrecht, N., MacDonald, S., Thomas, G.& Wettlaufer, A., 2012. "The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health", American Journal of Public Health. December 2012.
[47] Devic, A. 2013. "Expert calls for marijuana to be legalised to reduce harm of binge drinking in teens". Herald Sun. 10/07/2013. Available at http://www.heraldsun.com.au/lifestyle/health-fitness/expert-calls-for-marijuana-to-be-legalised-to-reduce-harm-of-binge-drinking-in-teens/story-fni0diac-1226676714223.
[48] Van Den Berg, L. 2012. "Smokers should be forced to have licenses to light up". Herald Sun. 15/11/2012. Available at http://www.heraldsun.com.au/news/victoria/smokers-should-be-forced-to-have-licences-to-light-up-public-health-professor-simon-chapman-says/story-e6frf7kx-1226516923608.
[49] Johnston, C. & Argoon, A. 2010. "Alcohol price spike fuels switch to ecstasy". The Age. 23/10/2010. Available at http://www.theage.com.au/national/alcohol-price-spike-fuels-switch-to-ecstasy-20101022-16xvj.html.
[50] Miller, P.G. & Droste, N. 2013. "Alcohol price considerations on alcohol and illicit drug use in university students". Journal of Alcoholism & Drug Dependency". v1. i2. Available at http://www.esciencecentral.org/journals/JALDD/JALDD-1-109.pdf.

Table 5 | Presentations for alcohol-related harms to two Gold Coast hospital emergency departments for alcohol-related problems

Year	Aged 15 – 29 years old	All other ages
2005-06	34.4%	24.4%
2006-07	33.1%	23.6%
2007-08	33.0%	23.8%
2008-09	36.3%	27.1%
2009-10	34.8%	27.1%

Source: Kisley, S. R., Pais, J. White, A., Connor, J., Quek, L., Crilly, J. L. & Lawrence, D. 2011. "Effect of the increase in "alcopops" tax on alcohol-related harms in young people: A controlled interrupted time series". Medical Journal of Australia.

Some health academics have become increasingly critical of the 'health-first paternalist' approach to policy development, especially as it seeks to justify any policy measure.

In 2011 the Alcohol Policy Coalition made up of the Australian Drug Foundation, Cancer Council Victoria, the Heart Foundation, Turning Point Alcohol and Drug Centre and Vic Health released a paper, *Cancer, Cardiovascular disease and alcohol consumption*. The paper reached a number of conclusions, but importantly claimed to bust the myth that responsible consumption of red wine would reduce the risks of cardiovascular disease.

The 'health-first paternalist' focus on the contribution of alcohol to cancer has since been rebuked. Boston University's School of Medicine Institute on Lifestyle & Health's International Scientific Forum on Alcohol research openly critiqued the Alcohol Policy Coalition's "misguided statement," with conclusions summarized as:

- "Ignor[ing] evidence showing the public health benefits of moderate alcohol consumption.
- Inflat[ing] existing evidence of the risks of alcohol consumption.
- Promot[ing] a prohibitionist agenda".[51]

The Forum declared the publication "biased and unscientific." One member of the forum went so far as to claim "it would be important to bring an honest appraisal of the best science forward for the purpose of improving public health, a mission not achieved by this paper."[52]

[51] International Scientific Forum on Alcohol Research. 2011. "A response from the Alcohol Policy Coalition of Australia to Critique #058: "A misguided statement on alcohol and health from a Coalition in Australia". Institute on Lifestyle and Health, School of Medicine, Boston University. Available at http://www.bu.edu/alcohol-forum/a-response-from-the-alcohol-policy-coalition-of-australia-to-critique-058-%E2%80%9Ca-misguided-statement-on-alcohol-and-health-from-a-coalition-in-australia%E2%80%9D/.

[52] International Scientific Forum on Alcohol Research. 2011. "Critique 058: A misguided statement on alcohol and health from a coalition in Australia – 28 September 2011". Institute on Lifestyle and Health, School of Medicine, Boston University. Available at http://www.bu.edu/alcohol-forum/reviews/critique-058/.

7.0 Conclusions

Public health policy has broadened from traditionally indiscriminate and/or communicable risks to the health of the population toward discriminate and/or non-communicable risks to the health of the population. This broadened definition creates a 'health-first paternalist' approach to public policy that prioritises health above traditional public policy considerations, including the rights of individuals and human rights when they are in conflict with health priorities.

Under the 'health-first paternalist' model, state sponsored universal healthcare and the subsequent costs to public finances have justified government regulation of any behaviours detrimental to health. Approaching public policy from a 'health-first paternalist' perspective leads to freedom and human rights being expensive and dispensable when they are in conflict.

The objective of 'health-first paternalist' policies is to prioritise health above the principles of individual choice and human rights, particularly related to the consumption of alcohol, tobacco, unhealthy foods and gambling. 'Health-first paternalist' policies designed to target tobacco consumption are now being replicated on gaming, unhealthy food and alcohol with questionable evidence of their merit or efficacy. Even when 'health-first paternalist' policy options fail, they are still advocated for because the potential for health benefits outweigh any perceived costs.

Such an approach promotes a self-reinforcing cycle to justify government action. If a policy is effective it should be followed up with a stronger 'health-first paternalist' policy *because* it is effective. If it does not work it should be followed up with a stronger 'health-first paternalist' policy because those already implemented were *not* strong enough.

Similarly, public funding for 'health-first paternalist' research is its own self-reinforcing cycle with 'health-first paternalist' advocates arguing for policy action by government off the back of government-funded research that was introduced as part of government policy action.

With at least $100 million provided to 'health-first paternalist' research since 2008, the Commonwealth government has been funding the expansion of 'health-first paternalist' research and its evidence-base. This research is then being used to justify further government 'health-first paternalist' interventions, as well as greater funding opportunities for 'health-first paternalist' research. Both the 'non-government' sector that researches and advocates for 'health-first paternalist' policies, and the government view 'health-first paternalist' advocacy as essential to securing public support for their agenda. Capacity for advocacy by the non-government sector is now included in the government's funding guidelines.

When produced, 'health-first paternalist' research seeks to promote qquestionable "social costs" studies of individual behaviour that concludes there are significant public and private costs to people's freedom. They also seek to highlight potential risks of behaviours and their link to cancer, or that they have equivalent addiction rates to illicit substances. This paper does not seek to assess or dispute whether they are accurate, only that there is a clear intention to highlight these risks.

In advocating the outcomes of research, the potential for unintended consequences from research often appears to be ignored. Notably, the rise in research on the risks of increasing taxes on alcohol leading to consumers switching to other products, including illicit substances, does not appear to be frequently acknowledged. Meanwhile, at least one 'health-first paternalist' academic, has argued that it is more desirable for consumers to consume currently illicit substances than legal drugs.

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Annex 1 | Identified Commonwealth funded health programs designed to influence people's behaviour, 2008 – 2013

Program	Institution	Title	Grant
ANPHA Weekly Grants Reporting	Summernats Pty Ltd	To promote the National Tobacco Campaign to encourage a reduction in smoking rates amongst all adult smokers	$49,500.00
ANPHA Preventative Health Research Grants Program	Monash University with Menzies School of Health Research	A community of practice model in supporting remote retail store public health nutrition workforce development	$77,500.00
NHMRC project grants	Curtin University	Per cent Daily Intake' versus 'Equivalent Walking Time': making sense of the kilojoules on food and drink labels	$77,758.20
ANPHA Preventative Health Research Grants Program	Monash University	Alcohol advertising and sponsorship in Australian sport: Associations with implicit and explicit alcohol attitudes and drinking behaviour	$79,970.00
ANPHA Weekly Grants Reporting	Monash University	This research aims to build the capacity of the public health nutrition workforce for remote retail stores	$85,250.00
ANPHA Weekly Grants Reporting	Monash University	This research aims to establish the relationship of the types and levels of exposure to alcohol advertising in sport media versus other non-sport genres with drinking expectancies and behaviours; and examine the strength of implicit cognitions between alcohol and sport and their relationship to alcohol advertising exposure	$87,967.00
ANPHA Preventative Health Research Grants Program	Centre of Excellence in Intervention and Prevention Science (CEIPS)	Identifying Systemic Drivers of the use of Evidence to Prevent Obesity: A Service Mapping Approach	$88,725.00
NHMRC project grants	Macquarie University	Influence of a brief early parent intervention on internalising outcomes in middle adolescence	$94,258.80
ANPHA Weekly Grants Reporting	Centre of Excellence in Intervention and Preventive Science (CEIPS)	This research aims to identify some of the factors that enable or discourage the use of evidence by local policy makers and practitioners to promote healthy weights in order to improve the quality of prevention and increase the evidence which informs decision-making	$97,597.50

ANPHA Weekly Grants Reporting	CuriousWorks	To raise awareness of the harms of binge drinking amongst the youth in Penrith and Mount Druitt area	$104,982.96
NHMRC project grants	University of Newcastle	RCT of a client-centred, caseworker-delivered smoking cessation intervention for a socially disadvantaged population	$130,550.00
ANPHA Preventative Health Research Grants Program	Australian National University	What roles do time, money and social position play in driving participation in a workplace health promotion program	$157,450.00
ANPHA Weekly Grants Reporting	The Corporation of the City of Adelaide	To reduce binge drinking and its associated risks in the Adelaide West End area	$166,119.80
ANPHA Weekly Grants Reporting	Australian National University	This research will investigate the temporal and financial barriers and possible solutions to participation in a workplace health promotion program and how these barriers affect the different workplace social groups	$173,195.00
NHMRC project grants	University of Sydney	Generating evidence of reduced rates of overweight/obesity in children: value adding to four established Australasian early intervention trials	$187,019.50
NHMRC project grants	Murdoch Childrens Research Institute	Modifiable influences on tobacco, cannabis and other drug use in early adolescence	$192,300.00
NHMRC project grants	University of New South Wales	Alcohol use disorders in young adults: 'Youthful epidemic' or diagnostic bias?	$193,650.00
NHMRC project grants	University of New South Wales	Determining the impact of opioid substitution therapy upon mortality and recidivism among prisoners: A 22-year data linkage study	$204,472.00
ANPHA Preventative Health Research Grants Program	Deakin University with SA Department of Health	Evaluating network and capacity development in large scale community obesity prevention	$207,080.00
NHMRC project grants	University of New South Wales	The feasibility and effectiveness of a family-based intervention for Indigenous Australians with alcohol dependence	$212,500.00
NHMRC project grants	Monash University	Predicting the impact of current obesity and diabetes trends on future prevalence of cardiovascular disease in Australia	$217,430.00
ANPHA Preventative Health Research Grants Program	Curtin University	The public health impacts of liquor outlets in Queensland communities: outlet numbers, alcohol sales and alcohol related morbidity	$224,792.00

ANPHA Weekly Grants Reporting	ACT Medicare Local	Undertake the Resource and Education About Diabetes for Refugees (READ) Project – to contribute to building the evidence for sustainable preventive health interventions that address local health needs	$227,645.00
ANPHA Weekly Grants Reporting	Deakin University	This project will build on the OPAL project to evaluate the role of networks and collaboration in the community-based childhood obesity prevention intervention (i.e. OPAL); how developing collaborative networks of community stakeholders and organisations contributes to achieving the objectives of promoting healthy eating, physical activity and healthy weight among children; and how this might contribute to ensuring the benefits remain beyond the project's end	$227,788.00
ANPHA Weekly Grants Reporting	Mushroom Marketing Pty Ltd	To promote the National Tobacco Campaign to encourage a reduction in smoking rates amongst all adult smokers	$236,500.00
NHMRC project grants	University of Sydney	Infant feeding including breastfeeding and Early Childhood Food and Beverage Intake: Relationships with Early Childhood Caries and Obesity	$240,000.00
NHMRC project grants	Bakers IDI Heart and Diabetes Institute Holdings Limited	Implications of the increasing duration of life spent with obesity for population health	$245,631.65
ANPHA Weekly Grants Reporting	Curtin University of Technology	This research will assess the association between the numbers of licensed outlets, alcohol sales and alcohol related hospitalisations in local communities	$247,271.20
ANPHA Preventative Health Research Grants Program	IDI and Monash University	The impact of obesity prevention policy on social inequalities in obesity	$247,340.00
ANPHA Weekly Grants Reporting	SAX Institute	Funding to support the development of a preventive health workforce strategy and the development of a preventive health workforce data collection framework	$255,354.00
ANPHA Preventative Health Research Grants Program	University of Sydney	Online food and beverage marketing to children and adolescents	$259,159.00
ANPHA Weekly Grants Reporting	Baker IDI Heart and Diabetes Institute	This research will analyse the extent to which potential obesity policies affect social inequalities in obesity in Australia and identify adaptions to potential policies that will lead to a reduction in social inequalities in obesity	$272,074.00
ANPHA Weekly Grants Reporting	Glenorchy City Council	To prevent and reduce youth binge drinking by developing interactive online resources	$273,501.38
NHMRC project grants	James Cook University	Cannabis withdrawal among Indigenous inmates in North Queensland	$279,375.00

NHMRC project grants	University of Melbourne	The effect of smoking on the exacerbation of stroke: oxidative stress involvement and cerebrovascular response	$280,500.00
ANPHA Weekly Grants Reporting	Queensland Remote Aboriginal Media Aboriginal Corporation	To reduce binge drinking in remote Indigenous communities in Queensland	$281,171.00
ANPHA Weekly Grants Reporting	Australian Red Cross Society	To change the attitudes of young people towards binge drinking in the Central West Queensland and Palm Island communities	$281,804.54
NHMRC project grants	University of New South Wales	Investigating the relationships between cannabis and other drug use, mental health, early-life factors and life-course outcomes: integrative analyses of data from four Australasian cohorts	$284,472.00
ANPHA Weekly Grants Reporting	The University of Sydney	This research aims to document energy dense nutrition poor food and beverage marketing on online forums; determine exposure to EDNP food and beverage marketing through normal internet usage; and assess behaviours, attitudes and beliefs in response	$285,074.90
ANPHA Preventative Health Research Grants Program	University of Adelaide	Steward or nanny state: Consulting the public about the use of regulation to address childhood obesity	$288,381.00
NHMRC project grants	Curtin University of Technology	A life course approach to characterising and predicting inactivity and sedentary behaviour of young adults	$291,473.91
NHMRC project grants	University of Melbourne	An investigation of physiological adaptations contributing to weight regain after weight loss	$292,750.00
NHMRC project grants	University of Melbourne	Alcohol and public health: the Australian experience	$296,375.00
NHMRC project grants	University of Queensland	Helping parents of teenagers at risk of alcohol/tobacco-related harm	$306,750.00
ANPHA Weekly Grants Reporting	Queensland Police-Citizens Youth Welfare Association, trading as Cloncurry Police Citizens Youth Club	To reduce youth binge drinking in the Cloncurry and Mt Isa community	$306,879.10
ANPHA Weekly Grants Reporting	Medicare Local Great South Coast	Undertake the Healthy Great South Coast Project – to contribute to building the evidence for sustainable preventive health interventions that address local health needs	$308,000.00

ANPHA Weekly Grants Reporting	Mulungu Aboriginal Corporation Medical Centre	To reduce binge drinking and its associated harms amongst young people in the Mareeba community	$308,999.02
NHMRC project grants	University of Newcastle	Yr 4 & 5 of a randomised controlled trial of an intensive intervention to reduce smoking among pregnant indigenous women	$314,875.00
ANPHA Weekly Grants Reporting	Melton Shire Council	To decrease the level of binge drinking in the Melton Shire and increase the awareness of harms associated with binge drinking	$316,010.20
ANPHA Weekly Grants Reporting	The University of Adelaide	This research will collect and evaluate public views on the use of regulations and laws to prevent childhood obesity in Australia	$317,219.10
NHMRC project grants	University of Sydney	The natural history of unassisted smoking cessation in Australia	$318,510.00
NHMRC project grants	Monash University	Physical activity restores energy homeostasis in obesity through hypothalamic neurogenesis	$322,524.00
NHMRC project grants	University of Sydney	Dietary fats as drivers of obesity-related inflammation	$324,750.00
NHMRC project grants	University of New South Wales	Alcohol, angry rumination and aggression: The role of acute impairment of executive functioning	$328,750.00
ANPHA Weekly Grants Reporting	Ngnowar Aerwah Aboriginal Corporation	To provide young people with educational programs and activities that raise awareness of the harms caused by binge drinking	$330,000.00
ANPHA Weekly Grants Reporting	Redundancy Payment Central Fund Ltd as Trustee for Redundancy Payment Central Fund (Inkolink)	To prevent and reduce the prevalence of binge drinking amongst young men working in the building and construction industry.	$330,000.00
ANPHA Weekly Grants Reporting	The Synod of the Diocese of the Northern Territory Inc Trading as Anglicare N.T.	To decrease incidences of alcohol-related harms in young people aged 12-25 years in the greater Darwin and Palmerston community	$330,000.00
NHMRC project grants	Monash University	Mediterranean diet and mortality: Analysis of longitudinal dietary patterns using newly developed statistical methods	$330,058.00
ANPHA Preventative Health Research Grants Program	Curtin University	Identifying opportunities for the prevention of harmful use of alcohol, tobacco and other drugs among young Noongar (Aboriginal) people in the south-west of Western Australia	$339,041.00

ANPHA Preventative Health Research Grants Program	Cancer Council Victoria with Cancer Institute NSW	Lifestyle media message-testing: Finding the keys to successful public health campaigns promoting healthy weight	$339,976.00
NHMRC project grants	University of Sydney	A dietary intervention in gestational diabetes to reduce child obesity: a randomised controlled trial	$342,125.00
ANPHA Weekly Grants Reporting	University of Adelaide	Research fellowship under the Preventive Health Research Fellowship Program	$344,717.00
NHMRC project grants	Deakin University	Identifying why some people consume excess dietary fat. A twin study	$352,846.85
NHMRC project grants	University of Newcastle	Double blind randomised controlled trial of electronic alcohol screening and brief intervention for hospital outpatients	$353,035.00
ANPHA Weekly Grants Reporting	Curtin University of Technology	This is a collaborative project between Southern Aboriginal Corporation and the NDRI, Curtin University to combine a longitudinal trend study of alcohol, tobacco and other drug use among Aboriginal adolescents in south-west Western Australia with an Indigenous capacity building component. It will enable an Aboriginal community-controlled organisation to develop an evidence-based strategy to address harmful effects of substance abuse at a local level	$372,945.10
ANPHA Weekly Grants Reporting	Cancer Council of Victoria	This research will identify the effective elements of existing Australian and International persuasive mass media campaigns promoting healthy weight, healthy eating and physical activity to inform recommendations for the development and airing of future campaigns	$373,973.60
NHMRC project grants	University of New South Wales	Intervention trial to reduce alcohol related harms among high risk Indigenous Australians	$379,931.18
ANPHA Preventative Health Research Grants Program	University of Melbourne with Cancer Council Victoria	A collaborative model for combating non-communicable diseases (NCDs): coherence between regulation on risk factors and international law	$389,640.00
ANPHA Weekly Grants Reporting	Youthsafe	To reduce the incidence of binge drinking and its associated risks and harms amongst apprentices and trainees	$392,345.80
ANPHA Weekly Grants Reporting	Monash University	Research fellowship under the Preventive Health Research Fellowship Program that will undertake an economic analysis of the consequences of childhood obesity	$392,900.00
ANPHA Preventative Health Research Grants Program	Curtin University with the University of New South Wales and	Young Australians alcohol reporting systems	$393,810.00

	Monash University		
NHMRC project grants	The Cancer Council of Victoria	How do media campaigns and tobacco-relevant news coverage influence adolescent and adult smoking	$395,725.00
NHMRC project grants	University of New South Wales	Causes of overeating	$414,300.00
NHMRC project grants	University of New South Wales	Does obesity have the characteristics of addiction?	$416,235.00
NHMRC project grants	Royal Prince Alfred Hospital	Effectiveness of an early intervention trial to prevent obesity - Phase 2: Follow-up and cost effectiveness analysis	$420,488.80
NHMRC project grants	University of Newcastle	Tracking the impact of drug regulatory actions: consumer health outcomes, risk-benefit issues and policy framework	$421,000.00
ANPHA Weekly Grants Reporting	Mitchell Community Health Service	To reduce alcohol related anti-social behaviour in young people, through a coordinated community response	$422,777.30
NHMRC project grants	University of Adelaide	Effects of gastric bypass and banding for obesity on gastrointestinal function, body weight, glycaemia and symptoms	$428,250.00
ANPHA Weekly Grants Reporting	The University of Melbourne	This research seeks to clarify the implications of trade and investment law for Non Communicable Disease (NCD) regulation in order to aid policymakers in ensuring domestic and international public health regulation to combat NCD risk factors are both effective and robust against legal challenge	$428,604.00
ANPHA Weekly Grants Reporting	Curtin University of Technology	This research will trial a young Australians alcohol reporting system combining information from existing data sources targeting young people (16-19 years old) engaged in risky drinking behaviour to provide an early warning system and timely information to inform policy, prevention and treatment initiatives	$433,191.84
NHMRC project grants	The Cancer Council of Victoria	Planning, timing and quit success: A randomised controlled trial	$434,274.80
NHMRC project grants	Monash University	An econometric investigation of harmful drinking and price response by alcoholic types to inform alcohol tax policies	$434,400.00
NHMRC project grants	University of Newcastle	Follow-up of healthy lifestyles intervention for cardiovascular disease among people with a psychotic disorder	$436,085.20
NHMRC project grants	University of Sydney	Calling the tune? Investigating corporate influences on media reporting of health	$445,500.00
NHMRC project grants	University of New South	The ecstasy check-up: A multi-site trial of a brief intervention for ecstasy use among	$446,250.00

	Wales	regular ecstasy users	
NHMRC project grants	Curtin University of Technology	A nutrition and physical activity intervention for mothers with young children	$455,750.00
NHMRC project grants	University of Wollongong	Is a higher intake of omega-3 fatty acids advantageous for weight loss?	$458,750.00
NHMRC project grants	Curtin University of Technology	Physical activity and nutrition for seniors (PANS)	$459,500.00
ANPHA Preventative Health Research Grants Program	Griffith University	The cost-effectiveness and consumer acceptability of taxation strategies to reduce rates of overweight and obesity amongst children in Australia	$463,442.00
NHMRC project grants	University of Newcastle	Brain pathways underlying vulnerability to drug relapse	$466,000.00
ANPHA Weekly Grants Reporting	Eastern Goldfields YMCA Inc	To reduce harmful, consumption of alcohol among youth in the Eastern Goldfields area	$467,366.90
NHMRC project grants	University of Sydney	Reconceptualising health promotion: the role of values, ethics and evidence in obesity intervention	$467,950.00
NHMRC project grants	Deakin University	Effectiveness of a skill-building and price reduction intervention for promoting healthy eating	$472,350.00
ANPHA Weekly Grants Reporting	Northern Adelaide Medicare Local	Undertake the *Northern respiratory Partnership Project* – to contribute to building the evidence for sustainable preventive health interventions that address local health needs	$477,972.00
NHMRC project grants	Queensland University of Technology	Helping women meet their activity goals: randomised trial of a personalised program delivered by mobile telephone	$480,475.00
NHMRC project grants	University of Melbourne	Corticotrophin releasing factor as a therapeutic target for alcohol and drug abuse	$483,750.00
ANPHA Weekly Grants Reporting	Leeton Shire Council	To prevent and reduce the incidence binge drinking and associated anti-social behaviour amongst 12-24 year olds in the Western Riverina area	$484,508.20
NHMRC project grants	University of Melbourne	Does the rate of weight loss influence the success of long term weight maintenance?	$485,163.00
NHMRC project grants	University of Melbourne	Cigarette smoke exposure suppresses alveolar macrophage responses to lipopolysaccharide by modifying the TLR4 pathway	$486,000.00
NHMRC project grants	University of New South Wales	How does paternal obesity influence offspring glucose tolerance?	$486,022.80
NHMRC project grants	University of Sydney	An Innovative Playground Intervention to Increase Physical Activity	$486,250.00
NHMRC project grants	Deakin University	A randomised controlled trial to prevent primigravid excessive gestational weight	$488,385.00

		gain and postpartum weight retention	
NHMRC project grants	University of Melbourne	A randomised controlled trial of physical activity with individual goal-setting and volunteer mentors to overcome sedentary lifestyle in older adults at risk of cognitive decline	$489,451.22
ANPHA Weekly Grants Reporting	Partners 4 Health, trading as Metro North Brisbane Medicare Local	Undertake the Health Promotion Navigator Project – to contribute to building the evidence for sustainable preventive health interventions that address local health needs	$500,000.00
ANPHA Weekly Grants Reporting	WentWest Limited	Undertake the Western Sydney Diabetes Prevention Program – to contribute to building the evidence for sustainable preventive health interventions that address local health needs	$500,000.00
NHMRC project grants	University of New South Wales	How does exercise ameliorate programming of metabolic dysfunction in offspring of obese mothers?	$506,030.85
NHMRC project grants	Baker IDI	Reducing prolonged workplace sitting time in office workers: a cluster-randomised controlled trial	$506,996.80
ANPHA Weekly Grants Reporting	Griffith University	This project seeks to find the acceptability and cost-effectiveness of taxation of junk foods in halting and reverse the problem of childhood obesity	$509,789.20
NHMRC project grants	University of Queensland	Obesity-related inflammation and insulin resistance in chronic liver disease: exercise and diet as treatment options	$517,000.00
NHMRC project grants	Curtin University of Technology	Does access to electronic games decrease physical activity in children?	$518,200.00
NHMRC project grants	Menzies Research Institute	Efficacy of education and advice delivered by text message to aid smoking cessation	$518,251.90
NHMRC project grants	University of Sydney	The effectiveness of motivational enhancement therapy for obese patients and support partners	$528,900.00
ANPHA Preventative Health Research Grants Program	University of Melbourne	Drinking patterns, regulation and market influences in Australia: the international alcohol control survey	$532,468.00
NHMRC project grants	University of Melbourne	Novel strategies to treat drug abuse	$536,250.00
ANPHA Weekly Grants Reporting	Youth Coalition of the ACT	To increase awareness of alcohol-related harm, personal responsibility, and positive decision making amongst 18 -24 year olds in the ACT	$539,653.40
NHMRC project grants	Mater Medical Research Institute LTD	Dietary intake of highly processed foods as a contributor to type 1 diabetes	$540,015.00

ANPHA Weekly Grants Reporting	Multicultural Centre for Women's Health Inc	To reduce alcohol related harm in young people from immigrant and refugee backgrounds	$541,493.70
ANPHA Weekly Grants Reporting	Carpentaria Shire Council	To reduce binge drinking amongst young people by providing a positive social and cultural environment	$542,300.00
ANPHA Weekly Grants Reporting	The Salvation Army (Victoria) Property Trust	to prevent and reduce the incidence of binge drinking by young people, aged 12-24 years in the Melbourne CBD and enhance safety in the area	$544,500.00
ANPHA Weekly Grants Reporting	Bathurst Regional Council	To prevent and reduce binge drinking among 12-24 year olds in the Bathurst region	$544,578.85
ANPHA Weekly Grants Reporting	Re-engage Youth Services Incorporated	To reduce binge drinking and associated anti-social behaviours amongst young people in Adelaide's southern suburbs	$547,189.50
ANPHA Weekly Grants Reporting	Clarence Valley Council	To reduce binge drinking among youth in the Clarence Valley area through education, promotion of healthy lifestyle choices and provision of alternative recerational activities	$547,569.00
ANPHA Weekly Grants Reporting	Shire Wide Youth Services Incorporated	To reduce underage and youth binge drinking	$550,000.00
ANPHA Weekly Grants Reporting	The David Wirrpanda Foundation	To reduce binge drinking amongst young Aboriginal females.	$550,000.00
ANPHA Weekly Grants Reporting	Mushroom Marketing Pty Ltd	To change the attitudes of young people in relation to binge drinking at live music events around Australia	$550,000.00
ANPHA Weekly Grants Reporting	Gap Youth Centre Aboriginal Corporation	To provide young people in Alice Springs with alternate alcohol-free events	$550,000.00
NHMRC project grants	Monash University	Sex, stress and obesity	$558,069.53
NHMRC project grants	University of Queensland	Randomised controlled trial of a telephone-delivered weight loss intervention for overweight and obese women with breast cancer	$558,675.00
NHMRC project grants	University of New South Wales	Economic evaluation of interventions to reduce the burden of harm from alcohol misuse in Indigenous Australians	$568,500.00
NHMRC project grants	Deakin University	A cross-national longitudinal comparison of modifiable influences for the development of harmful young adult alcohol use in Washington State, USA, and Victoria, Australia	$571,736.88
NHMRC project grants	University of Western Australia	RCT of the intragastric balloon and lifestyle intervention versus lifestyle intervention alone in obese adolescents	$573,000.00
NHMRC project grants	University of New South	The value of providing health interventions for heroin use: a cost benefit analysis	$579,300.05

	Wales		
NHMRC project grants	Monash University	Understanding uterine contractility: what can we learn from obesity?	$580,055.87
NHMRC project grants	Australian National University	Obesity, overweight and hospitalisation: Identifying targets for interventions to prevent adverse health outcomes	$581,750.00
ANPHA Weekly Grants Reporting	The University of Melbourne	This research aims to implement in Australia the International Alcohol Control (IAC) Study, an established multinational collaborative project studying drinking patterns and problems and their development in the context of market and social influences and of alcohol regulations on the sales and consumption of alcohol	$585,714.80
NHMRC project grants	University of Melbourne	Obesity in the Elderly: impact of weight loss therapy on physiology and function	$594,599.17
NHMRC project grants	University of Western Australia	Heroin dependence in WA: Identification of candidate genes involved in susceptibility & treatment outcome	$597,188.00
NHMRC project grants	Macquarie University	Randomised controlled trial of treatment for alcohol use problems and social phobia	$605,750.00
NHMRC project grants	University of Western Australia	Successful ageing in older men - Thriving not just surviving in the 'Health in Men Study'	$607,107.74
NHMRC project grants	University of Queensland	The aetiology of alcohol use disorders in adulthood: a generational perspective	$610,520.80
ANPHA Weekly Grants Reporting	Wide Bay Medicare Local	Undertake the Active by Community Design (ABCD) Project – to contribute to building the evidence for sustainable preventive health interventions that address local health needs, and to develop and maintain a Medicare Locals Preventive Health Knowledge Network Web Tool	$610,550.00
NHMRC project grants	University of Western Sydney	Pharmacotherapy for smoking cessation during pregnancy and the inter-pregnancy period: a population-based cohort study	$620,950.00
NHMRC project grants	University of Sydney	Identification of microbiome control of weight loss during dietary intervention	$625,477.50
NHMRC project grants	James Cook University	Alcohol Management Plans (AMPs) in remote Indigenous communities: Their impacts on injury, violence, health and social indicators and their cost-effectiveness in Cape York, far north Queensland	$626,395.09
NHMRC project grants	University of Melbourne	Creating Healthy Environments: Integrating and Evaluating Aboriginal Health Promotion in the Goulburn-Murray Region	$626,887.17
NHMRC project grants	University of Adelaide	Dietary and lifestyle advice and treatment for women with borderline gestational diabetes: the IDEAL randomised controlled trial	$632,979.60
NHMRC project grants	The Cancer Council of	Effects of current and plain cigarette package design on smokers' cigarette evaluation	$636,800.00

	Victoria		
NHMRC project grants	Menzies School of Health Research	A structured systems approach for improving health promotion practice for chronic diseases in Indigenous communities	$640,513.00
NHMRC project grants	Murdoch Childrens Research Institute	An Internet based intervention for overweight or obese adolescents	$654,668.00
NHMRC project grants	University of Adelaide	Effects of dietary protein on gastrointestinal function: Implications for the regulation of energy intake in obesity	$655,500.00
NHMRC project grants	University of Adelaide	Diet and exercise intervention for paternal obesity improves offspring health	$656,010.00
NHMRC project grants	The University of Queensland	A workplace-based exercise intervention to prevent and reduce the economic and personal burden of non-specific neck pain in the office personnel	$660,834.43
ANPHA Preventative Health Research Grants Program	Hunter New England Local Health District and University of Newcastle	Creating childcare environments supportive of child obesity prevention: effectiveness of an intensive population based dissemination intervention	$662,778.00
NHMRC project grants	The University of Adelaide	The contribution of maternal obesity and gestational weight gain to preschool child obesity	$673,008.86
NHMRC project grants	Deakin University	Long term impact, capacity gains and cost-effectiveness of a successful community-wide child obesity prevention program	$674,250.00
NHMRC project grants	University of South Australia	Can a Mediterranean dietary pattern improve cognitive health and psychological wellbeing?	$691,341.89
NHMRC project grants	Central Queensland University	My Personal Activity Advice – A RCT investigating the effectiveness of tailored videos in promoting physical activity via the Internet	$697,086.00
NHMRC project grants	Queensland University of Technology	A longitudinal multilevel study of change in physical activity in mid-age and factors associated with change	$705,000.00
NHMRC project grants	Monash University	The natural history of injecting drug use among IDU in Melbourne	$708,355.00
NHMRC project grants	University of Sydney	Ageing, nutrition and the geometric framework	$715,250.00
NHMRC project grants	University of Newcastle	Coping Together: A randomised controlled trial of a self-directed coping skills intervention for patients with cancer and their partners	$718,021.00
NHMRC project grants	University of New South Wales	The effectiveness of a comprehensive 'universal' and 'targeted' intervention to prevent substance use and related harms in adolescents	$723,665.00
ANPHA Weekly Grants Reporting	The University of Newcastle	This research will assess the effectiveness of an intensive, population based intervention in increasing the physical activity and healthy eating policies and practices of childcare services.	$729,055.80

NHMRC project grants	Curtin University of Technology	Understanding the barriers to improved access, engagement and retention of methamphetamine users in health services	$746,850.00
ANPHA Weekly Grants Reporting	Inner West Sydney Medicare Local	Undertake the Literacy Gap in Health Among Target Population (LIGHT) Project – to contribute to building the evidence for sustainable preventive health interventions that address local health needs	$750,000.00
NHMRC project grants	The University of Adelaide	Common risk factor approach to address socioeconomic inequality in oral health of contemporary Australian preschool children	$773,033.43
NHMRC project grants	James Cook University	Indigenous community action to reduce harms associated with heavy cannabis use in Cape York	$784,845.00
NHMRC project grants	Monash University	Benefit measurement for health economic evaluation and its application to priority health programs	$797,250.00
NHMRC project grants	Deakin University	An intervention to reduce sedentary behaviour, promote physical activity and improve children's health	$815,025.00
NHMRC project grants	Queensland University of Technology	Promoting protective feeding practices to prevent childhood obesity: follow up of a successful obesity prevention program commencing in infancy	$820,558.00
NHMRC project grants	University of Western Australia	The evolution of childhood obesity and its relationship to adult sleep disordered breathing	$843,060.00
NHMRC project grants	Deakin University	Assessing sustainability of positive outcomes in a successful child obesity prevention intervention: follow-up of The Melbourne InFANT Program	$850,666.50
NHMRC project grants	Monash University	Preventing weight gain in young to mid-aged women living in rural communities: a cluster randomised controlled trial	$863,888.00
NHMRC project grants	Australian National University	Validation of evidence-based screening instruments to identify unsafe older drivers and prevent injury	$877,030.20
NHMRC project grants	University of Sydney	Long-term effects of very low energy diet versus conventional diet on adiposity, lean body mass, muscle strength and bone density in obese adults, and mechanisms promoting changes	$890,900.00
NHMRC project grants	Flinders University	Does a Health in All Policies approach improve health, well-being and equity?	$968,325.00
NHMRC project grants	University of Sydney	Adolescent rural cohort study: hormones, health, education, environments and relationships	$975,651.60
NHMRC project grants	Queensland University of Technology	Achieving more effective weight loss with intermittent energy restriction	$976,175.00

NHMRC project grants	University of Queensland	An open-label randomised pragmatic policy trial of nicotine and smokeless tobacco products for short-term cessation assistance or long-term substitution in smokers	$1,014,392.50
NHMRC project grants	The University of Newcastle	Cost-effectiveness of a systems change intervention for smoking cessation in drug and alcohol treatment centres	$1,060,522.91
NHMRC project grants	University of Queensland	Early origins, progression and aetiology of obesity, metabolic syndrome and diabetes: a 30 years follow-up study	$1,151,675.00
NHMRC project grants	University of Queensland	Telephone counselling for maintenance of physical activity, weight loss & glycaemic control in type 2 diabetes	$1,215,800.00
NHMRC project grants	University of South Australia	Long-term effects of a very low carbohydrate, low saturated fat diet compared to a conventional high carbohydrate, low fat diet on glycaemic control and cardiovascular disease risk in overweight and obese patients with type 2 diabetes	$1,267,290.00
NHMRC project grants	The Cancer Council of Victoria	Evaluating population-wide efforts to reduce tobacco use: Continuation of the ITC-Four Country cohort in Australia	$1,317,292.00
NHMRC project grants	Deakin University	Longitudinal study of modifiable influences for the development of harmful young adult alcohol use and related-problems	$1,411,075.00
NHMRC project grants	University of Newcastle	Effectiveness of a resilience intervention in reducing smoking and alcohol consumption among secondary school students	$1,432,750.00
NHMRC project grants	University of Newcastle	Evaluating the efficacy of an integrated smoking cessation intervention for mental health patients: a randomised controlled trial	$1,442,270.25
NHMRC project grants	University of Adelaide	Limiting weight gain in overweight and obese women during pregnancy to improve health outcomes - a randomised trial	$1,466,625.00
ANPHA Weekly Grants Reporting	SAX Institute	Funding to support the National Partnership Centre for Better Health: Systems Perspectives on Preventing Life-style Related Chronic Health Problems	$1,650,000.00
NHMRC project grants	University of New South Wales	Impact of parental alcohol, tobacco and other substance use on infant development and family functioning	$1,910,470.00
NHMRC project grants	University of New South Wales	Randomised controlled trial of a financial counselling intervention and smoking cessation assistance to reduce smoking in socioeconomically disadvantaged groups	$1,951,192.50
NHMRC project grants	Menzies School of Health Research	A randomised trial to assess the impact of a price reduction with and without an in-store nutrition education strategy on purchasing of fruit and vegetables and low joule drinks and water in remote Northern Territory Aboriginal communities	$1,973,213.00

About the Institute of Public Affairs

The Institute of Public Affairs, founded in 1943, is the world's oldest free market think tank. The IPA is a not-for-profit research institute based in Melbourne, Australia with staff and associates based around Australia. Think tanks act as public policy incubators and develop public policy solutions.

The objective of the IPA is to promote evidence-based public policy solutions rooted in a liberal tradition of free markets and a free society. The IPA achieves these objectives by undertaking and disseminating research; participating in national and international policy debate through the media; and engaging with opinion leaders, stakeholders and public policy makers.

All work completed by the IPA is published in the public domain for the consumption of governments, politicians, domestic and international policy makers and the public-at-large.

The IPA has a demonstrated track record of contributing to, and changing the terms of the public policy debate in Australia and internationally. In particular, in recent years the IPA has been at the centre of public discussion in Australia and in appropriate international fora on:

- Regulation
- Trade
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- Water
- Energy
- Housing
- Industrial relations
- Taxation
- Investment

About the author | Tim Wilson

Tim is Director of the Intellectual Property and Free Trade Unit and Climate Change Policy at the Institute of Public Affairs. Tim also serves on the Australian government's IP industry consultative group as well being a Senior Fellow at New York's Center for Medicine in the Public Interest.

Tim has written extensively in defensive of individual choice and responsibility, including on gaming. Amongst many research projects, he wrote with Julie Novak *Gambling away perspective? A review of the evidence justifying electronic gaming regulations* that exposed the inaccurate data supporting the introductory of pre-commitment for electronic gaming machines in Australia.

He can be seen and heard being challenging, outspoken, and thought provoking on both radio and television. He has regular commitments on radio stations 2CC, 3AW, 4BC and 774 and television stations Sky News, Channel Ten and the ABC. He is also a regular guest on New York's nationally syndicated radio program, the John Batchelor show, with John Batchelor and US editorial board member, Mary Kissel. He also pens columns in many newspapers, particularly *The Australian* and *Australian Financial Review*. Tim has also contributed chapters to numerous books and regularly speaks at conferences.

In 2009 *The Australian* newspaper recognised him as one of the ten emerging leaders of Australian society, is a recipient of an Australian Leadership Award from the Australian Davos Connection, and was selected to participate in the inaugural Australian-ASEAN emerging leaders program.

Tim is currently a director of Alfred Health and a Board of the Australian Health Practitioner Regulation Agency. He formally served on the Board of Monash University as well as a number of service companies in the tertiary education sector.

He has worked in international development across South East Asia, consulting and politics, including delivering Australia's aid program for the Vietnamese government to host APEC and advising state and federal politicians. At University Tim was twice elected president of the student union.

Tim is currently completing a Graduate Diploma of Energy and the Environment (Climate Science and Global Warming) at Perth's Murdoch University. He has a Masters of Diplomacy and Trade and a Bachelor of Arts from Monash University, a Diploma of Business and has completed Asialink's Leaders Program at the University of Melbourne.

He has also completed specialist executive education on IP at the World Intellectual Property Organisation's Worldwide Academy and international trade, intellectual property, diplomacy and global health at the Institut de Hautes Études Internationales et du Développment, Geneva and New Jersey's Gibbons Institute of Law, Science and Technology at Seton Law School, New Jersey.