

Lifestyle Risks

This section discusses the regulation of “lifestyle risks”, a term that can apply to both substances and behaviours. Lifestyle risks take place along the line of “abstinence – consumption – abuse – addiction”. This can concern substances such as food, alcohol or drugs, as well as behaviours such as gambling or sports. The section also addresses the question of the appropriate point of equilibrium between free choice and state intervention (regulation), as well as the question of when risks can be considered to be acceptable or tolerable. In line with the interdisciplinary scope of the journal, the section aims at updating readers on both the regulatory and the scientific developments in the field. It analyses legislative initiatives and judicial decisions and at the same time it provides insight into recent empirical studies on lifestyle risks.

An Ounce for Prevention... Germany's Public Policy on Health Promotion and Disease Prevention

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I. Introduction

Germany has a new law on health promotion and disease prevention: The *Gesetz zur Stärkung der Gesundheitsförderung und der Prävention*¹ (or *Präventionsgesetz* abbreviated as “PrävG”²) went into effect on 25 July 2015. This report presents the distinctive features of the new German legislation and examines whether it can be interpreted as signalling a change in type of policy, toward a regulation of lifestyle risks, and if so, the extent to which the German government may have begun legal implementation of an approach emphasising individual responsibility in health promotion and disease prevention. It also looks at the consequences this may have for behaviourally informed policymaking.

The new legislation comes at a time when the zeitgeist focusses on individual lifestyle risks in health promotion,³ and behavioural economics⁴ influences policy. Regarding behavioural economics, there is ample discussion on the popular concept of “nudging”⁵ to influence behaviour intelligently. Chancellor Merkel began involving experts in behavioural economics in 2014⁶, so we would expect more German legislation focussing on individual behaviour in the future. However, the extent to which German policymaking is influenced by behavioural sciences, if at all, is unclear. This report fills that gap with an analysis of recent developments in Germany's public policy on health promotion and disease prevention.

If policy on health promotion and disease prevention emphasises the increase in widespread chronic

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1 “Act on enhancing health promotion and prevention”.

2 BGBl. I S. 1368.

3 There are many useful studies in public health on that. For comprehensive overviews see especially for the U.S. Nicholas Freudenberg, *Lethal but legal: corporations, consumption, and protecting public health* (New York: Oxford University Press, 2014), and for Europe and the US David Vogel, *The Politics of Precaution. Regulating Health, Safety, and Environmental Risks in*

Europe and the United States (Princeton: Princeton University Press, 2012).

4 Overview: Christina A. Roberto and Ichiro Kawachi, *Behavioral Economics and Public Health* (New York: Oxford University Press, 2016), Alberto Alemanno and Amadine Garde, *Regulating lifestyle risks: the EU, alcohol, tobacco and unhealthy diets* (Cambridge: Cambridge University Press, 2015).

5 Richard H. Thaler and Cass R. Sunstein, *Nudge. Improving Decisions About health, wealth and happiness*, 13rd ed. (London: Penguin Books, 2009).

6 For examples see Philipp Plickert and Hanno Beck, „Kanzlerin sucht Verhaltensforscher“, 26 August 2014, available on the Internet at <<http://www.faz.net/aktuell/wirtschaft/wirtschaftspolitik/kanzlerin-angela-merkel-sucht-verhaltensforscher-13118345.html>> (last accessed on 14 September 2015).

diseases, it has to find ways to reduce associated lifestyle risks. This report analyses whether and how the attention of the PräVg focusses on that, and it answers the question of whether the PräVg is a new step to public health policy that is promoting individual responsibility and contributing behavioural insight.

This report addresses the extent to which and how the recent legislation represents a critical juncture. In the past, policy on disease prevention was marginalised – empirically in German public policy and in political sciences. Discussions in both spheres concentrated on healthcare institutions and their funding for illness treatment⁷. This report is a source for further discussions on behaviourally influenced policymaking in the field.

II. The Stakes

When we examine (public) economic interests in health promotion and disease prevention we find a spectrum of items: The rising costs of chronic diseases are emphasised in legislation, international agreements, and elsewhere (e.g., UN resolutions, WHO and EU-programmes⁸). All these texts agree on the assumption that particular lifestyles are the cause of most chronic diseases: eating habits, physical inactivity and the like. Furthermore, a healthier population could at least cushion the negative effects of demographic change. If people are healthier they are able to work longer and will unlikely become an early nursing case. Moreover, capitalist societies are generally dependent on resilient, flexible and fit employees. Policy on prevention and health promotion could be driven by cost-benefit analysis, but such an economic focus is not the only driving force behind it.

The public – and to a lesser extent economic – significance of prevention policy is also to do with the foremost duty of the state to protect its citizens, as per Benjamin Franklin's famous quote, “An ounce for prevention is worth a pound of cure”⁹, in a broader sense. With regard to the lifestyle risks that affect human health this would include protection from potentially dangerous products and services (e.g., consumer protection policy) and discouraging participation in dangerous activities or behaviour (e.g., drug prevention). In the end public policy should protect the citizens from themselves and their own “unhealthy” decisions. The literature shows, however,

that social disparities influence individuals' health status and the likelihood of a healthy life¹⁰ (e.g., living environments, pollution, and knowledge of nutrition and health). A comprehensive policy on health prevention and promotion would consider these factors.

Individual behaviour becomes an object of public policy if the common good (a healthy society) is the result of the sum of each individual's healthy state. If public policy aims to promote individual health on this account, it will try to influence individual lives, trespassing the boundary between public and private affairs. This is in particular the case when (invisible) behaviourally informed policies are used to design a decision architecture that influences individuals' behaviour as a new form of “intrusive policy”. This report demonstrates how German policy-makers actually intend to intervene in individual lifestyles and how this intervention might differ from previous policies.

III. The Story so far: German Policy on Disease Prevention and Health Promotion

Literature on health care systems emphasises mainly health care institutions and insurance schemes. These institutions are designed to provide an infra-

7 This does not mean that there were no academic efforts to analyse public health policy (promotion and prevention), something that can be observed. However, these approaches at least “played the second fiddle” in practical health (care) policy and in policy research on health systems.

8 Resolution A/RES/66/2. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. In: Resolutions adopted by the General Assembly at its 66th session. New York: United Nations; 2012. Available on the Internet at <<http://www.un.org/Depts/dhl/resguide/r66.shtml>> (last accessed 16 May 2016). See for example WHO's programme to “reduce the exposure of populations and individuals to the risk factors for NCDs” <http://www.who.int/nmh/resource_centre/strategic_objective1/en/> (last accessed 16 May 2016), or the diversity of EU policies tackling chronic diseases http://ec.europa.eu/health/major_chronic_diseases/policy/index_en.htm (last accessed 16 May 2016)

9 Cited in: Daniel Kiel, “An ounce of prevention is worth a pound of cure: Reframing the debate about law school affirmative action” 88, *Denver University Law Review* (2011), p. 791.

10 For an overview of early research on obesity see Jeffrey Sobal and Albert J. Stunkard, “Socioeconomic status and obesity: A review of the literature” 105, *Psychological Bulletin* (1989), pp. 260-275. For a global comprehensive survey see Mariachiara Di Cesare, Young-Ho Khang, Perviz Asaria et al. “Inequalities in non-communicable diseases and effective responses”, 981, *The Lancet* (2013), pp. 585-597.

structure for illness treatment and are financed primarily by the statutory health insurance plans. Public policy has several ways of reacting when people become ill: Policies cover payments for non-productive time, treatments, medication etc. In this respect, the literature analyses policy change broadly as an “institutional change” focussing on benefits and services in case of illness¹¹. However, it considers policies on prevention and health promotion only marginally. In addition, the broad literature on “public health” has only a tenuous connection to welfare state literature on health care institutions.

There is a history of policy on disease prevention and health promotion in Germany, as far as certain risks are concerned, particularly communicable diseases, high-risk materials, and machines. There is also a long tradition of occupational health and safety measures, as well as voluntary immunisation programmes. Moreover, a nationwide regime for regular check-ups for babies, children and young adults was established in the 1970s. A considerable increase in programmes and measures took place in the 2000s, concentrating on a broader scope of preventive issues. From then onward, there has been a specific paragraph in the code of social law (*Sozialgesetzbuch V*) that assigns the financing of services meant to promote health and prevent illness to the statutory health insurance (§ 20, 20a SGB V). As latecomers to Europe in 2007, the German *Länder* (states) adopted “non-smoking-acts”, which can be interpreted as health prevention policy. That aside, German policy on prevention and health promotion was still very limited and visible mainly in the form of informa-

tion campaigns and singular disparate programmes. The national action plan on healthy nutrition and physical activity, *IN FORM* (<https://www.in-form.de/buergerportal/start.html>) was established in 2008 as the first nationwide comprehensive approach and might be seen as an initial step towards new policies.

Accordingly, the literature shows that prevention and health promotion were inadequately coupled in health policy. In this regard, Rosenbrock and Gerlinger diagnose a remarkable inappropriateness and undersupply¹². In particular, public health experts claim that individuals' living context and environment was poorly considered. The empirical results of research on German prevention and health promotion policy show:

- a broad spectrum and variety of haphazardly coordinated individual projects, and (with the exception of *IN FORM* and its recent enhancements)
- no comprehensive approach
- no focus on individual circumstances: education, environment, living and working conditions.

However, one exemption can be found: In Germany we see a particularly effective policy on HIV-prevention¹³. It follows an approach different from the “usual”, in that it includes the specific living and social environments of target groups and integrates people in the target group to develop suitable communication- and information-structures. Public policy experts recommend strongly, but unsuccessfully so far, that this approach should also be adopted with regard to lifestyle risks.

The following explanations might help to understand why policy on prevention and health promotion in Germany seems to be neglected: Germany carries the experience of two totalitarian regimes that focussed on public health based on strong ideological motives (*Volksgesundheit*)¹⁴. This might be one reason why “public health” used to be somewhat unpopular in German public policy. Empirically, today we can still observe a strong public antipathy even toward mere suggestions as to how to behave or what to eat (e.g., comparatively late implementation of non-smoking legislature, the debate on vaccination regimes and protests against strong suggestions to vaccinate, or proposals regarding nutrition, like the “Veggie Day”¹⁵). Secondly, the federal structure of Germany makes it difficult to find a comprehensive approach to a *national* policy on health prevention

11 In the tradition of Ellen M. Immergut, *Health politics interests and institutions in Western Europe*, 1st ed. (Cambridge u.a.: Cambridge University Press, 1992), Nils C. Bandelow, *Gesundheitspolitik - Der Staat in der Hand einzelner Interessengruppen? Probleme, Erklärungen, Reformen*, 1st ed. (Opladen: Leske + Budrich, 1992).

12 Rolf Rosenbrock and Thomas Gerlinger, *Gesundheitspolitik. Eine systematische Einführung*, 3rd ed. (Göttingen: Huber), pp. 110ff.

13 Formerly known as *Gib Aids keine Chance* (<https://www.gib-aids-keine-chance.de>), and in April 2016 established as *LIEBESLEBEN* due to the spread of different sexually transmitted diseases.

14 For an overview see Sigrid Stoeckel and Irene Hirschberg, *Prävention und Gesundheitsförderung – welche Rolle spielt die Gesundheitspolitik? Ein historischer Rück- und Ausblick*, 72 *Gesundheitswesen* (2010), pp. 35-40.

15 In 2013 (election campaign) the German Green Party suggested the introduction of a “Veggie Day”. Thus, lunchrooms and cafeterias should start to offer only meatless meals once a week (see: Thorsten Knus, “Der Speiseplan im Wahlkampf”, 6 August 2013, available on the Internet at <<http://www.fr-online.de/politik/veggie-day-der-speiseplan-im-wahlkampf,1472596,23924102.html>> (last accessed on 14 September 2015).

and health promotion: The *Länder* are responsible for public health services and wield several competences regarding prevention and health promotion, resulting in a very heterogeneous structure, comprising different policies¹⁶.

IV. Identifying Policy Change

In order to identify policy change of the kind that pertains to this report, Peter Hall developed a typology of policy change in the 1990s that proved useful to categorise policy developments¹⁷. In his work on macroeconomic policymaking in Britain, he showed how to distinguish changes in policy and highlighted the role that policy learning plays in respect of those changes. When looking at a completely different policy, namely that on disease prevention and health promotion, Hall's approach is helpful to evaluate systematically the policy process and to understand the mechanisms behind it. Hall differentiates between three levels of policy change¹⁸, which are used in this report:

- First order change: Experience and new knowledge inspire policymakers to modify the instrument setting. We find continuity of policy goals and of the general instruments used.
- Second order change: Though the same policy goals are still followed, the policy instruments and settings are changed.
- Third order change: Far-reaching changes produce new policies regarding instruments settings, the level of regulation, the policy instruments, and also the policy goals.

V. An Ounce of Prevention for a Pound of Cure? The 2015 German Legislation on Disease Prevention and Health Promotion

With very little public attention, the PräVg came into effect on 25 July 2015. This legislation aims to enhance health promotion and disease prevention by including all relevant stakeholders. To do this it focusses on the living environments (*Lebenswelten*) of people in Germany. Demographic change and thus the increased life expectancy, the rising numbers of chronic and psychological diseases, and the changing requirements of modern working environments

are emphasised as influential changes and challenges for policymakers. After two unsuccessful attempts at implementing such a law during previous election periods (2005 and 2013), the German government introduced the PräVg to meet these challenges.

1. Main features of the New Law

Several characteristics of the PräVg are highlighted here¹⁹: Firstly, the new legislation is formulated within the framework of the German health insurance system. It is neither an approach towards creating a public health system, nor is it characterised by cross-sectoral policymaking. Secondly, the legislation inserts a new supplement at the beginning of the code of social law (SGB V) that underscores the promotion of *individual* responsibility and what it calls the “self-capacity” (*Selbstkompetenz*) of all insured persons in compulsory health insurance plans. The core belief that every insured person is responsible for his or her health and has to act responsibly with regard to health risks is seen as the basis for the legislation. Health promotion is perceived as being at least partly the result of self-determined and health-conscious behaviour that lays the foundation for future behaviourally informed policymaking. Thirdly, the PräVg explains how those people are to be identified who have a special need for prevention policies, according to medical practitioners, because of unhealthy, risky behaviour and lifestyles. Doctors are expected to broaden their perspective beyond mere diagnoses, and into individual risk factors linked to consumption and behavioural patterns, which again, is important for behaviourally informed policymaking.

The legislation refers to risks as being caused by particular lifestyles. These risks are specified in the explanatory memorandum of the law: malnutrition, physical inactivity, obesity, smoking, excessive alcohol consumption and chronic stress. Although sever-

16 A comparison of the German *Länder* shows a clear east-west divide, where public health institutions in East Germany are more accepted due to the history of the public health system of the GDR.

17 Peter Hall, “Policy paradigms, social learning, and the state” 25 *Comparative Politics*, (1993), 275-296.

18 *Ibid.* at 278f.

19 The following concentrates on qualitative characteristics. For information purposes: with the PräVg the budget for prevention policy has been increased by 35 million Euro.

al of these risks represent the habits of adults, the PräVg focusses on young children and teenagers, which is why the “health competence” of families is emphasised. Concurrently, the focus is also on public services, like nurseries, kindergartens and schools, as well as workplaces and care facilities. These institutions are meant to offer low-level disease prevention and health promotion.

Whereas policies on prevention and health promotion have existed side by side until now without being part of a greater framework, the PräVg tries to combine existing programmes for disease prevention and health promotion. Maybe policymakers have recognised that a coherent policy is necessary in order to make “an ounce of prevention” actually be “worth a pound of cure”. Therefore, the PräVg also includes a “National Prevention Strategy” that functions as the basis for forthcoming policies. Aggregating data and connecting key players are the main pillars of that strategy. Interestingly, the PräVg does not address modern occupational health risks, like the effects of the work burden in the industrial and service economy and the lack of balance between life and work. Nevertheless, it regards the employer as an important player in campaigns and programmes for health promotion associated to lifestyle-risks.

2. Discussion

Two striking features of the PräVg need to be highlighted: Firstly, the new law does not break with the strong focus on the compulsory insurance system in Germany and shows that it is still bound to the traditional views and perceptions of the system. There is no comprehensive public health approach, but a combination of new elements within the logic of the insurance system. However, the concentration on self-responsibility and health competence underlines a move away from the solidarity principle that used to be the basis of the compulsory insurance system. The legislation does not include indications on *how* to “nudge” people into living healthily, but does expect a “low-risk” (or even no-risk) lifestyle from the insured persons. From now on, being a member of the insurance system does not only mean paying contributions, but more than ever also assuming responsibility for one’s own health. If you (or a deputy) are not paying the contributions, you will not receive any benefits or services from of the system. So far, it is

unclear whether a risky lifestyle would also be considered to be recklessness with regard to one’s own health and would be seen as a justification for reduced standards in care and provisions, or even of denial when it comes to benefits or services.

Secondly, the idea of the responsible citizen is not only a buzzword. It is the underlying assumption for the second striking feature: the identification of (high-)risk groups and the data collection of individual risk profiles can be seen as the starting point for new policies. Thus, the PräVg does offer concrete procedures and it sets the basis for future behaviourally-informed policymaking. Medical practitioners are involved in the creation of a broad database of risk profiles. Besides this, medical practitioners are to offer specific and individual advice to people following risky lifestyles. However, the law is not very clear about the use of this data collection beyond that purpose.

Although the legislators have understood the importance of individual circumstances (*Lebenswelten*) the law does not explain how to improve these effectively. This is especially the case with regard to people who have difficulties implementing a healthier lifestyle and who need help to act “responsibly”. There might be two explanations for the lack of concrete behavioural instruments or advice: First, the course and basis for such legislation had been set before behavioural experts were “on board” and could influence such a specific policy field. Second, the traditional networks and institutions are strong and path-dependent, preventing policymakers from showing openness towards novel approaches.

Returning to the typology of policy change by Peter Hall, the PräVg allows one to draw some conclusions. The policy goals have changed in respect of a statutory attribution of responsibility: Although the compulsory insurance schemes are still the major players and will contribute financially and institutionally to an effective disease prevention and health promotion policy, *the PräVg paves the way to a paradigm change* in that citizens are officially put in charge of their risky lifestyles. Admittedly, this one law may not be enough to identify a change of policy instruments in this field. However, it might turn out to be the first step towards a third-order change, which might be fulfilled if new concrete policies are produced as a follow-up. If an ounce of prevention is to be worth a pound of cure, the ounce has to be very effective. Perhaps the new PräVg grants the option

to set a new standard with this in mind, as never before in Germany has there been such a *far-reaching attempt to legally spell out goals and responsibilities for disease prevention and health promotion and to bundle activities in this policy field.*

VI. Conclusion

This report has shown how German policy makers put into effect the first comprehensive legislation on disease prevention and health promotion. We have learned from the analysis that the act in question seems not to profit from behavioural insight yet and does not effectively integrate new policy instruments. It has been shown, however, that the goals have changed, as the law underscores everyone's responsibility for their own health. Policy on disease prevention and health promotion is now at the forefront of German public health policy. Policymakers have started to pay more attention to this new approach, which is reflected in the funding being provided for it. Even so, surprisingly this development has failed to attract any public attention.

The results of this analysis contribute to the discussion about the focus on individual responsibility and prevention of lifestyle risks that will be a major feature of future policies. The ideas and paradigms of the new PräVg are in line with current debates on risk regulation and a promotion of healthier lifestyles, not only in Germany. This report has shown that this legislation allows German policymakers to implement policies that are behaviourally informed.

It lays the ground for concrete policies based on risk profiles (data base) and the assumption of individual responsibility. The WHO and EU policies support such a development, following similar approaches that reduce specific lifestyle risks and focus on the individual. Cost pressure in health systems and the assumption that lifestyle risks are the cause of specific diseases enhance this development. This policy change coincides with an increasing societal trend of healthier living or an attempt at it. People seem to be increasingly willing to document their behaviours and to make an effort to fight bad habits. This is surely to do with the current beauty ideal being that of a sportive person.

To reach the goals of the PräVg effectively and get the proper “ounce of prevention”, the scope of prevention and health promotion policies needs to be expanded. What should happen with the individual risk profiles remains an open question, as does the way in which claims of “individual responsibility” and “healthy or healthier lifestyles” are to affect medical care and benefits in cases of illness. Furthermore, this analysis of the PräVg shows that, since the law considers individual circumstances to be decisive, effective policies would have to be extended to consumer policy, environmental policy, agricultural policy and the like. In this way, policies should reach the individual and help people live responsibly with regard to health risks. Concerning this, the 2015 legislation is but a first step, but one might expect it to become a paradigmatic element of modern health policy, setting the cornerstone for behaviourally informed policymaking.