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# Improving diet and physical activity: 12 lessons from controlling tobacco smoking

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On behalf of Oxford Vision 2020, a partnership dedicated to preventing the forecast worldwide growth of chronic diseases, the authors suggest that 12 lessons learnt from attempts to control tobacco smoking could be used to tackle the chronic disease epidemics evolving from unhealthy diets and a lack of physical activity

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This year three new books have been published about the progress made globally in research, policy, and actions to control tobacco smoking.<sup>1–3</sup> In addition, Sir Richard Doll reported this year on 50 years of following British doctors to document the impact of smoking on their health.<sup>4</sup> We have reviewed the evidence and approaches taken to control tobacco smoking, well described in these new texts, because of the rapid global increase in the risk factors of unhealthy diets and lack of physical activity. As part of the Oxford Vision 2020 process,<sup>5</sup> we have proposed 12 lessons from tobacco control that might speed up progress in tackling these new public health threats. We also drew on other recent insights from tobacco control in addressing other chronic disease risks.<sup>6–8</sup>

## 1. Address the issue of individual responsibility versus collective or environmental action early and often

This issue pervades debates on the role of government versus that of the individual, and both sides of the issue need to be addressed. However, the World Health Organization's statement in its Ottawa charter remains valid: "Healthy choices need to be the easy choices."<sup>9</sup> Individual responsibility can have its full effect only in a society where governments, private interests, and other sectors work together to support individuals making healthy choices. In all societies special support is required for children, who are neither competent nor legally able to make fully informed decisions about behaviours with lifelong effects on their health.

## 2. Evidence of harm is necessary, but is not sufficient to motivate policy change

Although sufficient evidence exists to guide clear policies on, for example, reducing salt, sugar, and fat in the diet and promoting physical activity, some essential epidemiological gaps need to be closed in relation to diets and outcomes in developing countries. This uncertainty in some areas and the resulting call for more research may be used to delay policy change, and some interested parties will probably continue to dispute the evidence. Undertaking research necessary to close the remaining knowledge gaps is therefore important to eliminate any persisting uncertainty, particularly with regard to the health effects of obesity.



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Increasingly, developing countries need to tackle obesity and associated chronic diseases as well as hunger and undernutrition

## 3. Decisions to act need not wait for evidence of the effectiveness of interventions

Initial tobacco control interventions were not evidence based but represented sound judgment at the time. It is now clear from this experience that actions such as restrictions on advertising, pricing interventions, and broad community projects can be effective at changing behaviour. This knowledge and an intuitive approach should enable us to develop interventions for diet and physical activity. This should be done in such a way that they can be critically evaluated in terms of effectiveness, and adjustments made over time. Oxford Vision 2020 is planning to develop scalable demonstration projects on this basis.

## 4. Fully implement interventions known to be effective

Identification of effective methods for stopping smoking has not led to their widespread use. To decrease chronic disease mortality and severity by 2020, we need to increase rates of stopping smoking among current smokers and of weight loss among those who are overweight or obese and improve diets in other ways. Stopping initiation of smoking and reversing trends in childhood obesity will only have an impact well beyond 2020.

Stopping smoking leads to rapid reductions in mortality from cardiovascular disease: the excess risk roughly halved after one year of smoking abstinence. Barriers to implementing programmes for stopping smoking need

to be urgently addressed, such as the lack of training by healthcare workers; limited infrastructure to support interventions; reimbursement issues for counselling, drugs, and intervention dissemination; and smokers' hesitancy to use drugs to help quit.

There is evidence of the beneficial effects of reducing serum cholesterol concentrations and increasing physical activity on cardiovascular disease, reducing salt intake on hypertension, and increasing fruit and vegetable intake on diabetes. For obesity, we currently lack evidence of effective interventions. A strategy should be developed to address obesity as a chronic relapsing disorder that may require several weight loss attempts and the use of effective drugs that are developed in collaboration with the public health community.

### **5. Real and perceived needs and concerns of developing countries need to be addressed even if they involve going beyond the initial scope of the risk being addressed**

For tobacco control, this has meant addressing all forms of tobacco use, not just cigarettes, and considering the concerns of tobacco farmers and providing convincing evidence that their livelihoods were not under threat in the mid-term.

With regard to diet and nutrition, the needs and concerns of developing countries will be more complex. Close interaction will be needed between those working to address hunger, micronutrient deficiencies, and undernutrition in general and those working to develop policies for overweight and chronic disease prevention. The goal should be to promote the optimal diets for all. It also requires that greater attention be paid to the complex agricultural and economic issues related to subsidies and decisions about what is cultivated.

### **6. The more comprehensive the package of measures considered, the greater the impact**

Narrow approaches tend to be emphasised currently in relation to diet and physical activity—more exercise at schools, more education at work, etc. Few take a broad perspective.

Those implementing a comprehensive package of measures to control tobacco or improve diet and physical activity need to understand where governments are constrained in their actions in order to help them find solutions. For example, some countries have a constitutional impediment to a complete ban on tobacco advertisements: a way round this is to support them going to the limit of their law and at the same time investing more in effective counter-advertising.

It is important to avoid dissecting comprehensive programmes in attempts to ascertain the effectiveness of individual components. The components work together to create a social and policy milieu that works collectively rather than as separate elements.

### **7. Broad based, well networked, vertical and horizontal coalitions are key**

Vertical coalitions include all levels of health services—from local health departments to regional and national

authorities to WHO. It is increasingly clear that a wide array of players outside the traditional boundaries of health care need to be engaged and, often, encouraged to take the lead on certain aspects of the problem. But health workers still need to provide overall direction and leadership. This has been achieved for WHO's Framework Convention on Tobacco Control in the United Nations, among non-governmental organisations, and, to a limited extent, across departments in many governments. More needs to be done for diet and physical activity, however.

### **8. Change in support for tobacco control took decades of effort led by media savvy and politically astute leaders**

The global breakthrough came with Gro Harlem Brundtland's willingness, as director general of WHO, to tackle an unpopular topic, speaking out often about smoking as a real global concern to heads of state, major donors, and those in industry. But progress had been made since the 1960s through the reports of the Royal College of Physicians and of the US surgeon general to develop the scientific basis for the content of the Framework Convention on Tobacco Control. Key networks of advocates and non-governmental organisations were thus empowered to support this first ever international health treaty. Such international interest has happened to only a limited extent in relation to diet and physical activity.

### **9. Modest, well spent funds can have a massive impact, but without clear goals funding may not be sustainable**

Some countries have set targets for tobacco control but then not resourced their attainment. For both tobacco and diet there are no agreed targets or internationally accepted indicators of progress. A global initiative to develop these for selected countries could be extremely useful; the figures could also be used for advocacy and budgetary purposes. Ministries of finance and ministries of health alike need evidence for allocating scarce funds for preventive health interventions. It is far easier to fund medical care systems than prevention programmes, but the broad effects of secondary and tertiary medical care interventions are far less cost effective than preventive, policy based interventions on tobacco control. This understanding needs to extend to diet and obesity control programmes.

### **10. Complacency that past actions will serve well in future may retard future progress**

Despite all the progress in tobacco control, the bottom line remains that global consumption continues to increase, albeit slowly. Few countries have achieved sustained reductions in smoking prevalence of more than 2% a year for a decade (though South Africa has reported a 6% decline a year for eight years). The ability to achieve only slow rates of decline when dealing with such a huge public health problem means that we need to look afresh at our policies and interventions. We must consider what is needed to reach an annual decline of 8-10% and then to maintain smoking

prevalence well below 10% in all social classes and ethnic subgroups.

A stronger emphasis on smoke-free policies combined with increased tobacco prices and greater access to aids to stopping smoking could certainly achieve higher levels of decline in per capita tobacco consumption. New approaches, including the use of plain packaging and health oriented trade policy, need to be considered as well.

For diet, and especially obesity, there is still insufficient research of community based interventions to show best practices. Investment in large scale, community based research is needed to yield evidence of progress against obesity and other adverse outcomes of poor diet and physical inactivity.

### 11. Rules of engagement with the tobacco and food industries need to be different and continually under review

In recent years the public health community has not officially met with the tobacco industry, with the exception of the US Centers for Disease Control and Prevention and WHO in their recorded discussions about product regulation. This reflects concerns about the tobacco industry's longstanding efforts to manipulate and distort scientific evidence, as revealed by its internal documents released during US litigation.<sup>10</sup>

While constructive dialogue with the tobacco industry remains only a distant prospect, until they can show incontrovertibly that they have changed, engagement with the food industry is different as, unlike tobacco, food is not a product that is harmful when used as intended. Here, there is scope for shared exploration of issues such as marketing to children, joint action to promote physical activity and healthy eating, and support for priority research—although it is important to recognise that, even for responsible industries, commercial pressures exist, and observation of the tobacco industry indicates the need for effective vigilance. Oxford Vision 2020, with selected others such as the International Business Leaders Forum, could provide leadership in developing consultations involving governments, non-governmental organisations, the food industry, and academia.

### 12. Risk factor envy is harmful—a joint approach is needed

As the media and others have focused on obesity, less attention has been paid to tobacco smoking. Agencies that fund public health research and interventions may be shifting their funding criteria as a consequence. There seems to be a tendency to focus on one major public health problem at a time, and thus a competition for attention and funding develops. We urgently need to build synergies rather than competition between those active in tobacco control and those addressing diet and physical activity. It is important to consider not only the death toll from specific causes but to develop a holistic approach to public health that includes multiple risk factors. A grand coalition of the interested parties could do more good for changing public health policy than they could working in isolation from each other.

### Summary points

Progress in tobacco control required high level, sustained advocacy and political acumen; progress in addressing obesity will require the same

Tobacco smoking remains a major global threat despite a shift in media attention

Opportunities for joint approaches to nutrition and tobacco related health problems have been neglected

The potential for positive interaction with the food industry in finding common solutions remains high provided the industry shows transparency

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