Published in *Dancing in the Rain* in 2015 by Future Leaders (www.futureleaders.com.au)

3

NCDs and the Culture Wars: Creating Healthy Policies to Prevent NCDs

Rob Moodie

By not acting we are killing people.
Nicola Roxon, Australian Federal Minister of Health (2010)

As explained earlier in the book, NCDs are closely related to human behaviour. We are what we eat. We are also what we drink, smoke and exercise. And these behaviours are very much part of the prevailing culture of a nation, or a community or a family. They are also highly changeable, for better or worse.

Over time, what is normal has changed — cultural dietary patterns have changed so that over-consumption of energy dense, nutritionally poor (EDNP) foods and beverages has become the new normal. *Junk food has become the new black*. They have never been cheaper, more advertised and more available. An example is the ubiquity of the vending machine on every level of office buildings, on train station platforms, in airport departure lounges and in schools. They are always tempting us to consume calories we don't need. Never before in history have we been able to shove as many calories down our throats in such an effortless fashion!

And at the same time with this our activity patterns have changed — in countries such as Australia and the United States we have become more car dependent, with far fewer jobs that involve exercise and a huge rise in screen-based entertainment that keeps

our posteriors glued to the couch. In these countries, the average citizen has decreased their energy utilisation while greatly increasing their average energy (caloric) intake.

There are, however, some encouraging signs in countries such as the United States where 'Calories consumed daily by the typical American adult, which peaked around 2003, are in the midst of their first sustained decline since federal statistics began to track the subject, more than 40 years ago'.[1]

If we are to continue to live healthier and longer lives then influencing our behaviours — in essence, influencing our culture — is a major part of the battle. And establishing and implementing the most effective policies is fundamental to our good health.

What exactly is policy?

Policy is 'a plan or course of action, as a government, political party, or business, intended to influence and determine decisions, actions, and other matters'. It is your map. It tells you where you are going. Good policy is essential for good health but it is not sufficient, in itself, just as a map on its own won't get you anywhere. Just as you have to travel the road, policy has to be implemented.

Or it is the equivalent of an orchestral score, which leaders, like conductors, can use to produce harmonised action to produce the outcomes they desire. But again, the orchestral score needs to be played — it is greatly frustrating when enormous effort goes into developing policy, consulting stakeholders, asking for public submissions, having technical working groups and so on, only to see nothing implemented — the policy that just stays on a shelf is like an unplayed musical score.

A hundred years ago, Charles Winslow from Yale described public health (in this case we will substitute NCD prevention and control) as 'the art and science of preventing disease, prolonging life and promoting health and well-being through organised community effort'. Policy defines what the *organised community effort* is.

Building healthy public policy is the first of five key pillars of action according to the 1986 *Ottawa Charter for Health Promotion*. Healthy public policy is the organising framework and is supported by the creation of supportive environments, strengthening community action, developing personal skills and lastly, reorienting health services to promote health.

Outstanding policy successes

The 20th century and the first fifteen years of the 21st century have seen some outstanding successes in many high income countries, as well as in low and middle income countries.

These include major improvements in maternal survival and infant and childhood health. This has been through a combination of better nutrition, better education, increased standards of living as well as better health service (for example, mothers delivering babies in hospitals), and through reductions in vaccine preventable diseases such as smallpox (eradicated completely) and dramatic decreases in the number of cases of polio, measles, and hemophilus influenza. In the last 15 years, building on many years of work by WHO, UNICEF, and Gavi, the Vaccine Alliance and its partners has reached a half a billion children, averting over 7 million deaths, in many of the poorest countries across the globe.[2]

Many countries have seen significant reductions in road deaths despite major increases in the number of cars being driven, due to good policies that cover driver behaviour (speed, alcohol and drugs, wearing of seatbelts), better and safer roads, and safer cars. In many countries the cultural norms that shape the way people drive have changed substantially over many decades. What was normal behaviour 30 years ago, such as driving drunk at high speed without wearing a seat belt, is simply not the norm now. Globally, 88 countries have reduced their road traffic deaths in the last decade, with the highest rates of reduction in high income countries,[3] although the global total at 1.24 million remains unacceptably high, and it is middle and low income countries where rates are the highest.

Increased contraception use, education and other factors mean that many countries have far fewer unintended pregnancies and families are much more likely to achieve desired birth spacing and family size.

There have been major declines in deaths from heart attack and stroke in the OECD countries. They are still these nations' (and the globe's) top causes of preventable premature deaths. The public health community has helped achieve remarkable declines in deaths from both diseases; for example, since 1950 in the United States, deaths from cardiovascular disease have declined by 60%, and stroke rates have declined by 70%.

In many countries, tobacco control is a great example of establishing good policy and then putting it into practice. In Australia, for example, the percentage of men smoking has reduced from over 70% in the 1950s to below 13% of Australian men and women in 2014. The policies that have been so successful in many countries (mainly high income countries to date) across the globe include increasing the price of cigarettes through taxation, banning of advertising, promotion and sponsorship, introducing smoke-free laws, graphic warnings on plain tobacco packs, and assisting people to quit.

The tobacco industry spent the first 60 years of the 20th century convincing people across the globe that tobacco smoking was not only normal but also glamorous and desirable. The policies mentioned above all contribute to de-normalising, de-glamourising and making tobacco smoking undesirable. In other words changing culture — changing what is normal.

The tobacco industry is without doubt one of the most unethical industries to ever produce goods. Since the 1960s, the tobacco manufacturers have known that their products are not only addictive but result in the premature deaths of their clients. Yet they continue to expand their markets and fight their critics using highly amoral, sometimes regarded as criminal, tactics.

Some policy failures

Despite great success in countries such as Australia, Sweden, Thailand, the United States and the United Kingdom, we are still losing the global battle against the tobacco industry. Two-thirds of Indonesian men smoke and more than half of Chinese men smoke. Even more disturbing is that 40% of 13- to 15-year-old Indonesian boys smoke. How have these levels been reached while the world has known for more than 50 years that tobacco is such a deadly habit? The tobacco industry has moved rapidly to 'colonise' countries with the least regulation (that is, with non-existent or least effective policies, or policies that exist but aren't implemented); they are expanding their markets and influence across the globe, seemingly with no capacity to diminish or mitigate the harm they do.

It is astonishing that an industry such as tobacco, which is so harmful to human health, can wield so much power. In Indonesia, Philip Morris and its affiliate, Sampoerna, are investing $US174 million to improve production capacities so that, as Sampoerna's President has said, 'Indonesia would be the centre of the Marlboro brand production to cater [for] demands in the Asia-Pacific region'. One has to ask, why do they need to expand their activities? Or why do governments allow them to do so? Aren't the existing 700 million smokers in the region enough? Especially when we know that two-thirds of them will die prematurely, each losing about 10 years of life to tobacco.

In China, it is now estimated that 114 million people have diabetes. Globally, the International Diabetes Federation estimates that there are 387 million people living with diabetes, and project a further 205 million cases by 2035 if we continue as is.[4]

In 2012, about 3.3 million net deaths, or 5.9% of all global deaths, were attributable to alcohol consumption. Although high-income countries tend to have the highest alcohol per capita consumption (APC) and the highest prevalence of heavy episodic drinking among drinkers, alcohol harm is having a significant

impact[5] in countries such as South Africa, which has one of the highest per capita alcohol consumption rates in the world, with more than 30% of the population struggling with an alcohol problem or on the verge of having one.

Tobacco, alcohol, and diabetes related to being overweight and obesity all have one feature in common. They are each largely driven, and in the case of tobacco completely caused, by powerful commercial interests in the form of transnational corporations. It has been said that China's booming economy has brought with it a medical problem that could bankrupt the health system.

Raising resources — not yet!

New global coordinating mechanisms, chiefly through the World Health Organization, are being established to prevent and control these NCDs — yet they are currently disproportionately under-funded. NCDs result in 50% of the global burden of disease, yet receive the smallest amount of donor funding of all major global health areas, accounting for only 1.23%, or US$377 million, of all development assistance for health (DAH) in 2011.[6]

Wealthy country aid agencies (known as bilateral aid agencies) such as the United States Agency for International Development (USAID), the UK's Department for International Development (DfID) and the Scandinavian agencies are the dominant funding sources for global health, providing 52% of overall DAH, but only provide 11% of the very small amount to prevent and control NCDs. At the moment, the Bloomberg Foundation and Gates Foundation provide considerably more funds than direct bilateral funding. To date, these major agencies have been largely absent as direct contributors in NCD policy, funding and human resources. But they are not alone in their absence, as the big international development NGOs such as CARE, Oxfam, World Vision and Medicins sans Frontieres (MSF) have no policy and provide little or no funding to assist in dealing with NCDs globally.

The most effective way for governments to raise revenue for prevention and for their health systems and, at the same time, reduce tobacco consumption is to raise tobacco taxes. This has been a very successful approach in many countries such as Australia and Thailand, but progress in this area has been relatively slow over the last 30 years.

There was, however, 'success' at the recent Third UN International Conference on Financing for Development, which took place in July 2015 in Addis Ababa. It concluded that '… as part of a comprehensive strategy of NCD prevention and control, *price and tax measures* on tobacco can be an effective and important means to reduce tobacco consumption and health-care costs, and represent a revenue stream for financing for development in many countries'. It is important that this is finally becoming global policy given that this was first enacted with the establishment in 1987 of the Victorian Health Promotion Foundation (VicHealth), which used a dedicated tax on tobacco to buy out tobacco sponsorship and fund NCD prevention and control.

The new battle lines for policy: personal and parental responsibility versus societal responsibility

The major battle lines for global health in the 21st century are now being redrawn and they are less to do with malnutrition and vaccination, and more to do with behaviours relating to tobacco use, poor diets, physical inactivity, and the harmful use of alcohol.

If we look at these four major risk factors we find a recurring debate about who has responsibility to ensure healthy behaviour. Most often the arguments are that it is either the sole responsibility of individuals (or in the case of children, the responsibility of their parents) or that it is the responsibility of governments or society as a whole.

It is in my view a combination of both, and generally speaking the higher the employment, education and income levels of a group then the greater control, and hence the greater responsibility people

can take over their behaviour. On the other hand, individuals, families and groups with lower levels of education, employment and income have lesser degrees of control over the decisions they make. And they tend to be more susceptible to advertising and more reliant on cheaper food, which is why fast food chain and alcohol retailers have higher densities of their outlets in poorer areas — they know they will make more money.

As NCDs began to impact more on our lives, they have often been labelled as *lifestyle diseases* due to the personal choice of individuals, families and communities. This implies that it is only a matter of personal responsibility. If, however, you acknowledge the fact that there are very powerful industrial and commercial forces at work that have a great impact on our health behaviours, then NCDs can be equally considered to be *industrial diseases* as well as *lifestyle diseases*.

The Culture Wars: Who and what determines normal? The challenge of policy making for NCDs

To prevent and control NCDs, global agencies such as the World Health Organization[7] as well as Australia's National Preventative Health Taskforce[8] recommend policies that include the phasing out of junk food advertising, tighter liquor licensing regimes, phasing out of alcohol sponsorship in sport, better pricing and taxation and finally public education and social marketing. Because these measures are effective at reducing consumption of harmful products and therefore impact corporate profitability, all of them are highly contested and controversial.

There is powerful opposition from manufacturers, retail chains, advertisers, and the media (who benefit from the advertising). This opposition is compounded at a global level — for example, by the International Olympic Committee (IOC) and the International Football Federation (FIFA) — and in countries such as Australia where major sporting bodies (Australian Football League, National Rugby League Cricket Australia and the Australian Rugby Union) are sponsored by junk food and drink and alcohol

companies. Often led by their industry associations, these industries and bodies have become very convincing coalitions of the unwilling — coalitions that governments across the globe fear, and are often very reluctant to take on. These are financially and politically powerful transnational corporations that have no allegiance to any particular country — just to their shareholders — and we now see them suing governments, with the example of Phillip Morris suing the Australian government over plain packaging legislation, the cost of which is estimated to be up to AUS$50 million[9]

Over the last ten years one of the more effective strategies has been the labelling of any legislative or regulatory approaches as the manifestation of the *nanny state* — which highlights the relationship between the authority of the state and the agency of the individual.

The rhetoric of the nanny state — and who invented it?

The expression 'nanny state' is a cogent example of the use of the metaphor to lobby, frighten and cajole for one's own views. Take some examples from when the Australian National Preventative Health Strategy (focused on obesity, tobacco and alcohol related harm) was released in 2009. Neil Mitchell from 3AW and the *Herald Sun* said:

> … if Kevin Rudd [the then Australian Prime Minister] is seduced by the 300 pages of social-engineering strategy that sit on his desk he will become the Super Nanny of Australian history.[10]

Another response was:

> get ready to be told you need to exercise more, eat less fat, stop smoking and stop drinking. Nicola's health taskforce has observed that the stuff we've been told to do for 30 years isn't working, and their solution is, ah, to do more of it? Australian community hasn't been totally regulated away yet. But it's disappearing. Unless governments drop their nanny-first attitude, we'll lose it.[11]

The term *nanny state* was born in a 1965 *Spectator* column by leading British Conservative politician, Iain Macleod, a Health Minister who smoked furiously and died at 57 of a heart attack.

As Professor Mike Daube from Curtin University points out, the phrase caught on and has become a staple for those who want to attack health groups and governments, especially interest groups bereft of real arguments and journalists in search of clichés. It has become a special favourite of tobacco, alcohol and junk food companies and their supporters. It is, of course, never applied to the 'law and order' measures that governments take when dealing with other societal issues, such as illicit drug use.

After Macleod coined the phrase, others promoted it, notably the even more conservative polemicist Auberon Waugh. Waugh, who opposed any action on smoking and even wrote a book promoting its virtues, claimed that: 'we live in a nanny state, where nanny, far from being the gentle, indulgent, feckless old thing of Labor dreams, is a ferocious virago of Tory nightmares'. Waugh, like MacLeod, was a heavy smoker, and he too died of heart disease at 61.[12]

A common retort to anyone interested in controls on alcohol is to label them a wowser. The word 'wowser' was first coined in Australia in the early 1900s. See below the eloquent and humorous definition attributed to US journalist HL Mencken:

> a drab-souled Philistine haunted by the mockery of others' happiness … he must devote himself zealously to reforming the morals of his neighbours, and, in particular, to throwing obstacles in the way of their enjoyment of what they choose to regard as pleasures.

Janet Hoek, from the University of Otago, has explored this phenomenon in depth in her paper entitled the 'Wicked Witch of Anti Marketing? Myths, Metaphors and the "Nanny State"'.[13] She seeks to explore how archetypal images offer insights into political philosophies that, in turn, influence how marketing is regulated.

Daube also points out that it is evident that those who use the term rarely if ever actually define it. 'Nanny state' is one of those terms that sounds critical, implies that governments and those seeking action are doing something wrong — but doesn't actually explain why.[14]

Trade and economic development versus health

We now face a major dilemma: unrestrained commercial development is pitted against the health and wellbeing of populations. This dilemma is not new — opponents of the abolition of slavery complained it would ruin the economy — but it is manifesting in more obvious ways in the 21st century.

The tobacco, alcohol and ultra-processed ('junk') food and drink industries have been rapidly expanding in low and middle-income countries. In the past decade, tobacco retail sales growth in these countries was 20 times that of the developed world. For alcohol consumption, it was three times, and for sugar-sweetened beverages it was twice. But it isn't only Indonesia, China and South Africa where we find this dilemma; it is alive and well in Australia.

For years we have known that the tobacco industry promotes and funds biased research findings, co-opts policy makers and health professionals, lobbies politicians and officials to oppose public regulation, and influences voters to oppose public health measures through expensive public relations campaigns. This success has been noticed, and over the past decade alcohol and ultra-processed food and drink companies have been emulating these very same tactics.[15]

This is of little surprise, given the flow of people, funds and activities across the industries. For example, Philip Morris owned both Kraft and Miller Brewing; the board of SAB Miller (the second largest alcohol manufacturer) includes at least five past or present tobacco company executives and board members; and the Diageo (one of the biggest alcohol transnational corporations) executive director responsible for public affairs spent 17 years in a similar role at Philip Morris.

The major tobacco, food and alcohol companies have assets that are greater than many countries and can wield this power in parliament, law courts and the media, against the interests of the public's health.

We must seek a balance that maximises economic development and health and wellbeing simultaneously. Those who advocate for public health regulation, however, acknowledge that economic development plays a very important role in the health and wellbeing of populations. Income, employment and education levels are all major determinants of good health. Businesses create wealth, provide jobs and pay taxes (but, as we have seen, not all of them). One of the best ways to protect and promote health is to ensure people have safe, meaningful jobs. The more evenly wealth and opportunity are distributed, the better the overall health and wellbeing of a population.

The future of NCD policies

We undoubtedly have a dilemma. We know what to do to prevent and control much for the burden of disease currently caused by NCDs, but alas the opposition of some very powerful industries, their advertisers, the sporting associations they sponsor and some media corporations, makes progress very difficult indeed.

What are the key ideas, actions and approaches that will change this?

First, the voice and actions of the community can and do lead politicians — it is not always the other way around. This is happening through advocacy of NGO groups (for example, the NCD Alliance globally, the Obesity Policy Coalition in Australia), community groups (Dunk the Junk in the United States), parents' groups (The Parents Jury), and individuals using social media.

There is a growing push for active travel (cycling, walking and public mass transit), retrofitting suburbs to encourage walking and cycling, and redesigning buildings (reintroducing stairs that can be seen and used) and workplaces (using standing desks). Countries

can learn much from each other — for example, Australia and the United States can learn much from their European, Scandinavian and Japanese colleagues.

There are now great co-benefits from increasing active transport and mitigating climate change — we are in a situation in many countries where we use too much fossil fuel and not enough personal fuel (calories) to get around. This is gradually changing, but with the right political and community leadership, change can be much quicker and much healthier.

At the same time, academics have an important role to be researching what works and what doesn't work, and to make sure this evidence is communicated to the community, to bureaucrats and political leaders.

Which brings us to the need for bipartisan or multipartisan approaches ('de-politicising' policies). One of the most damaging features of highly adversarial politics is that every time governments change, their policies change with it. Witness what the Abbott government did in Australia in 2013 when it abolished the National Preventive Health Agency and then removed almost $400 million from community-based prevention programs implemented by state governments.

It seems we have real problems in explaining and convincing many parts of society, especially our political leaders, about the benefits of prevention. We have managed to do this effectively with tobacco (despite long and nasty opposition by the tobacco companies), but we have yet to succeed in the areas of diet and physical activity and alcohol.

An example is the estimated benefits of salt reduction in our diet. Professor Bruce Neal from the George Institute estimates that a $20 million (well researched and implemented) national salt reduction campaign would result in the equivalent improvements in health currently produced by $1.5 billion in anti-hypertensive medications. At that potential effectiveness it is surely worth a try.

And finally, just like the three fundamentals of real estate being the three 'Ps', the three fundamentals of great NCD policy are also three 'Ps' — persistence, persistence, and persistence.

Endnotes

1 M Sanger-Katz, 'Americans are finally eating less', *New York Times*, 2015, retrieved from http://www.nytimes.com/2015/07/25/upshot/americans-are-finally-eating-less.html?&moduleDetail=section-

2 Gavi Alliance – See more at http://www.gavi.org/Library/News/Press-releases/2015/Half-a-billion-children-vaccinated-and-seven-million-lives-saved-thanks-to-Gavi-partners/#sthash.u9AaXB5I.dpuf

3 WHO, *WHO global status report on road safety*, 2013, retrieved from http://www.who.int/violence_injury_prevention/road_ safety_status/2013/en/

4 International Diabetes Federation, 'Diabetes: facts and figures', *IDF diabetes atlas*, 6th ed update, 2014, retrieved from https://www.idf.org/worlddiabetesday/toolkit/gp/facts-figures

5 WHO, 'WHO management of substance abuse alcohol', retrieved from http://www.who.int/substance_abuse/ facts/alcohol/en/

6 Institute for Health Metrics and Evaluation, retrieved from www.healthdata.org/

7 WHO, 'Draft Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020', 2013, retrieved from http://www.who.int/nmh/publications/ncd_action_plan2013.pdf?ua=1

8 Australian National Preventative Health Taskforce, 2009, National Preventative Health Strategy, retrieved from http://preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/national-preventative-health-strategy-1lp

9 P Martin, 'Australia faces $50m legal bill in cigarette plain packaging fight with Philip Morris', *The Age*, 29 July 2015, retrieved from http://www.theage.com.au/federal-politics/political-news/australia-faces-50m-legal-bill-in-cigarette-plain-packaging-fight-with-philip-morris-20150728-gim4xo.html

10 N Mitchell, *Herald Sun*, 2 September 2009.

11 C Berg, 'Meet the nanny spider', *The Sunday Age*, 4 October, 2009.

12 M Daube, 'Welcome back Nanny? Civil liberties versus the public good', Public Debate, July 2009.

13 J Hoek, 'The wicked witch of anti marketing? Myths, metaphors and the "nanny state"', 2009, retrieved from http://www.duplication.net.au/ANZMAC/PDF/S20/Hoek%20S3%20S5%20P4%20.pdf

14 M Daube, ibid.

15 R Moodie et al., 'Profits and pandemics', *Lancet*, 381, 2013, pp. 670–679.