

Moving beyond global tobacco control to global disease control

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INTRODUCTION

More than 60 years have now passed since epidemiological studies first linked tobacco smoking to lung cancer; the 50-year anniversaries of the 1962 Royal College of Physicians of London and 1964 US Surgeon General's reports, which indicted smoking as causing lung cancer, are approaching.^{1,2} While millions of people have since died prematurely from smoking, the policy and prevention initiatives that were motivated by the scientific evidence in these and subsequent reports have finally led to a decline in smoking-caused diseases in many high-income and a few low- and middle-income countries.³

Will 2011 become the start of a similar pivotal era for non-communicable diseases (NCDs), as was the 1960s for tobacco control? There are parallels including the powerful descriptive evidence for multiple epidemics of NCDs—diabetes, cardiovascular diseases, chronic lung disease and cancer—and some avoidable causes are obvious to all—physical inactivity, poor diet, the persistence of tobacco smoking and harmful alcohol consumption. These epidemics have now received political attention at the highest level possible. The UN High-Level Meeting on Prevention and Control of NCDs was held on 19–20 September 2011 in New York, the first UN General Assembly summit involving heads of state to address the threat of NCDs and only the second special summit to take on a health issue directly. The first special summit was held on HIV/AIDS in 2001.

Such high-level governmental attention to NCDs worldwide is long overdue. Rates of obesity have risen precipitously in recent decades and predictably, higher rates of diabetes and cardiovascular disease

will follow. There is well-grounded concern that the strategies of the multinational tobacco companies will continue to increase tobacco use in low- and middle-income countries as well. While HIV/AIDS, tuberculosis and malaria, have been central in the global health agenda, epidemics of NCDs already represent 60% of the global disease burden and 80% of these deaths occur in low- and middle-income countries.⁴ The largest percentage rise in NCDs over the next 10 years is projected for Africa, a continent still struggling to address infectious diseases.⁴ This double disease burden threatens future development in many low- and middle-income countries, particularly in those of Africa.

Despite the growing global burden, there has been a sustained and regrettable lack of emphasis on NCD control by multiple sectors at national and global levels on such matters as funding by governments and by non-governmental organisations for research and prevention, development of coordinated strategies and diplomatic initiatives to address the multinational dimensions of the problem. With regard to NCDs, tobacco control stands as the only domain where significant progress has been made at the global level. Many factors have contributed to this progress: the rise of a global tobacco control network, leadership by the WHO, completion and dissemination of policy-relevant economic studies illustrating the cost effectiveness of tobacco control interventions, the successful adoption, entry into force and initial implementation of the Framework Convention on Tobacco Control (FCTC), significant funding through the Bloomberg Initiative, and a global surveillance programme led by the WHO and the US Centers for Disease Control and Prevention.

Here, we look to the mounting challenge of NCD control and the roles that the tobacco control community can play in the burgeoning global NCD movement. Central to this commentary is whether 'lessons learnt' from tobacco control can foreshorten the NCD pandemic and whether the global tobacco control

community can become a platform for broader global NCD activity. While our experience in tobacco control provides some lessons that extend to NCD control, there are distinct challenges in bringing approaches from the more focused domain of tobacco control to the diffuse and poorly bounded domain of NCD control. Nonetheless, we propose that in many places the tobacco control community needs to engage more broadly in disease prevention and bring its strategies, experience and enthusiastic advocacy to encompass a broader global NCD movement. Such engagement could become a 'win' for the tobacco control community and a 'win' for NCD control.

THE UN HIGH-LEVEL MEETING ON NCDs

The recent UN High-Level Meeting on NCDs aimed to bring greater political commitment to preventing and treating NCDs worldwide, especially in low- and middle-income countries. The initial goal of the process, as called for by the UN Secretary General, was to produce an outcomes document. An outcomes document, such as was produced from the HIV summit, includes specific targets through which progress can be monitored and tracked. The outcomes document from the HIV summit, for example, helped provide the foundation for monitoring and action throughout the following decade. In the case of NCDs, the political negotiations failed to reach consensus on a large number of issues ranging from which diseases to include, classification of essential medicines and vaccines, allocation of financial resources, or even process leadership and management. In the absence of consensus, the outcomes document was abandoned and substituted for with a political declaration. Though the political declaration does contain strong language on the threats posed by the growing burdens of NCDs and calls for national plans by 2013, the document falls far short of generating the trackable targets originally called for by the Secretary General.⁵

There are a number of reasons why member states were able to agree to an outcomes document for HIV, including the sharp focus on the threat, the acuteness of the problem, engaged political leadership and consensus around the response (table 1). Similar factors served as the foundation on which political agreement was reached on the WHO FCTC. In comparison, at the time of the UN High-Level Meeting on NCDs, the global NCD

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Table 1 Comparing HIV, tobacco and NCD movements

	HIV-AIDS	Tobacco	NCDs
Focus	One disease with few interventions (improved access to antiretrovirals, along with expanded care and prevention services)	One product with one primary form of consumption (smoking)	Multiple diseases encompassing diverse risk factors, treatment regimes and populations affected
Readiness/political will	Understood as a transnational security threat that could destabilise societies, already a history of big investments (eg, UNAIDS)	Accepted cause of disease and death driven by an industry proven to lie and increasingly recognised as a social pariah	Costs and consequences of inaction are invisible or understood, environment of economic hardship, competing with existing priorities
Marketability/perception	Innocent victims; women/babies; acute	Children and young adults swayed by marketing and retained by addiction	Older people, lifestyle choice
Leadership	Vocal, coherent social movement led by UNAIDS	Aggressive leadership by WHO, social movements in many countries	Diverse social movements and no clear organisational leader
Strategy	Consensus on specific 'asks', targets, and funding requests	Consensus on evidence-based policies, legal process (FCTC), and institutional leadership (WHO)	Inability to devise a coherent plan on financial, policy and institutional 'asks'

FCTC, Framework Convention on Tobacco Control; NCD, non-communicable disease.

control and prevention movement lacked the focus, leadership and consensus needed to generate high-level political action. Inherent characteristics of NCDs, some identified in table 1, partially led to this initial outcome and will remain barriers to political progress in the future. Alternatively, the ability to generate political will for tobacco control illustrates the ability of the international community to act collaboratively on NCD prevention and control and lessons from tobacco control can and should be applied to the other major NCD risk factors.

LESSONS FROM TOBACCO CONTROL

While the tobacco pandemic continues, the tobacco control community's successes at the global level offer relevant lessons to the nascent global NCD control movement. Key aspects of the global tobacco control community's experience that can inform the broader NCD movement include greater attention to upstream (often transnational) determinants of disease, increased engagement and competence in politics and enhanced multisectoral collaboration and networking.

One key lesson from tobacco control is the need to focus on the upstream factors driving the NCD pandemics such as multi-national corporations and globalised advertising and promotion of unhealthy products. At the global level, tobacco control activity has been driven by recognition that actions by the transnational tobacco industry and increasing globalisation of aggressive marketing and changing social norms around smoking make it increasingly difficult for any one country to control tobacco use within its borders, necessitating a collective response. The tobacco control commu-

ity's experience in moving beyond individual or even community-focused interventions is embodied in the FCTC text and the MPOWER package.^{6 7} Such policies, including those focused on increasing price, decreasing access, restricting advertising and improving labelling could potentially be applied to other products that promote NCDs, particularly alcohol and processed foods high in sugar and fat.

A second key lesson from global tobacco control is the need to add a political orientation to the public health approach. Similar to the situation for NCDs generally, tobacco control was long defined by a lack of attention by political leadership or funding agencies. In fact, political leaders often acted in the interest of the tobacco industry. The tobacco control community was able to change this stance over the last two decades. A key step was establishing a politically and economically relevant evidence-base. Experience in tobacco control suggests that data focused on the burden of disease and the number of deaths are not sufficient to motivate policymakers to act. Analyses of the costs of the disease burden caused by smoking proved to a more effective way to show the implications of inaction. The 1999 World Bank report *Curbing the Epidemic: the Economics of Tobacco Control* signalled a turning point in the way that the tobacco epidemic was discussed at the global level.⁸

There has already been some progress in developing an economic evidence base for action, including the recent release of the World Economic Forum and WHO's report *From Burden to "Best Buys"*.¹⁰ There has also been success in tying NCDs to the millennium development goals (MDGs), including their inclusion in the final

outcomes document issued by heads of states at the MDG review summit in September 2010 which positions NCDs as a key issue for inclusion in the 2015 MDG successor goals.¹¹ Tobacco control advocates should continue to support these activities as they recognise tobacco control interventions as the most cost-effective approaches to NCD control and the contribution tobacco control can make to sustainable development.

The tobacco control community also gained political influence with the identification of allies within governments and the UN. The FCTC, for example, only became a political reality after Gro Harlem Brundtland became Director General of the WHO and gave priority to tobacco control. Global tobacco control leaders within WHO, such as Judith Mackay (Senior Policy Advisor) and Derek Yach (transition team/Director of the Tobacco Free Initiative) contributed to WHO's leadership on tobacco control. Throughout the FCTC process, the tobacco control community worked closely with governments to sustain momentum. Similarly, NCD control will need political champions to advocate from within the halls of power. Interestingly, governments (particularly those within the Caribbean and Latin America regions supported by the efforts of the InterAmerican Heart Foundation) initiated the recent focus on NCDs at the global level, while much of civil society has struggled to organise itself in support of the political process. Currently there is still a lack of leadership for NCDs. The NCD alliance was pivotal, if not a bit late, in coordinating civil society organisations in preparation for the Summit, but formal institutional leadership, such as from WHO, still remains weak.

Finally, experience with the FCTC process suggests that perhaps the most significant outcome of the new diplomatic attention to NCDs could be the platform it provides for greater coordination around NCDs within the UN, individual governments and civil society. In the domain of tobacco control, the existence of the FCTC led a number of countries to establish inter-ministerial committees charged with discussing and addressing their domestic burden of tobacco and the UN established an Interagency Task Force on Tobacco Control under WHO's leadership in 1999. Tobacco control advocates have had networking platforms for decades; the World Conference on Tobacco or Health began in 1967 and GLOBALink, the leading online tobacco control network, has existed since 1989. This networking has been instrumental in supporting global tobacco control. Country representation within GLOBALink, for example, has been found to be a significant indicator of early FCTC ratification and policy adoption.^{12 13} The focus on upstream determinants of the disease and the collection of non-health focused evidence were facilitated by extensive multisectoral networking.

Consequently, we suggest that a broader spectrum of researchers and advocates need to become engaged in NCD issues to establish the foundation on which sustained political action can be built. The tobacco control community can facilitate this by reaching out to colleagues in other sectors and bringing them in to the broader discussion on NCDs and supporting similar forums such as the World Tobacco or Health Conference and GLOBALink for NCDs. The establishment of virtual networks and international conferences involving multiple chronic disease control communities could be helpful in forming a broader civil society movement in support of NCDs. The current diplomatic attention to NCDs could also encourage governments and the UN to establish focal points and multi-sectoral committees for NCDs.

COMPARING THE NCD AND TOBACCO CONTROL MOVEMENTS

While the tobacco control community has learnt to be effective on the global stage, we attribute some of tobacco control's success to the particular characteristics of the tobacco epidemic that have made the targets for tobacco control clear and helped to consolidate a strong and sometimes outraged advocacy community to

take action. A comparison of these characteristics of tobacco control with broader NCD control is useful, particularly for defining the limits of applicability of tobacco control tactics.

The tobacco epidemic is unique in that it has a single, predominant agent (cigarettes) and a large consolidated vector (the tobacco industry). The full burden of attributable disease and premature death is avoidable and there is only one action required to eliminate it—to stop tobacco consumption. The most cost effective approaches for reducing consumption (appropriate taxation and smoke-free places) have very little cost to governments and taxation can be revenue generating.

By contrast, NCDs comprise a diverse group of diseases that are caused by many agents (eg, unhealthy food, alcohol, drugs and environmental exposures), and there are numerous vectors ranging from global (ie, multinational fast food companies) to local (ie, unwalkable streets). Unlike every tobacco-related disease, not every case of NCD is preventable. The multiple causes and approaches to prevention and control of NCDs require multiple targets, such as reduction of caloric intake and greater physical activity, and therapeutic interventions, such as effective and far-reaching treatment of hypertension.

The complexity of NCDs has a number of implications for a potential global NCD control movement. First, there is not a single target for intervention or a threat that unifies the various disease-control communities. Consequently, we are not certain that a single NCD movement will arise. Historically, chronic disease communities have been far too 'siloed' and sometimes competitive with one another, in part because of the contention over limited financial resources. Recent debates as to whether tobacco or obesity generates a greater burden of disease exemplify divisive competition that has no productive consequences. Clearly, control of tobacco use and of obesity are both critical to chronic disease prevention. Such divisions between disease groups could hamper efforts at global NCD control.

Second, NCDs lack the clearly identifiable 'industry enemy' that continues to galvanise the tobacco control community. In the case of tobacco, the industry is increasingly consolidated; its unethical and illegal tactics for maintaining and growing its market have been amply documented, including particularly repulsive targeting of children. The tobacco

industry's products are unneeded, except by the approximately one billion people addicted to nicotine, and kill when used as intended. Other industries contributing to growing epidemics of NCDs are not as clearly antagonistic to health. In contrast to tobacco smoking, people need sufficient caloric intake and sugar, fat and salt are essential nutrients. While the tobacco industry is identifiable and monolithic, food is produced at various economic levels from subsistence and family farmers and vertically integrated multinationals such as Nestle, PepsiCo, Unilever and Kraft.

Third, NCD control requires the development of diverse cost-effective prevention and therapeutic interventions. By contrast, the homogeneity of tobacco use around the world has facilitated the promotion of global policy recommendations and the tobacco control movement has largely ignored clinical treatment at the global level, with cessation services virtually non-existent in low-income countries and communities. For NCD control, there is a need for a wide array of interventions that can be adapted to address diverse lifestyles and behavioural choices among populations and global control of NCDs necessarily requires new therapeutic interventions. Broader NCD interventions include a number of inexpensive and easy interventions, while others are likely to be relatively more costly than tobacco control and consequently much more politically challenging to implement.

These comparisons suggest that there will be major differences in the way that NCDs are addressed at the global level when compared with tobacco. NCD control programmes will necessarily go beyond the package of interventions currently promoted in tobacco control to include a greater emphasis on treatment, including access to drugs and capacity building in primary care, and a more nuanced approach to regulation and partnerships with the private sector. The sheer number of chronic diseases encompassed within NCDs will require the development of integrated programmes that have the capacity to address multiple diseases and causes, as well as terminal care management. The relative complexity and costs of interventions to prevent and control NCDs suggests that political success may be more difficult to achieve than has been the case for tobacco and new approaches will likely be needed.

THE WAY FORWARD

Despite key differences, the successes and failures of global tobacco control provide a useful platform for shaping a future NCD control movement. Initially, the global response to NCDs should focus on generating multisectoral evidence about the transnational factors influencing the rise in NCDs and the potential impact of policies proposed to control them. The tobacco control community can assist by sharing its strategies, experience and enthusiastic advocacy to support global NCD control. Tobacco control practitioners should take advantage of integrated disease treatment and control programmes to ensure that chronic diseases and tobacco use are addressed together. Moreover, they should support and participate in the growing ‘Health in all Policies’ movement that promotes the mobilisation and coordination of health throughout all sectors of governments. By including health concerns into the policy development process of all sectors and agencies, governments can address the key determinants of health in a more systematic manner.¹⁴

While the NCD control community would gain critical expertise and experience from the tobacco control community’s involvement in the areas outlined, the tobacco control community could gain from integrated NCD programmes that emphasise healthy living and clinical interventions that result in greater capacity to address treatment of nicotine dependence. Already efforts to identify best buys for NCD control and prioritisation of NCD issues have highlighted tobacco control.^{15 16} Tobacco control organisations, including the Framework Convention Alliance, actively participated in civil society activities leading up to the UN summit, which resulted in calls for accelerated implementation of the FCTC by the highest levels of government.^{5 17}

Of course, we do not propose retrenchment from tobacco control; much work must still be done to control tobacco use throughout the world. Resources must continue to be allocated towards controlling the determinants of tobacco-caused death and disease. However, tobacco is only one of the many powerful causes of the epidemics of chronic disease that are emerging worldwide. Resources can and should increasingly support integrated programmes that address global lifestyle changes; needed efficiency will be gained. The inherent challenges in fighting an aggressive, powerful industry and changing entrenched cultural norms have made the tobacco control community a tough group of staunchly committed researchers and advocates. The tobacco control community’s ardent posture and spirited personalities have proved useful in the past and now it is time to channel this energy towards the challenge of spearheading the emerging NCD control movement.

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