How Can Progress on Global Tobacco Control Inform Progress on NCD?

Derek Yach

New York, NY, USA

ABSTRACT

Dr. Gro Harlem Brundtland's appointment as Director General of the World Health Organization (WHO) in 1998 led to a stronger global focus on tobacco control, and eventually, all noncommunicable diseases (NCD) and mental health. Since the adoption of the Framework Convention on Tobacco Control (FCTC) in 2003, global health has turned toward addressing all NCD. I pose 2 questions. 1) What lessons can we apply from the WHO FCTC development and implementation processes to broader aspects of NCD prevention and control? 2) In retrospect, what could we have done better? I also propose 3 lessons: 1) it takes a broad-based alliance to make progress; 2) visible and courageous leadership matters, and is aided by financial support; and 3) in developing the FCTC, WHO focused on a few messages: demonize industry, tax, and regulate tobacco. We now need to broaden public and private players required for progress, use insights on levering market forces for NCD control, and build approaches that demonstrate empathy for millions struggling with NCD risks.

The appointment of Dr. Gro Harlem Brundtland as Director General of the World Health Organization (WHO) in 1998 led to a stronger global focus on tobacco control, and eventually, all noncommunicable diseases (NCD) and mental health. One of her early decisions was the creation of 2 "pathfinder projects": Roll Back Malaria (RBM) and the Tobacco Free Initiative (TFI) [1]. They were charged to do more than address a specific risk or disease, but instead were tasked with galvanizing new actions to show how WHO could have a real effect following years of perceived decline. The Roll Back Malaria project represented infectious diseases and the pressing problems of the poorest countries [2]. TFI addressed the emerging future drivers of an increasing NCD global burden, particularly among emerging economies, and used the development of a Framework Convention on Tobacco Control (FCTC) as the major vehicle to drive progress. TFI was located in the newly created NCD and mental health cluster that, for the first time in WHO's history, was given equivalent organizational visibility to communicable diseases.

Since the adoption of the FCTC in 2003, the focus of global health has increasingly turned toward addressing all NCD. By NCD, I refer to 4 major risks—tobacco use, excess alcohol intake, physical inactivity, and unhealthy and excess diets—that together explain 60% of global deaths, and which are the main preventable causes of cardiovascular disease, diabetes, several cancers, and chronic respiratory disease [3]. In this paper, I pose 2 questions. 1) What lessons can we apply from the WHO FCTC development and implementation processes to broader aspects of NCD prevention and control? 2) In retrospect, what could we have done better? I propose 3 lessons for accelerating progress.

IT TAKES A BROAD-BASED ALLIANCE TO MAKE PROGRESS

TFI's mandate was to use WHO's treaty-making right for the first time to lead global efforts that resulted in the FCTC [4]. It did so by building strong partnerships among tobacco control advocates, disease-specific groups affected by tobacco, United Nations (UN) agencies (including the World Bank), pharmaceutical companies who addressed tobacco cessation, and health professional bodies. These relationships were seen as critically important to future NCD prevention and control efforts and not just for tobacco control.

The need for such partnerships remains critical today, but the cohesion of the partnerships that were initially created to address control has weakened over the years. UN collaboration during the FCTC process leveraged actions within the World Bank, UNICEF, and the Food and Agriculture Organization (FAO) that supported tobacco control. The World Bank focused on the centrality of excise taxes and stopped providing support for tobacco farming, UNICEF included tobacco control within the guidance it provided related to the Convention on the Rights of Children, and the FAO provided projections showing that successful tobacco control would not adversely affect tobacco farmers for many decades. UN cohesion on tobacco control was cemented into the Economic and Social Council structures [5]. The new Economic and Social Council NCD structure developed afterward, and in

Derek Yach is a full-time employee of Vitality/Discovery (a business that promotes healthy lifestyles); has been a full time employee of PepsiCo; has provided paid consultancy/advisory services to Mars, PepsiCo, AstraZeneca, Novo Nordisk, AB Inbev, and Tesco; and is the Chairman of the World Economic Forum Global Agenda Council on Ageing. From the Vitality Group, New York, NY, USA. Correspondence: D. Yach (dyach@thevitalitygroup.com).

GLOBAL HEART

VOL. 11, NO. 4, 2016
ISSN 2211-8160/$36.00.
http://dx.doi.org/10.1016/j.gheart.2016.10.014

response to the UN High Level Meeting (HLM) in 2011 could potentially achieve major gains, but has tended to remain bogged down in bureaucratic inertia [6]. For example, we have not seen better alignment between FAO policies on agriculture and WHO's needs for healthier diets, nor have we seen UN-HABITAT express greater support for healthy urban design linked to NCD.

Strong relationships with pharmaceutical companies on joint approaches to tobacco cessation dissipated as WHO became more hostile to private-public partnerships in recent years. The deep involvement of the world's leading medical, nursing, and dental professional associations, which were so critical to the successful completion of the FCTC, has not carried through into the implementation phases of the FCTC nor has it been expanded as NCD's visibility has increased within the UN.

Successful NCD control demands a broad-based coalition comprising of those with a material interest in tackling the 4 major risks listed in the previous text, those leading efforts to tackle the key diseases or outcomes caused by failed prevention, and those from the mental health community. It is notable that WHO decided in 1998 to separate NCD from mental health in most major policy initiatives, including the output of the UN HLM in 2011. This was done for strategic reasons in the hope that both would benefit from receiving separate profiles and attention. In retrospect, that has impeded progress on tackling mental health and missed the obvious 2-way interaction that exists between NCD and mental health. It split academic and policy communities with interests in tackling NCD and mental health together. The recent World Bank focus on mental health may well redress this failing [7].

VISIBLE AND COURAGEOUS LEADERSHIP MATTERS, AND IS AIDED BY FINANCIAL SUPPORT

Dr. Brundtland's stature as a past successful head of state (Prime Minister of Norway from 1986 to 1989 and again from 1990 to 1996) allowed WHO easy access to leadership within the World Bank, the Organization for Economic Cooperation and Development (OECD) and their Development Assistance Committee, the UN Secretary General's office, the World Economic Forum, and to the heads of state of countries we knew would be critical to have on board if the FCTC was to succeed. These included China, Brazil, Japan, Germany, India, and the United States. Access to UN agencies and the OECD led to increased funding, and even more importantly, to tobacco control being moved from being an issue of importance to a few developed countries to one worthy of the highest attention by all countries. This was reinforced each time governments convened to negotiate the FCTC. Ongoing FCTC Conference of the Parties sessions remain underused as a means to galvanize broader aspects of NCD control, despite their focus on the FCTC. TFI was among the first recipients of UN Foundation's funding. It was used to build a strong NGO network globally (that eventually galvanized into the Framework Convention Alliance) and to support effective media advocacy in key developing and developed countries [8].

Dr. Brundtland challenged the very notion of what then comprised the "global health agenda"—infectious diseases, undernutrition, and maternal and child health. This has had enduring effects and has legitimized academics, researchers, and policy makers working on tobacco control within global health settings. Global visibility for tobacco control has diminished in recent years even as political support for NCD has increased. Infectious disease pandemics, humanitarian crises, and the specter of climate-induced health problems have displaced attention from NCD and many other health issues. This trend is likely to continue.

Director Generals Lee and Chan used annual meetings of the regional committees and World Health Assembly to highlight the importance of NCD, but without the passion, focused attention, and vigor of Dr. Brundtland. Governments responded accordingly, and few developing countries have increased their national budgets to address NCD, despite pledging to do so during the UN HLM [6]. It has been left to relatively small and underfunded, but well organized, NGOs under the NCD Alliance umbrella, including the World Heart Federation, the Framework Convention Alliance, and the Union for International Cancer Control, to advocate for more resources and actions [9]. This comes at a time of slowly diminishing global development assistance for health [10]. Funding for tobacco control, although meager relative to the burden it causes, has been supported by Bloomberg Philanthropies and the Bill & Melinda Gates Foundation. In contrast, no significant foundation or OECD Development Assistance Committee funding has been made available to support the myriad other needs associated with NCD. Without funding, progress will remain slow.

IN DEVELOPING THE FCTC, WHO FOCUSED ON A FEW MESSAGES: DEMONIZE INDUSTRY, TAX, AND REGULATE TOBACCO

Prior to 1998, tobacco control tended to highlight the failings of smokers at the expense of the negative effect of the tobacco industry on health policy. A very deliberative process led by TFI and supported by NGOs and the media reframed the debate as one focused on the lack of corporate accountability [8]. This opened the door to systematically "demonizing" the tobacco industry versus the smoker as the problem. This was a relatively easy task at the time and built on new evidence from a study commissioned by the WHO that showed how the tobacco industry had systematically undermined public policy for decades [11]. In the process, we ignored the real needs of smokers for nicotine and undervalued the importance of innovating to reduce the harm caused by tobacco [12]. Over the last 5 years, technological innovation, led by entrepreneurial e-cigarette and multinational tobacco companies, has made

substantial progress in producing products that substantially separate the damaging constituents of cigarettes from relatively inert nicotine, leading to a new category of harm-reduction products. Although this was envisaged in the original text of the FCTC, WHO and many governments have yet to embrace the potential health benefits that this will yield [13].

An unforeseen consequence of demonizing the tobacco industry was to leave NGOs, academics, and governments with a sense that a similar approach should be applied to the food industry and other industries related to NCD. Many still believe that what worked for tobacco would work as well for food policy [14]. At WHO we addressed this, although in the years that have followed, WHO, academics, and NGOs have tended to seek the simple route of demonizing all industries associated with NCD risks and simplifying policy to what worked with tobacco as opposed to carefully considering a fundamentally different approach: making markets work for NCD [15,16].

Years after the FCTC had come into force, I asked Dr. Brundtland about her views on the use of treaties to address other aspects of NCD control. She responded that the era of grand multilateralism that dominated the Cold War may well be over. In its place, progress in tackling complex social and environmental issues required private-public engagement and partnerships [17]. I agree, and I can see many ways in which we need to move beyond the tobacco control "script" if we are to succeed in NCD prevention and also accelerate tobacco control [18].

Fear of engagement with the private sector has undermined progress in working with (and even meeting) private companies—and for understandable reasons. Past and many continued industry transgressions have led WHO and many in public health to regard all possible engagement as being inherently fraught. Nonetheless, times are changing. Many leading companies whose core products and services affect NCD incidence and severity are transforming their business models in ways aligned with health goals [19,20]. This is not happening for moral or ethical reasons, but because investors, shareholders, consumers, and employees (especially millennials) are increasingly demanding it [21].

Public health leaders have an opportunity to work with those pushing for change within industry in many ways: steering their research and innovation agendas to address product transformation aligned with health goals; advocating with companies for changes in government policies that impede progress; and through regulatory reform, identifying smarter ways to direct and nudge people toward healthier diets, more activity, and reduced-risk tobacco products. Leading academic economists and lawyers have started doing this [22]. The deep insights from Nobel laureate Daniel Kahneman about what truly motivates and sustains complex behavior change rests upon shifting from current regulatory approaches toward those that draw on emerging behavioral economic insights [23-25].

Here we return to the 2 opening questions.

What lessons can we apply from the WHO FCTC development and implementation processes to broader aspects of NCD prevention and control? We should learn that most behavioral changes required to live healthy lives require a more subtle and innovative relationship among regulators, corporations, and the people we seek to serve. Smarter regulations that protect people and steer companies toward healthier products and services; increased public support for prevention science and evaluation of behavioral economic strategies; deeper engagement by investors, stakeholders, and consumers in corporate decisions mediated through more transparent reporting of progress and effect; and less demonization of industry and reliance of single interventions will accelerate NCD (and tobacco) prevention and control.

What should we have done better? In retrospect, much of what was done was needed. Dr. Brundtland knew that NCD would remain ignored until governments and NGOs felt the outrage caused by NCD inaction and acted on it. The FCTC has been a pathfinder for NCD progress. We now need to broaden the coalition of public and private players required for greater progress, draw upon insights on how best to leverage market forces for NCD control, and ensure that we build approaches that demonstrate empathy for millions struggling with NCD risks and their consequences.

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