*As I see it*

# Philip James

*Philip James writes:* What are we trying to achieve, in our *Rio2012* conference this month? Events on my recent travels have brought vividly home to me the challenge of what we should be doing to support UN member states and their agencies, following the high-level meeting on the prevention and control of non-communicable diseases, held in New York last September. This challenge will no doubt be a major theme at Rio. It certainly should be. For me it's been evident for many years – too many! – that if we in our profession are going to make a real lasting serious difference in the world, as we should, we are going to have to raise our game.

*Nutrition*

## Where the power lies

I am writing this month by way of prefacing our *Rio2012* conference, and am suggesting – rather strongly – that we as a profession need to get a whole lot more determined and serious, to have any real hope of making a real difference for the better in our world. What follows below is an account of some of the journeys I have made this year. I want to give you an idea of why I made them, and how they illustrate the great challenges we face now.

Here briefly is the context. The decisions that most effectively determine food systems, dietary patterns, and therefore the food that populations buy and consume, and therefore to a large extent their general states of health, are taken at high levels. Senior officials working within the UN system and for bodies like the World Bank, the World Trade Organization, and the World Economic Forum, know this. They are part of the process, and seek to guide it.

As it has happened, I also have played some part, ever since the 1960s, usually at senior governmental and UN levels, as an advisor, consultant, advocate, writer of reports, and more recently as founder of the International Obesity Task Force. I got involved originally because I was invited to do so. It then became obvious to me that unless we professionals concerned with public health got stuck in and learned the

rules of the international game and became players, we were – to change the metaphor – babes in the woods.

And dark woods they are, with plenty of big bad wolves too. My concern, which if anything has became more acute and deeper as time has passed, is that startlingly few of us in public health nutrition seem to be aware of how systems of governance work and how international and important national policies are made and enacted. What follows illustrates this concern.

***WHO knows?***

Mind you, I am not suggesting that we are all clueless and that the UN mandarins know it all. For example, in the last few days of December last year I was invited to Geneva by the group in WHO responsible for non-communicable diseases. The task was to decide what key goals we should aim for, following the September UN high level meeting in New York. WHO has been given the task of leading the global response. In the meeting I witnessed the ways in which UN bureaucracies tend to react to astonishing opportunity**.**

In New York last September, the heads of state and of governments of all UN member states unanimously called for a radical new plan to prevent and control non-communicable diseases. WHO, as the UN agency that was – and is – charged to take the lead, is assigned the task of determining a new approach to public health. This necessarily involves all relevant aspects of government and indeed of society.

Imagine my dismay when we were presented with the top ten cost-effective measures all of which were confined within WHO's own internal remit. The simple dual policies of eliminating *trans* fats and reducing salt in processed products were again listed as the most cost-effective measures, also known rather revealingly as 'best buys', to be placed high on the priority list. Was this because the very strong US influence in WHO had highlighted that these measures had been agreed – and indeed offered – by the food manufacturing industry? Therefore by definition they were cost-effective 'best buys', because industry would fund the changes, which would require minimum commitment or effort from governments!

How much impact this might have on international public health is, of course, an entirely different matter. I predict that *trans* fat will be substantially reduced by major food companies. But this does not apply to inter-business sales of products, and certainly not to the multitude of small suppliers of fats unless there is legislation banning the use of industrially generated *trans* fats. Including salt reduction as a simple cost-effective measure may also be naïve if this relies on food producers changing their practice, particularly if they are able to claim on labels that 'lower salt'

products are healthy. Also, there are entirely different challenges in lower income countries.

When I highlighted that the WHO narrow priorities did not touch on the main theme of the high-level meeting, which is to engage the whole of government and the international dimension, I was told that WHO was liaising with its other UN partners. I was assured that this was indeed an important aspect, which we would hear about in due course! I will not dwell on the curious nature of this process, except to say that WHO has the duty to be the UN's technical arm for the whole of governments.

Let me explain this a bit more. It is a crucial point. In 1990, I was chairing the WHO technical consultation that resulted in the '797' report *Diet, Nutrition and the Prevention of Chronic Diseases*. I was informed by the lawyers in WHO that it was entirely proper for WHO to address not just health ministries, but all branches of national governments directly, when there was need to do so. This mandate was reinforced in New York last September. WHO is able to respond to all departments of government that are concerned with any issues that have a health dimension. The concerns of the New York high level meeting are not confined to those of health ministries. In Geneva it seemed to me that we were taking some big steps back from a real understanding of how modern public health needs to develop.

### *I've been around the world*

Between 1 and 21 March – this month, as I write – I found myself reflecting on the public health and nutrition challenges that face us all. This was in course of a hectic schedule of trips, meetings and lectures. First was in Athens in the first three days of the month where I was invited to speak by the Greek Association for the Study of Obesity. Second was in Singapore where I spoke to the health promotion board before going on to Indonesia.

Third was in Jakarta where Danone wanted to show me their microcredit scheme to help poor townspeople and villagers to sell more nutritionally appropriate products. Also my old friend Widjaja Lukito was anxious to see me – more of this below. I was also to lecture in meetings of the Indonesian societies of paediatrics, obstetrics and gynaecology, and to midwives as well at the University in Jakarta.

Then after a few days back home in London, I was off to Copenhagen to lead a discussion at WHO on the challenges presented by the non-communicable disease epidemic in the whole of the WHO European region, which includes 53 countries from Vladivostok on the east coast of Russia to Limerick in western Ireland.

### *Greece: Who is getting the message?*

In Athens I found many hundreds of enthusiastic doctors, young and old, struggling to cope with the extraordinary problem of obesity in a society being torn apart by a financial crisis. I expected to see people sleeping on the streets outside my hotel. But I seemed to be in a medical capsule – that is, until the end of my lecture, when I was constantly challenged, as I set out the preventive agenda, on how to cope with the cost of healthy foods. My lecture was packed out with intent students as well as elderly medical statesmen who were, it seemed, trying for the first time to link the big economic questions to the individual health of their patients.

Yet that evening it was me who was struggling, as I tried to reconcile the intense economic crisis with being taken to a packed restaurant a few steps away from the hotel, where exquisite Greek food was being served by a TV celebrity chef. We were told that we could only have our table for a relatively short time because of the pressure of waiting diners. It was as though there was no economic crisis at all. Such are the effects of inequity.

### *Singapore: Big medicine*

Twenty-four hours later I was on my way to Singapore. I found myself plunged into extraordinary new developments, with the Singaporean government determined to create the best medical and biological research in Asia. Having given a lecture to the paediatricians of the hospital, I met several colleagues including my old friend Jeya Henry from Oxford, who is setting up a clinical nutrition unit in Singapore.

But how could I help the newly appointed chair of a clinical guidelines committee charged to deal with the problem of obesity in Singapore, when official policy is to consider such problems as a matter of individual responsibility, with government playing no part except to ensure that food is microbiologically safe?

I had already asked to see again the Singapore national health promotion board with whom I had worked for some days last April. I was forewarned by the gurus of public health in the university that any real public health endeavour involved changing the mind-set of a government intent on operating in a so-called 'free market' – as if this would solve all the problems. All this, despite new information that 12 per cent of Singaporean adults are diabetic. Worse, diabetologists have suggested that at least as many again are glucose-intolerant and therefore already liable to cardiovascular complications before imminent development of full-blown diabetes. Even more terrifying are the new observations that 18 per cent of pregnant women in Singapore have gestational diabetes with all its appalling consequences. Slightly defensively I felt, my hosts in Singapore said this was not as bad as in Hong Kong where the prevalence of gestational diabetes is 21 per cent.

That afternoon I returned to the health promotion board, where staff were planning new cycling routes linking the parks of Singapore. Economic and political initiatives were evidently not on any agenda. This remarkable city-state of Singapore, with all its expertise and major new centre dealing with epigenetics, still has not woken up to the fundamental requirements for economic and statutory measures to preserve and enhance the health of its people.

Just once I felt that my message hit home. This was when I highlighted the impact of the Japanese occupation and consequent starvation of the citizens of Singapore during the 1940s, with dreadful conditions during the 1950s. This is now debilitating middle-aged and elderly Singaporeans, with their enormous rates of diabetes and cardiovascular disease. Economic development really only started when Singapore became independent in 1965. Children born before independence were all brought up in deprived circumstances. Now, with the over-abundance of westernised Chinese food, stuffed with oil and with sugary soft drinks, Singapore is facing the full-blown effects of a programmed and epigenetic mass susceptibility to non-communicable diseases.

On the day I was there, the Singaporean government announced the building of many more hospitals and the training of hundreds more doctors. There is as yet no sign of responding with rational economic and regulatory measures.

### *Indonesia: The need to know the facts*

Then to Jakarta. The Danone corporation, having heard me lecture in graphic terms to their senior management and annual meeting of senior staff about the need for major changes in the food industry, supported my travel to and accommodationin Indonesia and helped arrange a profusion of lectures and meetings with different groups. They also arranged for me to visit in Jakarta a micro-credit scheme they had started in Bangladesh with Nobel Laureate Muhammad Yunus, and transferred to Jakarta. One of the women running the scheme was sited in a local health centre.

In Jakarta obesity is dramatically increasing, and diabetes rates are already at a prevalence of 12 per cent in adults. Yet in this extraordinary country of 240 million people scattered over thousands of islands across 5000 kilometres and three time zones, up to 30 per cent of children are still stunted, and diarrhoeal disease among children remains an appalling problem.

Once again I was made aware of the major role of nurses in the local health service. I talked briefly to 500 midwives who are trying to reduce the dreadful rates of maternal mortality and heard a vibrant lecture by Damayanti Rusli Sjarif as she

taught, pleaded with and goaded the midwives to do better in a highly interactive session. Of the 2,000 paediatricians in Indonesia 700 work in Jakarta. When lecturing in Jakarta I was coping with very sophisticated questions about genetics, metabolic and congenital diseases. By contrast when I was in Palembang – an hour's flight away – I began to see how irrelevant paediatricians often are to the health of the 240 million, who have to rely on the 100,000 midwives with their nursing skills.

Nevertheless I was privileged to take part in a special meeting of leading paediatricians with members of the national ministry of health and education as well as of the Indonesian Food and Drug Administration, to consider how best to cope with the combined problems of stunting and obesity in Indonesia's children. This was an exceptionally valuable meeting. The leading medical specialists suddenly realised that they could exert a major societal influence if they got organised as a professional group, and spelt out the need for better governmental and other measures to improve the food supply, improve breastfeeding, limit marketing of processed food to children and other crucial measures.

Curiously there were constant complaints about the neglect and abuse suffered under Dutch rule, when little infrastructure has been created and sustained. I even heard regrets that Indonesia had not been colonised by the British!

My initial reason to visit Indonesia was to respond to the plea from my old colleague and friend Widjaja Lukito. I had met him a couple of years ago in a WHO World Health Assembly. He was leading the Indonesian delegation and he had asked me to come to Indonesia to discuss preventive strategies He is now head of human nutrition research at the University of Jakarta. He preceded my lecture with his own on the enormous health problems of stunting in overweight children, their anaemia, the persisting malaria and escalating HIV epidemic.

He is also the executive secretary dealing with health issues in the Indonesian president's advisory council. He had asked me to speak to Emil Salim, the chairman council. At first, I was encouraged when Widjaja Lukito brought in the chief executive secretary to the president's advisory council. He was enthralled and enthused by my starting with economic and agricultural development as a priority, rather than merely focusing on medical-type approaches.

I was then taken to the advisory council's building, next to the national president's white marble palace, to meet the chairman. I was invited to a private lunch which I took to be a simple gesture of courtesy with an exchange of polite messages which would take at most half an hour. However, it turned out to be more than a two and a half hour debate, with the most rigorous analyses of the opportunities for the development of a country that I have been privileged to take part in.

The problems are endless. Indonesia has not yet signed the UN Framework Convention on Tobacco. Why? Two of the most influential billionaires in Indonesia had made their fortunes from tobacco. Emil Salim was astonished to hear that Indonesia's huge palm oil industry is a major threat to health. He had never heard of such a proposition. Indeed, one of their historically vibrant industries is sugar. So I suddenly found myself giving vivid three minute lectures on the cost-effectiveness of alternative strategies. I could not cope with the question of whether their palm oil plant could be engineered to provide more benevolent fatty profiles than the current one, with all its palmitic acid. The use of palm oil for bio-fuels is well recognised, but this is not so profitable as using it in the processing of food.

The fact is, that Indonesia has tens of millions of people already below the $US 1 dollar a day poverty line. If this line was raised to $US 2 a day, then 130 of the 240 million population would be classified as living in poverty. I was reminded yet again that there is absolutely no point in proposing substantial public health measures in any country until one has some real understanding of the circumstances of that country. To make proposals without real knowledge and also sympathy is futile and also insulting, and you won't get invited again.

We then talked about the need for industrial, community and household refrigeration, to reduce the need for salt; the need for cultural analyses of the different food systems on the various islands; and the value of food writers and television chefs promoting and teaching how to prepare traditional Indonesian foods, which are very low in fat and sugar, that could be as attractive as Chinese and Thai foods.

Then I was challenged to consider the water and agriculture needs of the island of Java, where it was already predicted that there might be up to 250 million people in the coming decades. How to reclaim land? How could this be done? By the end of my time with him, the thoughtful and wise elder statesman Emil Salim had gone through every phrase on my slides which I had prepared just in case they might be needed. He told me that he had never understood before how the economic and social developments for which he was responsible have such a huge impact on health. He also said that he now saw how conventional health planning has very little impact on the health and well-being of a population compared with the major industrial opportunities and threats..

Did I convince him to convince the President of Indonesia to sign up to the Tobacco Convention? Perhaps not. The president of the Republic is currently engrossed in how to reduce the subsidy on petrol costs. But I do believe Emil Salim, who as well as his formal eminence is a close friend of the president of the republic. rnow realises that the fundamental economic framework for the development of Indonesia must build health into basic economic and social planning.

James WPT. Nutrition: Where the power lies, and other stories *[Column]*. *World Nutrition*, April 2012, **3**, 4

I have long been convinced that public health cannot be promoted by ministers of health. This was confirmed yet again by my discussions with Emil Salim. We need to work with the key economic and political thinkers and doers if we are to make and sustain real progress.

### *Europe: transformation needed*

This perception was reinforced in the two days in late March just before I sat down to write this piece, as I helped the European region of WHO, based in Copenhagen, to consider its review of its last five-year plan for nutrition. Non-communicable diseases have gone right up the agenda. With a very strategic, experienced and innovative regional director, Zsuzsanna Jakab, the challenge is how to cope with 53 countries, where anaemia and stunting are still a major problem, while obesity and non-communicable diseases dominate the health burden and costs of most countries. What is needed is a transformation of economic and political thinking, so that the whole food system of the region protects the health of Europe.

How to achieve this in Europe? And how, in Africa, Asia and Latin America? I hope to return from Rio with at least some of the solutions.