As I see it

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London. Public health nutrition has to be seen within the context of general public health as a whole, and not as a selective stand-alone piece. We don't work in a void, as I show this month. First I identify some of the political and ideological obstacles in the way of those of us who are trying to prevent and control obesity in the UK and elsewhere. Then, in some detail, I outline what is behind the Copenhagen Consensus project, whose answer to chronic non-communicable diseases is drugs, surgery and education.

We live in a world where the elected governments of most powerful countries are ceasing to do their duty to protect public health and the public interest. Instead, they 'leave it to the market' – meaning big business, as amplified by the media, which is also a big business. Please don't get me wrong. Progress requires engagement with industry. But that's different from surrender to the profit motive.

In writing my first story below, on attempts to confront obesity in my country, I was reminded that before first becoming an elected politician, the current UK Prime Minister was for eight years, corporate affairs executive for a commercial television company. I am also reminded this month that the race to the US presidency is not the prerogative of the Olympians, but is usually won by the candidate who raises most funds in particular from corporate sources. This is the world in which we try to defend the public interest and public goods. We need industry. We also need balance, and we need elected governments that hold that balance in a way where business can flourish but without damaging and preferably promoting public health.

Obesity. The UK 'responsibility deal'

Privatisation of public health

This month I am trying to work out what officials and professionals in local government can do to combat the awful impact of obesity on the UK population. This is needed more than ever now that the current UK government has moved the major

responsibility for meeting public health targets from the national to the local level. What is going on? There is a context here – there always is.

Responsibility for obesity

Three years ago, soon before the general election as a result of which the UK government became dominated by the right-wing Conservative Party led by David Cameron (now UK Prime Minister seen on the left in the picture strip below), my colleagues in the International Obesity Task Force were asked to go to meet the 'shadow' minister of health, David Cameron's colleague Andrew Lansley (next picture). He was clearly very knowledgeable, and had read the UK Chief Scientist's *Foresight* report on obesity (1), which describes all the factors promoting the epidemic. However, the meeting was interrupted by David Cameron, who came into the room and made clear that for him, the concept that multiple societal and environmental factors were responsible for the obesity epidemic was nonsense. Obesity 'was an individual responsibility', as he soon emphasised in a public speech. He told the IOTF team that he would do nothing, in any way, to impede the enterprise of the UK food manufacturing and allied industries.

Sure enough, soon after David Cameron became Prime Minister in May 2010, Andrew Lansley, as Minister of Health, excised the nutrition department from the prestigious and reasonably independent Food Standards Agency (FSA), as demanded by the Food and Drink Federation, the body that represents the interests of UK and international manufacturers. From then on he directly controlled any policy proposals or announcements, because the potentially troublesome nutritionists and public health experts in the FSA were either removed or else placed within the Department of Health.

He then sacked the government's expert advisory group on obesity (2), and partnered with the leaders of the food and drink industries in a so-called 'Responsibility Deal', where manufacturers agreed to a voluntary arrangement to improve the nutritional profile of the UK food supply in order to counter obesity and its associated chronic non-communicable disease burden.

In response Hugh Stephenson of the UK Academy of Royal Medical Colleges said rather mildly: 'Doctors think it's inherently unlikely that huge companies that make money from selling high-calorie foods and drinks, like McDonald's and Coca-Cola, are going to persuade their customers [to eat more healthily]. It's like asking the petrol companies to say to people, "why not go on your bicycle?" It just does not seem likely that's going to happen.'(3).

When I lecture to leaders of the medical profession in the UK, I am continually astonished at how naïve they are and how ignorant of such political skullduggery. More importantly, when I talk with groups of public health specialists, they wonder

what on earth they can do, now they are being completely reorganised in the context of a monumental reconfiguration of the whole National Health Service. This is designed to bring the NHS into the 'market economy'. Responsibility is being removed from central government. Instead, competitive tendering for health services is being imposed, the deal being that commercial companies that win bids will be guaranteed a slice of the action.

Health and public duty

Here in the UK the politicians now in office believe that government should withdraw from the provision of public services, and that what works most effectively and efficiently is private provision. The justification for this approach is said to be experience in the US. However, in World Health Organization reports on effective and efficient national health provision (4), the US ranks far down the list. Its provision is assessed at more or less at the same level as for example Brazil, Poland, Greenland and (pre-second invasion) Iraq, and as inferior to that for example of Algeria, China, Venezuela and Iran.



UK (left), David Cameron, Andrew Lansley: for industry. US (right), Michael Bloomberg, Thomas Farley: for regulation. Where is the man in the middle?

So what can I say to the public health workers who are now suddenly being assigned to local government? Is the situation hopeless? Fortunately there is good evidence that all is not lost as we learn from within other countries where commercial interests also dominate and effectively control health and economic policy making.

The New York example

The US is an example. There it is taken for granted that public health measures do follow powerful legal challenges to existing practice, or else as a result of grass roots action demanding change at a community level. In the US everybody knows that the legislators in Congress are controlled by big business. The President will not make a move, and his First Lady, while calling for change and understanding the economic drivers of the obesity epidemic, faces impossible odds and has no legislative role.

But in the US there is effective action at big city level. It is illuminating to see the initiatives that Michael Bloomberg (second from the right in the pictures above) as mayor of New York City, who ironically is a multi-billionaire, is taking. His public

health team is banning *trans* fat in the food chain, requiring calorie labelling of menus in canteens and restaurants, and limiting the size of soft drink containers where the City has jurisdiction. As I discovered in discussions with the Bloomberg Foundation in New York, there is a very clear understanding that reliance on individual choice, for example to limit smoking or reduce road traffic accidents, does not protect public health. Now Michael Bloomberg, through his foundation, has started to take on the obesity problem internationally, as well as in New York City.

Could it happen here? Can we turn to the man in the middle in the pictures above? This is Boris Johnson, the mayor of London, a flamboyant right-wing politician with a flair for publicity and rhetoric, and for annoying the current government. He has said that he plans to emulate mayor Bloomberg's initiatives. Thus: 'A superb 2012 legacy for London would be the obliteration of childhood obesity. We are championing effective plans across the capital to fight this, and I hope that working with New York will result in leaner, fitter children and families in both our cities. I want to take on the fast food companies who mercilessly lure children into excessive calorie consumption. Instead of junk snacks let's encourage kids to grow their own food…' (5).

Strong words. He spoke them before David Cameron took over as prime minister in the UK. Is he serious? (6). I remind public health groups in the UK that before the introduction of the 1948 National Health Service, in every city the Chief Medical Officer of Health was the most important policy maker and controller, after the mayor or council chair. Is this the new model? Thomas Farley, by Michael Bloomberg's side above, the New York City Health Commissioner, has a powerful post.

So what can be done now, within cities? For a start, soft drinks and junk food generally can be excluded from all publicly funded or supported institutions, plus other measures designed to protect deprived and impoverished communities. In the UK, a new local government law also enables communities to set out their vision for statutory future planning policies. This could transform cities over time. Local action can improve food supplies and what people eat in publicly funded schools and institutions, by limiting large serving sizes, stopping the serving of inappropriate foods, and pricing policies that favour the supply of healthy foods

So perhaps the lesson to be learned from the surrender of national government to commercial interests, is to start again, and focus on working with cities whose elected officials have statutory powers. In my country this can start now, with reference to the good work being done in New York and many other US cities. But we all need to be aware of the realities of democracy in its current form. We also can't rely on politicians who are so wealthy that they can finance their own campaigns. Elected politicians may know what is right and what is wrong, but those in government typically will only back reforms that they think will win them more votes next time round. Are we prepared to commit ourselves to the task of projecting what is correct, and what is right, in ways that are compelling and popular? I hope so.

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World aid. Copenhagen Consensus 2012

Drugs, surgery and education are not enough



The Copenhagen Consensus on smart ways to save the world, in process of taking shape, with a panel of US Nobelists advised by technical experts

These are indeed interesting times for all of us who currently engaged in public policy. Take 'The smartest ways to save the world', perhaps this year's most self-confident op-ed headline. Published in May this year in over 400 newspapers round the world (1), it heads a piece by Bjørn Lomberg, who in 2001 was identified as a 'global leader for tomorrow' by the World Economic Forum. Adjunct professor at the Copenhagen Business School, he is a climate change sceptic, which he characterises as 'not the end of the world' (2).

Describing himself as an 'intellectual entrepreneur', he is also founder and director of the Copenhagen Consensus initiative. Funded originally by the Danish government and co-sponsored by *The Economist*, the idea is to come up with the best researched, most rational and promising independent answers to the great issues that confront us. The first initiative in 2004 gave a special priority to HIV-AIDS (3). The top priorities in 2008 were providing vitamin A and zinc supplements to impoverished children, liberalising trade, fortifying salt and staple foods with iodine and iron, and expanding childhood immunisation; cutting greenhouse gases was bottom of the list.

The 2012 initiative has been on how best to spend aid money, given all the competing priorities. Recently I participated in a meeting here in London setting out the basis for the newly published 'Copenhagen Consensus 3'.Rachel Nugent, previously of the Center for Global Development in Washington DC, now associate professor and director of the Disease Control Priorities Networkin Seattle at the University of Washington's Gates-funded Department of Global Health, explained to us her work in helping to prepare and run the process which led to the latest Copenhagen Consensus *(*4).

First, the main topics are chosen. For 2012 these were armed conflict, biodiversity, chronic disease, climate change, education, hunger and malnutrition, infectious disease, natural disasters, population growth, and water and sanitation. Corruption and trade barriers were added but not analysed, the reason given being 'because the solutions to these challenges are political rather than investment-related'. This seems to imply a preconception favouring money as the most effective way to do good in the world.

Of the top ten chosen challenges for the Copenhagen Consensus, we can count three as clear concerns for public health nutritionists: chronic disease (also now known as NCD); hunger and malnutrition; and also infectious disease. For the 2012 Copenhagen Consensus process,as background and as a basis for decisions and judgements, high-quality 'challenge papers' were prepared. These are all well worth reading. Of the twelve authors, seven were based in the US, either in Washington DC or Washington State, three in Canada, and one each in the UK and India.



The 2012 Copenhagen consensualists: Vernon Smith, Robert Mundell, Thomas Schelling, Finn Kydland, Nancy Stokey, all economists from the US

The next standard part of the process was to assemble a panel of eminent economists. As stated on the official website (4): 'The Expert Panel will look at all of

the solutions to all of the problems, and identify the most cost-effective ways of achieving good in the world. The final outcome will be a list of priorities with all the solutions identified by the scholars ranked by the expert panel according to the potential of each solution for solving the world's greatest challenges most cost effectively'.

The judges chosen by Bjørn Lomberg and his team for the 2012 process were five distinguished economists, all working in the US, three of whom are US citizens These, shown in the picture strip above from left to right, included four venerable Nobel Prize winners: Vernon Smith, Robert Mundell, Thomas Schelling and Finn Kydland, with an average age of 80, and also Nancy Stokey. In a sense the US dominance is unremarkable: 34 of the 38 winners (all but one male) of the Nobel economics prize since 1992 are US citizens or else US-based. The ideology of the 2012 judges is mostly monetarist.

They were convened in Copenhagen in May with a challenging brief to 'change the game'. They were asked to judge what major benefits to society would emerge if they could decide how to spend an additional $US 75 billion, which is 15 per cent on top of the current total global aid budget, over a four-year period. They evaluated the evidence from the challenge and other background papers. They sat with technical and other expert advisors and reasoned together, as in the picture below, which shows Vernon Smith of Chapman University, California, making a point, watched by Nancy Stokey of the University of Chicago, with Thomas Schelling, previously of Yale and Harvard, now of the University of Maryland, also in the picture.



2012 Copenhagen. Economic Nobelist Vernon Smith emphasises a point, watched by Nancy Stokey. Also in the picture, left, is Thomas Schelling

Table 1 below, shows the 2012 Copenhagen Consensus conclusions, ranked in order, on the most cost-beneficial policies and actions in the ten selected areas.

Table 1. 2012 Copenhagen Consensus

The most cost-beneficial policies and actions designed to improve human welfare

Judgements made by the 2012 Copenhagen Consensus group of Nobel Economics Prize laureates, supported by background 'challenge papers'

	Challenge	Solution
1	Hunger & Education	Bundled Interventions to Reduce Undernutrition in Pre-Schoolers
2	Infectious Disease	Subsidy for Malaria Combination Treatment
3	Infectious Disease	Expanded Childhood Immunization Coverage
4	Infectious Disease	Deworming of Schoolchildren
5	Infectious Disease	Expanding Tuberculosis Treatment
6	Hunger & Biodiversity & Climate Change	R&D to Increase Yield Enhancements
7	Natural Disasters	Investing in Effective Early Warning Systems
8	Infectious Disease	Strengthening Surgical Capacity
9	Chronic Disease	Hepatitis B Immunization
10	Chronic Disease	Acute Heart Attack Low-Cost Drugs
11	Chronic Disease	Salt Reduction Campaign
12	Climate Change	Geo-Engineering R&D
13	Education	Conditional Cash Transfers for School Attendance
14	Infectious Disease	Accelerated HIV Vaccine R&D
15	Education	Information Campaign on Benefits From Schooling
16	Water and Sanitation	Borehole and Public Hand Pump Intervention
17	Climate Change	Increased Funding for Green Energy R&D
18	Population Growth	Increase Availability of Family Planning
19	Chronic Disease	Heart Attack Risk Reduction Generic Pill
20	Water and Sanitation	Community Led Total Sanitation
21	Water and Sanitation	Sanitation as a Business
22	Chronic Disease	Increasing Tobacco Taxation
23	Natural Disasters	Community Walls Against Floods
24	Water and Sanitation	The Reinvented Toilet
25	Biodiversity	Protecting All Forests
26	Natural Disasters	Retrofitting Schools to Withstand Earthquake Damage
27	Hunger	Crop Advisory Text Messages
28	Biodiversity	Extension of Protected Areas

As you see, childhood malnutrition features prominently (#1,3,4), with food production and supply issues (#6), and water supplies and effective sanitation (#20,21,24), are still recognised as priorities. For chronic diseases the panel was evidently most impressed by the apparent promise of low cost drugs for heart attacks (#10), and the chronic use of the polypill (#19). Hepatitis immunisation was specified, to reduce liver cancer (#9). The panel also identified tobacco taxation (#22), and salt reduction campaigns (#11).

They concluded that they would spend each year for the specified four-year period, the following amounts, just on the first 16 priorities, as shown below in Table 2. This is what Bjørn Lomberg positions as 'the smartest ways to save the world':

Table 2.2012 Copenhagen Consensus

The best use of money to help resolve the world's biggest challenges

Annual budgets for four years, in order of priority

The expert panel allocates its budget of $75 billion over four years as follows:

Solution	*Amount Allocated Per Year, in $US Billion Dollars*
Bundled Interventions to Reduce Undernutrition in Pre-Schoolers	3.0
Subsidy for Malaria Combination Treatment	0.3
Expanded Childhood Immunization Coverage	1.0
Deworming of Schoolchildren	0.3
Expanding Tuberculosis Treatment	1.5
R&D to Increase Yield Enhancements	2.0
Investing in Effective Early Warning Systems	1.0
Strengthening Surgical Capacity	3.0
Hepatitis B Immunization	0.12
Acute Heart Attack Low-Cost Drugs	0.2
Salt Reduction Campaign	1.0
Geo-Engineering R&D	1.0
Conditional Cash Transfers for School Attendance*	1.0
Accelerated HIV Vaccine R&D	0.1
Information Campaign on Benefits From Schooling*	1.34
Borehole and Public Hand Pump Intervention	1.89
Total	**$18.75**

The expert panel based its budget allocations on the proposals from authors, and on their own views of appropriate expenditure.

*Estimate included; final figure to be included later.

Given their training, their beliefs, the nature of the background papers, and the brief they were given, it is not surprising that the economists chose 'near-market' interventions, likely to generate direct evidence of an effect. For addressing hunger and malnutrition, where papers have been developed from decades of discussion and assessments, these can indeed be effective. For instance, immunisation programmes (#3), cash transfers for school attendance (#13) borehole and pump interventions (#16), as well as conventional 'bundles' of interventions (#1) are known to work.

But in the area of chronic non-communicable diseases, the 2012 panel has merely made proposals for medicine and surgery (low cost drugs for acute heart attacks, #10, strengthening surgical capacity, #8) and information and education (campaign for salt reduction, #11). There seemed to be no thinking about the social determinants of health and disease, or of issues of equity and sustainability.

Participants at our London meeting were dismayed. Are economists, however eminent, always the best judges of world issues that involve equity, human rights,

social and environmental upheaval, and other matters in which money and income is just one factor? But even if they are, we wondered why Bjørn Lomberg and his team continued to select economists who as a group favoured monetarism and the Washington Consensus.

There are other more broad-minded economics Nobelists who could have judged the evidence and also advised on what evidence is most relevant. Five, all now based in the US, are pictured below: Paul Krugman, Joseph Stiglitz, Daniel Kahneman, Robert Fogel, pictured with his late wife), and Amartya Sen_former Master of King's College, Cambridge). Such a panel might well have had a more lively discussion and come up with more imaginative lists of priorities. Indeed, such a panel would almost certainly have challenged some of the principles underlying the Copenhagen Consensus process.



Paul Krugman, Joseph Stiglitz, Daniel Kahneman, Robert Fogel (with wife), AmartyaSen: Nobelists not engaged in the Copenhagen Consensus process

This year's Copenhagen Consensus 'challenge' and other background papers highlight the need for the authors of such work to be familiar and sympathetic with broader analyses, and to have easy access to such work. In our field these should show the impact on health and potential reversibility of disease by means of diet and nutrition, for example through strategic measures such as changes in the food supply, or in the relative cost of different commodities.

Without such analyses it is no wonder that the 2012 Copenhagen Consensus Nobelists ended up relying on enthusiasm for poly-pills and other measures often backed by trials funded by interested industrialists. It is a pity that they were not offered the Simon Capewell analyses I referred to last month (5), which show that preventive interventions can show greater benefit than treatment strategies with the effects becoming apparent within a very few years.

The fact that the 2012 Copenhagen panel did not set out coherent intersectoral policies was not because they are economists. It was because as a group they were narrow-minded economists with apparent little feeling or sympathy for what economics as a social science should really be about, especially in the context of low and middle income countries.

For example, changes in trade agreements can alter major factors affecting health – particularly food. This emerged for me clearly in the first major meeting of the Caribbean Heads of State which eventually led to the UN high-level meeting on chronic non-communicable diseases in September last year. Vincent Atkins, an economist who is trade advisor to CARICOM, the Caribbean Community Secretariat, stated that trade policies have not really considered public health nutrition at all, and there are ample opportunities for adjusting agreements within the current World Trade Organization rules. This eventually led to a detailed analysis of trade, food and health in all its dimensions as set out in a book published in 2010.

We should get a grip on this. How very much more work we in public health nutrition need to do.

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