After several decades of successful efforts to reduce the use and related health impacts of tobacco industry products, governments and health-sector stakeholders are now increasingly focused on preventive health-care strategies to address other causes of illness. Primary among these is the rising weight of the population and the impact that obesity is having on health outcomes and life expectancy. There is an “epidemic of overweight and obesity that is threatening Ontario’s health.”

Health-care stakeholders must ask themselves whether any of the successful approaches to control the use and impacts of tobacco industry products can be applied to the control of obesity via preventive health-care strategies. A summary of tobacco control interventions in Ontario from 1994 to present appears in Appendix 1, and a listing of OMA position papers on tobacco control, 1996-2010, appears in Appendix 2 (see p. 15).

The Ontario Medical Association has been involved in many campaigns to minimize or eliminate the consequences of tobacco use, and we agree with an emerging consensus that there are lessons to be learned from the strategies of the tobacco control movement. This is especially true with respect to foods that are high in fats and sugars, and have little nutritional value.

We believe that exercise and healthy food choices are essential to preventing obesity. The OMA has policy on increasing exercise, especially for kids, and has promoted the improvement of nutritional information to consumers, through menu labelling. We agree with the expert consensus, though, that more must be done to target the over-consumption of high-calorie, low-value junk foods.

Tobacco and food products are different in many ways, and unlike food, tobacco products are unique in that they have no safe level of use, but lessons can still be learned from the very significant reduction in smoking rates, and the methodologies employed to achieve these.

A point of comparison for all the risk factors is the degree to which the public, the media and government will tolerate what may be perceived as manipulative or coercive measures to control behaviour. In Ontario, public opinion on tobacco control has dramatically evolved during the past two decades from a position of considerable resistance to many interventions, to attitudes in which smoking is no longer socially acceptable, and intensive regulation is seen as appropriate.

The OMA and other health stakeholders were integral to increasing both public understanding of tobacco risks and public acceptance of new tobacco laws. Physicians played a prominent role in pushing the health-based anti-tobacco agenda, and have the opportunity to do the same with the factors contributing to the obesity epidemic.

Transferable Interventions
Having reviewed the suite of anti-tobacco interventions that have come into effect in Ontario since the early 1990s (the period when serious tobacco control began to take shape in the province), we have considered the transferability of these control mechanisms to obesity prevention.

There were certainly some governmental initiatives that worked better than others, and it was the utilization of a number of co-ordinated behavioural change tools that effected change, but...
the following anti-tobacco interventions were deemed to be the most effective:4
1. Public information/education (especially in the beginning).
2. Tax/price increases (the single most effective measure).
4. Removing retail counter displays/advertising (making tobacco less commonplace/denormalizing it).
5. Advertising bans.
Of course, there is no junk food equivalent of second-hand smoke, but the other interventions can be applied to certain foods.

Taxation
Experts agree that the taxing of tobacco products has proven to be the single most effective means of deterring consumption, particularly among young people. The price of tobacco products is the most significant influence on demand, and the way that the government influences product price is through taxation. The revenues from this tax were also seen by some as partial offsets to the health-care costs associated with smoking. It follows that this approach be applied to the significant challenges of obesity.

Increased taxes on high-sugar, high-fat foods, with no nutritional value, would increase their price and make them less attractive. Any increased costs to families for such pricing measures should be offset by reducing the tax on some healthier foods, and help to promote their consumption.

Consumer Information
The OMA believes that consumers should be provided with the information that will enable them to make their own health-promoting food purchases, and has long supported caloric labelling. It follows that Ontarians must be given more information about the levels of certain potentially harmful substances in food to promote healthier eating. So it is recommended that there be a requirement for specific package and advertising-based information about the risks to health from excess consumption of high-sugar, high-fat foods that provide little nutritional value.

In order to further assist consumers to choose healthier options, we should take the lead from tobacco campaigns and identify opportunities to put warnings on products containing high levels of fats and sugar, that have no accompanying nutritional benefit. Such prominent information would advise consumers of the health risks associated with excessive consumption of these foods, with respect to their contribution to obesity and subsequent incidences of diabetes, heart disease and other related illnesses.

Advertising And Retail Display
Similarly, retail displays of high-sugar and high-fat foods — particularly in locations frequented by young people — should be clearly marked with prominent information advising consumers of the health risks associated with excessive consumption of these foods.

The control of tobacco-related advertising can be broken into three categories: non-product-based, media advertising; product-based advertising, such as package designs; and sponsorship advertising. Most advertising restrictions have been put in place by the federal government, although Ontario gave itself authority to regulate packaging in its 1994 legislation, which it has never used.

In contrast, food advertising is ubiquitous, and often includes messaging for products that contain high levels of sugar, sodium and certain fats which are increasingly widely understood to be risks to health when consumed in excess.

The OMA has previously supported initiatives to restrict mass media advertising to children, but believes that restrictions on package advertising and sponsorships are also appropriate to address obesity and subsequent illnesses. For many years, educational campaigns about the harmful effects of tobacco were necessary to counter-
act the industry’s direct-to-consumer and sponsorship-based advertising and product promotions. It is clear that similar campaigns are appropriate with respect to counteracting the influence of advertising of high-sugar, high-fat, unhealthy foods, especially when that advertising is targeted at children and youth.

It is also recommended that, in addition to the School Food and Beverage Policy in Ontario, there be a restriction placed on the availability of high-sugar, high-fat, low-nutritional value foods and drinks in sports and other recreational facilities primarily frequented by young people. The fact that junk food is all that is available in most youth sports facilities sends the wrong message, and normalizes these unhealthy foods in these public venues.

A Cautionary Note About The Food Industry
While the Ontario government has taken many important steps to control the tobacco epidemic, the tobacco industry, its allies and surrogate groups have provided unceasing opposition to the government’s initiatives, many of which were supported by physicians and even advocated for by the OMA.

Although healthier eating initiatives are just getting started, it is important to note that the producers and distributors of foods and beverages that are considered obesogenic have a financial interest in the continued success of these products. This does not put them against health, but more in favour of initiatives that don’t negatively impact their business interests.

It is interesting to note that in an August 2012 report, entitled “Healthy Eating, Active Living and Healthy Weights,” Ottawa Public Health identified sugar-sweetened beverages (e.g., pop) as one of many contributing factors to obesity, and wrote that consuming sugar-sweetened beverages “increases the risk of becoming overweight or obese.”

Since then, both Ottawa Public Health and the Medical Officer of Health have been targeted by Coca-Cola, who has engaged the media, complained to senior officials, and undertaken a letter-writing campaign to city councillors against any initiative that would target pop.

Conclusion
If there is a single trait that must characterize our approach to reducing health impacts of high-sugar, high-fat, low-nutritional value foods and drinks, it is urgency. The United States and Canada began to address the tobacco epidemic through public information and education in the 1960s. Today, while considerable progress has been made, there are still almost 2 million smokers in Ontario, and 4.7 million smokers Canada-wide, with continuing attendant costs to health-care systems and economies.

Our society does not have a comparable period of nearly five decades to make significant inroads against the range of diseases associated with excessive consumption of these junk foods — led by childhood obesity and the resulting growing incidents of diabetes — before they overwhelm Ontario’s health-care system.

The recommendations provided on page 13 may appear radical to some, but the urgency of our situation demands aggressive action. A quick policy response from government is essential, as is a comprehensive approach to these modifiable disease risk factors.

Just as no single intervention has been proven effective against the tobacco epidemic, no one or two isolated approaches to obesity prevention can hope to be effective. Ontario must set an aggressive course, with a comprehensive, multi-pronged suite of policies, in order to meet these challenges — and it must do so immediately.

References
## Appendix 1

**Tobacco Control Interventions In Ontario, 1994-Present**

<table>
<thead>
<tr>
<th>Federal</th>
<th>Provincial</th>
<th>Municipal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advertising restrictions, including elimination of sponsorship advertising.</td>
<td>• Prohibition on sales to minors.</td>
<td>• Smoke-free workplace and public place bylaws.</td>
</tr>
<tr>
<td>• Smoke-free mass media campaigns.</td>
<td>• Prohibition of drug store sales.</td>
<td>• Bylaws mandating various smoke-free outdoor sports and recreation settings.</td>
</tr>
<tr>
<td>• Requirement for graphic picture warnings on cigarette packages.</td>
<td>• Elimination of cigarette vending machines.</td>
<td>• Smoke-free workplace and public place bylaws.</td>
</tr>
<tr>
<td>• Restrictions on flavouring and package size of little cigars.</td>
<td>• Ban on smoking on school property.</td>
<td>• Bylaws mandating various smoke-free outdoor sports and recreation settings.</td>
</tr>
<tr>
<td>• Virtual elimination of tobacco advertising.</td>
<td>• Elimination of exposure to second-hand smoke in all provincial workplaces and public places.</td>
<td>• Smoke-free workplace and public place bylaws.</td>
</tr>
<tr>
<td>• Tax increases (and reductions).</td>
<td>• Ban on display of tobacco industry products at retail.</td>
<td>• Bylaws mandating various smoke-free outdoor sports and recreation settings.</td>
</tr>
</tbody>
</table>

## Appendix 2

**Ontario Medical Association Position Papers On Tobacco Control, 1996-2010***

- Second-Hand Smoke and Indoor Air Quality, November 1996
- Rethinking Stop-Smoking Medications: Myths and Facts, August 1999
- More Smoke and Mirrors: Tobacco Industry-sponsored Youth Prevention Programs in the Context of Comprehensive Tobacco Control Programs in Canada, March 2002
- The Duty to Protect: Eliminating Second-Hand Smoke from Public Places and Workplaces in Ontario, February 2003
- Investing In Tobacco Control: Good Health Policy, Good Fiscal Policy, December 2003
- Exposure to Second-hand Smoke: Are We Protecting Our Kids? October 2004
- Rethinking Stop-Smoking Medications: Treatment Myths and Medical Realities, March 2008
- Tobacco, Illness and the Physician’s Perspective, April 2010

*All papers are available on the OMA website at www.oma.org*