# Learning from Tobacco Control: Adapting Strategies for Food and Nutrition Policy Development

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## INTRODUCTION

Several researchers and practitioners have recognized the potential for food and nutrition advocates to learn from tobacco control efforts. The research for this paper was conducted to examine historical approaches to tobacco control with a view to informing the work of those developing strategies and policies related to food and nutrition in Ontario. I reviewed research and sector reports from Canada and beyond and interviewed several individuals who have been involved in Canadian tobacco control efforts (see Appendix A for names of interviewees).

My research suggests significant progress has been made over the last 20 years, enabled by efforts begun in the 1950s, and so I have started the story here. The evolution of tobacco control efforts includes strategies to educate the public about the impacts of tobacco on health and to engage members of the health care, public health and education sectors in reducing consumption. In the case of tobacco, most efforts focused on reducing access and consumption of the product, reducing exposure to secondhand smoke and denormalizing the tobacco companies and their practices. In the case of food and nutrition, increasing access to and consumption of healthy foods, while also reducing consumption of low nutrition foods needs to be addressed through strategy and policy.

This paper examines different aspects of tobacco control efforts and outlines corresponding considerations for food and nutrition advocates. Readers are encouraged to focus on sections of interest, since some of the content may already be familiar. The paper begins with a brief history of the evolution of tobacco control efforts in North America. This is followed by an overview of interventions and strategies used in tobacco control in North America and beyond. The third section illustrates how strategies and policies were developed and implemented in the province of Ontario over the last 20 years. The fourth outlines some of the key enablers in tobacco control efforts. The final section examines the critical role that framing the issue played in shifting public opinion and support for tobacco control policies and regulations.

Although both tobacco and food are both public health issues, the two products and industries vary greatly. In Appendix B I have compared and contrasted the two industries. Key similarities and differences to keep in mind while reviewing this paper include: tobacco is a single, toxic product, whereas there is an almost infinite variety of healthy and less healthy food products. And while the tobacco industry was a clearly defined 'enemy' and cause of the epidemic for tobacco control advocates, the food industry is much more diverse, and many in the food system produce healthy products. So while some aspects of the food industry (e.g. use of trans fats, sugar and salt) need to be opposed in the same way as was done with tobacco, there may be greater potential, and likely a need, to work 'with' industry to solve the complex problems related to food, nutrition and public health.

## BRIEF HISTORY OF THE EVOLUTION OF TOBACCO CONTROL

Tobacco control strategies introduced over the last 60 years have gradually shifted society's perceptions of smoking from attractive and desirable to more or less distasteful. The evolution of strategies used in tobacco control range from attempts to influence individual behaviour to policies and programs designed to shape conditions in the environment; interventions have spanned the full 'individual behaviour-environment' spectrum. Many of

the interventions were experimental as advocates knew a multi-pronged approach was required and did not know which would be most effective. Sixty years on, tobacco control efforts have significantly reduced the presence of smoke in North American Society. Those interested in advancing issues related to food and nutrition may be able to learn from and adapt tobacco control strategies and interventions (e.g. policies, legislation, programs, etc.).

Kenneth Warner's memo, "Lessons for addressing obesity from the history of tobacco control"*(1),* prepared for Berkley Media Studies Group's (BMSG) Acceleration meetings in January 2004 described the first phases of this evolution in North American tobacco control exceptionally well. Most of the historical data was identified by Menashe and Siegel *(2).* In Phases 3 and 4 I've highlighted mainly Ontario interventions.

**Phase 1 Direction (1950s-1960s): Inform, educate, and persuade smokers to quit**

- Drivers: 1950s research; 1952 Reader's Digest Article "Cancer by the Carton"; 1964 US Surgeon General's Report on smoking and health – the first definitive evidence linking smoking to lung cancer and other diseases
- Emphasis: mainly focused on individual behaviour/personal responsibility; paternalistic tone: 'we will help them' understand why they should quit.
- Public opinion: bans on smoking were inconceivable in the 1960s when roughly half of the Canadian population was smoking.
- Key Tools: introduction of health risk warning labels on packages and advertising (1965 U.S.); delivery of school health education; use of simple, novel media messages; broadcasters in U.S. were asked to donate airtime to anti-smoking cause to offset effects of advertising (1967); advertising prohibited on TV and radio (1970 US); some taxation increased prices.
- Industry reaction *(3)*: Industry's 1954 "Frank Statement to Cigarette Smokers", a paid publication in 448 newspapers was the first step in tobacco's campaign to deceive and delay shifts in public opinion. **Development of a 'playbook'** or script written by lawyers to guide industry executives, lobbyists, lawyers, scientists and supportive members of government when talking about tobacco. Key 'plays' in the book were initiated during this time: counterattacks and lobbying campaigns; alignment with the advertising industry, media, restaurant associations and civil libertarians; product modification (filters were introduced in the 1950s and this was followed by the introduction of low-tar/nicotine options in the 60s; both were essentially public relations devices); disputation of science linking smoking and disease and funding of science designed to instil doubt.
- Impacts: Consumption dropped in the two years after the Reader's Digest article, but resumed after heavy marketing of filtered cigarettes. Interventions produced a moderate overall decrease with a greater decrease in smoking among the highly educated; interventions failed to reach the less educated.
- Evaluation: widely considered a failure at the time; however in retrospect **this phase was considered critical to readying society for Phase 2 interventions.**

**Phase 2 Direction (1970s-1980s): Protect 'innocent victims' by upholding non-smokers' rights**

- Drivers: 1972 US Surgeon General warns smoke could damage the health of non-smokers; 1981 the first scientific study links second-hand smoke to lung cancer; 1984 US Surgeon General issued concise message "tobacco kills", placing responsibility on tobacco companies; he envisioned a smoke-free society by 2000.

- Emphasis: interventions broadened to shape the environment; the tone shifted to 'protecting ourselves from 'them''; the control movement recognized the need to appeal to smokers' intrinsic values, particularly related to their own health. This shift in focus expanded the range of possible solutions.
- Public opinion: support for taxation grew, particularly when some revenues were used to fund youth anti-smoking campaigns.
- Key Tools: first local bans on smoking in public places introduced; tax increases continued and in 1980s were adopted globally; introduction of smoking cessation programs; school campaigns continued; push for the elimination of advertising (driven in 1985 by civil society organizations in U.S.). Despite a bigger focus on shaping the environment, many interventions remained focused on influencing individual behaviour.
- Industry reaction: recognized that the non-smokers' rights movement was their greatest threat… led to the formation and funding of industry support/front groups (e.g. Smokers' Freedom Group in Canada *(4)*)
- Impacts: legislation for smoke-free spaces had a significant impact in terms of reducing smoking and ensuring cleaner indoor air for non-smokers; this legislation affected the acceptability of smoking; this, combined with higher prices reduced the number of smokers.
- Evaluation: **altering the social environment to make it more conducive to healthy behaviour was crucial in changing behaviour; taxation (higher prices *and revenues for government*) was identified in the 80s as "the single most effective policy"** *(1)*, particularly in effecting behaviour change amongst children and the poor. In terms of other interventions, cessation treatment was found to be cost-effective, but media campaigns were more so (although at this stage it was unclear which media approaches really worked or what scope was required). School-based education campaigns did not appear to have lasting effects. Overall the movement was hindered by a lack of infrastructure (e.g. formal networks, coordinated research efforts, dedicated resources, etc.) *(5)*.

**Phase 3 Direction (1990s-2011): Make Tobacco a Public Health Issue**

- Drivers: early 1990s US Environmental Protection Agency (EPA) report on passive smoking; 1996 US Food Drug Administration (FDA) finding: nicotine is addictive… they described cigarettes as 'a drug delivery device' *(2, p. 309)*. Non-governmental organizations (NGOs) played a more significant role during this period and some staff/experts were invited into government (e.g. in Ontario) to supplement a lack of expertise related to tobacco control. Canada signed the WHO Framework Convention on Tobacco Control (FCTC), an international treaty adopted by the World Health Assembly (effective 2005).
- Emphasis: significant expansion of smoking bans combined with continued tax/pricing increases.
- Ontario Acts: Tobacco Control Act (TCA), 1994 and Smoke Free Ontario Act (SFOA), 2006.
- Key Tools: the legal smoking age in ON was raised to 19 (1994); introduction of large graphic labels accompanied by bold messages covering 50% of the package (2000); Ontario banned display of tobacco products (2008); expansion of local and provincial smoke-free legislation (smoking in public places); Ontario banned smoking in cars where youth were present (2009); some extension of smoke-free bans to the outdoors in Toronto (2009) and in children's spaces, Vancouver beaches, and parks (2010); promotion and payment for pharmacotherapy (e.g.

nicotine replacement therapy was found to be an effective support that is too costly for many *(6)*); taxes increased in some regions; more programs delivered by NGOs (e.g. Canadian Cancer Society hosts Ontario's Smokers Helpline).

- Industry reaction: in 1994 the CEOs of every major tobacco company swore under oath they did not believe smoking caused lung cancer; industry began to use warning labels as a shield to hide behind in litigation; expansion of contraband tobacco products; Canadian Tobacco Manufacturer's Council (a trade and lobbying group) provided $800K to the Canadian Hotel Association to support their 'Courtesy of Choice' program (to accommodate smokers with ventilation *(7)*) and in 2004 the industry began funding pro-smoker's advocacy group and website: mychoice.ca (note: no longer active).
- Impacts: A 10% price increase in the 1990s was credited with a decrease in consumption of approximately 4.5% *(8)*. The more graphic labels introduced in Canada in 2000 led to the single greatest annual drop (5%) in smoking *(9)*. Between 2003 and 2006, 4.6 billion fewer cigarettes were sold in ON *(10)*. Between 2005-2009, smoking rates in ON declined from 20% to 18%, and exposure to second-hand smoke decreased from 11% to 3% *(11)*.
- Evaluation: Smoke-free policies and media campaigns helped to change social norms and led to reductions in consumption and prevalence *(2)*. Public support for expanded protection measures/restrictions has increased significantly in recent years *(11)*. Comprehensive social marketing was identified *(12)* as a key part of cessation strategies but some marketing in ON was found to have a very limited reach (e.g. only 5% of smokers were aware of different cessation support options *(11)*).

**Phase 4 Direction (2012-): Achieve a smoke-free society**

Building on our Gains, Taking Action Now: Ontario's Tobacco Control Strategy for 2011-2016 *(13)* outlines some of what lies ahead. They make the case for more resources based on recommended spending guidelines issued by the Centres for Disease Control and Prevention.

- Drivers: the Ontario Tobacco Research Units' (OTRU) Oct. 2011 Evaluation Update *(11)* indicated that progress has levelled off in Ontario particularly among smokers of low socioeconomic status; the prevalence of smoking among young adults remains high and youth adoption remains a concern along with the widespread availability of contraband products. Smoking remains a social norm in Ontario and beyond.
- Emphasis: decrease supply *and* demand through comprehensive strategies; de-normalize and de-legitimize the tobacco industry; decrease smoking around children so they aren't tempted to emulate; address health threats posed by smokeless products (e.g. chewing tobacco); focus more on addiction and increase awareness and accessibility of interventions to help smokers quit. Take a whole of government approach (i.e. a coordinated approach across different ministries and levels of government).
- Key Tools: extend outdoor smoking bans to patios, city-owned parks, playgrounds, etc. (Ottawa, Hamilton and Georgina are scheduled for spring 2012 *(14)*); introduction of larger labels covering 75% of packages back and front in Ontario (June 2012); introduction of peer-to-peer approaches to combat youth smoking; use of innovative media and social marketing strategies (*6*); divestment of provincial investments in tobacco holdings.
- Industry reaction: to be determined – continued legal challenges expected.
- Goals: Ontario vision: a smoke-free society by 2030.

- Impacts: to be determined.

***Considerations for food and nutrition***
*Making progress on food and nutrition issues requires a long-term perspective and multi-faceted policy interventions across the individual behaviour-population/environment spectrum. Experiments combined with evaluation will be important. Individual change interventions such as nutritional food guides have had limited success to date; many advocates are recognizing that more attention and energy needs to be invested in changing conditions in the environment/foodscape to make it easier for people to choose healthier foods. While there is no direct equivalent of smoke-free environments for food and nutrition, regulations can be put in place in some environments (e.g. as has been done in some schools and hospitals). In addition, there is a great deal of work to be done in redesigning Ontario's foodscape to make healthier food options more accessible, affordable, appealing, and sustainable. Although governments are widely averse to introducing new forms of taxation, price can be a powerful signal and as their budgets are stretched this may eventually be considered more palatable.*

## KEY INTERVENTIONS & STRATEGIES IN TOBACCO CONTROL

The evolution of tobacco control efforts outlined above illustrates that a comprehensive range of policy and program interventions and strategies were introduced over time. Engelhard, Garson and Dorn *(9)* define aggressive, hard policy interventions as those with the potential to "change behaviour on a massive scale" *(p. 18)* because they are designed to change conditions in the environment. The BMSG paper Accelerating Policy on Nutrition *(5)* reinforces the importance of this focus on the environment, because "even with the best of intentions, making the "right" choices can be difficult" *(p. 5)*. Engelhard et. al *(9)* believe that aggressive policies can be amplified by 'soft' policies that support individuals in making healthy choices. The authors identify a number of key tobacco control interventions and considerations for adapting them to food and nutrition.

**Hard interventions**: Engelhard et al. *(9)* note that **the top three interventions that may be applicable to combating obesity (and related food/nutrition issues) include taxes, labelling and marketing bans**; all of which are low cost interventions. Taxes have proven particularly attractive because higher costs not only influence purchase decisions and reduce consumption, but the tax generates revenues for government. When these revenues are re-invested in related prevention programs, the overall impact is increased and public support for tobacco taxes grows. They note that the evolution of labelling formats from cautionary wording to bolder messages accompanied by graphic images increased efficacy significantly. Studies have found that exposure to point-of-sale advertising of tobacco products increases the likelihood of purchasing tobacco, and that youth are particularly susceptible to these point-of-purchase marketing tactics *(Smoke-free Ontario backgrounder (10) cites an article by the American Nonsmokers' Rights)*. Based on a literature review Engelhard et al. also identified clean air regulations (smoke-free environments) and restrictions on youth access as other key interventions.

**Soft interventions**: On the softer side, Engelhard et. al. identify anti-smoking education programs (media, schools, and community), and cessation support programs (including pharmacological treatments) as two key interventions in reducing tobacco use. The BMSG

article *(5)* cautions that education for personal behaviour change is always the easiest strategy, and that, while necessary, it is not sufficient on its own.

### *Considerations for food and nutrition*

*Since the Ontario tobacco control movement borrowed strategies and approaches from other jurisdictions, I have included some examples of interventions applied in North America and beyond.*

- *Taxation: Many processed foods are taxed in Ontario,* ***but higher taxes applied more broadly*** *(i.e. at the point of purchase and at the producer level) could play a significant role in driving healthy food choices (Engelhard et. al. (9) reference a 2009 study by Brownell and Freiden that found that a 6.8% increase in the price of carbonated soft drinks could reduce sales by ~8%). Determining which items to tax can be a challenge; the UK uses the Rayner nutrient profiling model. Tax revenues could be used to subsidize fruits and vegetables to increase affordability; subsidize public health education and media programs; and be directed to the health care system to off-set the cost of treating food-related conditions. Engelhard et. al estimated, that in the U.S., a 10% tax on fattening foods (foods classified as 'unhealthy' in the Rayner model) could generate ~$240 billion over 5 years (9, p. 29). California's $.01 tax on 20oz sodas generates $200 million annually (15). The food and nutrition movement would need to determine if the political appetite for this exists or whether efforts first need to be invested to shift public opinion.*
- *Labelling: Current back of package nutritional labels have been found to be confusing and of limited effectiveness.* ***Colourful, graphic labels on the front of packages*** *(FOP) may be more effective in influencing point of purchase decisions (more evidence is needed). The UK introduced a FOP graphic traffic-light image with key nutritional information to help buyers distinguish between healthy and less healthy products. These labels, when placed on taxed food items, convey a stronger, clearer message; after they were introduced, Tesco supermarket saw sales of less healthy prepared meals drop by up to 41%, while those with healthier profiles more than doubled (9). At least one Canadian retailer/producer has voluntarily introduced FOP nutritional information (e.g. Loblaw's graphic nutrition labelling of its Blue Menu products in 2012).* ***Menu labelling*** *has also proven somewhat helpful (more research is needed) in guiding decisions in restaurants; this approach has been used in some U.S. municipalities and is poised for expansion.*

*(source: NHS Choices website)*

- *Marketing bans: a* ***comprehensive marketing ban on low/no nutrition foods*** *was seen as having potential. "Evidence shows that exposure to food advertisements significantly and directly affects consumption of fattening food by both children and adults"… and "At least 50 countries regulate television advertising aimed at children" (9, p. 41). Quebec banned all print and broadcast advertising to children in 1980; unfortunately the effectiveness of this approach (which has also been taken by some European countries where it may be more publicly viable) is unclear. More analysis is required and the scope of any marketing ban needs consideration in the today's digital marketing age.*
- *Access: the availability of unhealthy foods, particularly for youth, is being controlled somewhat in the school environment (e.g. restricting the contents of vending machines, what's on the menu, etc). In October 2011 Ontario's New School*

*Food and Beverage Policy (16) was introduced outlining nutrition standards for food and beverages sold in schools (junk food was not banned since the policy does not apply to food and snacks from home); at the time media reported some resistance and observed that the availability of nearby retail alternatives has undermined the intervention's success. More evaluation is needed.*

- *Agricultural policy: some have recommended governments* ***subsidize production*** *of healthy foods, and/or reduce subsidies for crops typically used as fillers (e.g. corn and high fructose corn syrup used in highly processed, low nutrition foods (17, 18));* ***help farmers transition*** *to production of healthier foods and transition to organic growing methods to reduce the public health impacts related to industrial farming practices (18).*

## Taking Advantage of the Municipal-Provincial Dynamic

Throughout the history of tobacco control efforts, a number of **progressive, innovative interventions and strategies introduced at the local/municipal level** helped to push the envelope and pave the way for broader implementation. The BMSG report *(5)* notes that the local level is often fertile ground because communities may have a greater sense of self-interest since the interventions affect their neighbourhoods; as well, individuals can appeal more directly to local policy makers. Successful local efforts often involve collaboration between community members, lawyers, researchers and other advocates. Supporting these collaborations, especially in high risk/need communities can be helpful. This might be a consideration for municipalities characterized by food deserts where there is limited access to fresh produce and healthy foods.

Opposition at the local level may be weaker since many lobbyists and groups tend to focus at the national or provincial level. The BMSG report *(5, p. 19)* quoted a tobacco industry spokesperson as saying that fighting multiple municipal policy changes at the same time is like "getting pecked to death by ducks".

The tobacco control experience also provides a reminder that, once a local policy or regulation is introduced, there is real danger that industry may try to undermine or overturn it by lobbying for the inclusion of a weaker or self-regulatory approach at the provincial or national level. This tobacco industry 'play' is evident in the food industry's response to recent menu labelling laws introduced in New York and other U.S. municipalities. One of the interviewees (see Appendix A) noted that the tobacco control movement learned from the U.S. experience that **it is critical to incorporate anti-pre-emption language into laws**, **setting minimum provincial standards which leave municipalities free to establish more restrictive standards.**

## APPROACHES TO TOBACCO CONTROL IN ONTARIO

The content in this section is drawn mainly from the four interviews conducted as part of my research (see Appendix A for names). In preparing this paper for wider circulation, interviewees reviewed and corrected some errors in the previous version of the paper; I would like to thank them all for their efforts. The tobacco control movement in Canada is a story of successful social change. One interviewee noted that Canada went from having one of the highest smoking rates in the world of ~50% in the 1960s, to a rate of ~17% today. The work done in Ontario, particularly since the early 1990s is highly regarded and has influenced approaches to tobacco control internationally.

Tobacco control strategies and Acts developed in Ontario illustrate a progressive evolution that parallels a shift in public opinion that was actively influenced by those working in the tobacco control movement. This shift in public opinion ultimately supported advocates' efforts to introduce progressively bolder population-based regulations. The movement's capacity to develop strategy and influence policy development was affected by the degree of political will of different provincial parties, and also premiers' individual interest in the issue.

In the early 1990s Ontario's NDP government asked the Ministry of Health to produce a comprehensive strategy for tobacco control. Some individuals working on the strategy went to the U.S. to speak to representatives from the National Cancer Institute (NCI), to learn from their research and development efforts. At the time, California's program was being developed and it was modeled on the US National Cancer Institute's American Stop Smoking Intervention Strategy for Cancer Prevention (ASSIST); this program was outlined in "Smoking and Tobacco Control Monographs 1. Strategies to control tobacco use in the United States: a blueprint for public health action in the 1990's" *(12)*. This model of tobacco control was also used as a platform for the design of Ontario's 1992 strategy, including elements of the 1994 Tobacco Control Act (TCA) (and this also became a model for other provinces). This is one of several examples of knowledge exchange and sharing of lessons learned between the U.S. and Canada.

One interviewee noted that, while the number of deaths and costs to the health care system made it clear that action was required, it was not clear in the early days which interventions would work since evidence of their effectiveness was limited. The tobacco control movement applied the precautionary principle (informally) when introducing interventions and then evaluated the interventions. "The precautionary principle denotes a duty to prevent harm, when it is within our power to do so, *even when all the evidence is not in.*" *(19)*. The lack of evidence in this case refers to the effectiveness of the interventions, not the negative effects of tobacco which were well-known at the time.

Support for the tobacco control movement waned initially under the Harris government (during the period 1995 to 1999). Health care budgets were cut during this period and government capacity in the tobacco control area was reduced. Momentum slowed, however some members of government remained committed to tobacco control, and in 1999, interest in the renewal of an Ontario strategy resurfaced. Since limited tobacco expertise existed in government at this point, leaders at the Ministry of Health reached out to individuals who had been involved in the early 90s. In addition to engaging individuals who knew the tobacco control issue, the government also engaged individuals with expertise in economics, policy development and worked with NGOs. Government decided to outsource

some strategy implementation to health NGOs: steering committee planning to Cancer Care Ontario; cessation to the Canadian Cancer Society; youth interventions to Ontario Lung Association; and mass media communication and media advocacy to the Heart & Stoke Foundation of Ontario who focused on shifting public attitudes. The overall capacity of tobacco control efforts was expanded through government-NGO partnerships.

In their 2003 electoral platform, the Liberals identified four tobacco control elements. In 2003, when they formed government, they engaged a new Chief Medical Officer of Health (CMOH), Sheela Basrur. The Premier reinforced to the CMOH his commitment to banning smoking in public places within three years and the urgent need to develop a comprehensive tobacco control strategy[1]. The CMOH reached out to a tobacco control veteran at Cancer Care Ontario (CCO), and asked him to propose a plan for moving forward. She opened doors and gave him authority to talk to officials within government; he presented options and made the case for re-building the strategy. This included discussion with a variety of individuals in the Premier's, cabinet, minister's office senior public servants across Ontario government ministries. Much of the policy work around Smoke-Free Ontario was developed in a remarkably short time frame characterized by a period of intensive work.

The Smoke-free Ontario Strategy (SFOS) replaced the Ontario Tobacco Strategy in 2004, and the Tobacco Control Act was renamed the Smoke-free Ontario Act (SFOA) in 2006. The SFOS budget was raised from about $10 to $40 million in 2005 and to $60 million in 2006. These increases reflected a recognition of the health and economic burdens tobacco use was placing on Ontario and the need for a robust, well funded model of tobacco control based on guidelines for comprehensive tobacco control issued by the US Centers for Disease Control and Prevention *(13).*

Although the SFOA came into effect in 2006, much of the work done to control second hand smoke in the late 1990s and early 2000s in different municipalities laid the groundwork for this, particularly in terms of shifting public opinion and making it obvious to the province that province-wide legislation was feasible by the mid 2000s. The important role of issues framing and media advocacy was first recognized in the U.S. In 2000, as part of the Ontario Tobacco Strategy, "The Media Network for a Smoke-Free Ontario" was established to further enhance effective media advocacy by NGOs; it was eventually merged into CCO's Program Training and Consultation Centre (PTCC). The network aimed to increase positive media coverage; the program: "provides expertise on media relations and media advocacy, as well as knowledge exchange, to tobacco control practitioners across Ontario" (PTCC website re: the Media Network for a Smoke-Free Ontario https://www.ptcc-cfc.on.ca/media_network/tobacco/). Over the years the network did background research related to specific policy changes, monitored media, identified talking points, trained public health staff, and supported local media buys. In parallel with

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[1] *NOTE: According to one interviewee, nutrition and physical activity were also on the Premier's priority list in 2003, and while policy work was done – e.g. the "Healthy weights, healthy lives" document was developed in 2004, there was a delay of several months and in that period the window of opportunity started to close. In 2006 the "Healthy Eating and Active Living Action Plan" was introduced to build on the 2004 document; however the plan was not adequately funded. This reinforces the need to move quickly when a window opens and understand how to navigate the system to maintain momentum at the policy and public service level. The lack of infrastructure to support food and nutrition policy development also appears to have hampered progress in food and nutrition during this period.*

this, the Ontario Heart & Stroke Foundation ran a series of targeted advertisements between 2000-2005 with the goal of shifting public attitudes; in the year 2000, 58% of the public supported province-wide legislation that would make all public places 100% smoke-free, by 2006 this support had increased to 71% (see Media Campaign, page 14 and public opinion, page B-6).

Although it took a long time to shift social norms, today public support for tobacco control has shifted so significantly that it is difficult for politicians of any party to object to environmental level controls which would never have been considered 20 years ago. Advocates have become increasingly bold as a result; it likely helps that there are fewer smoking voters. Coalitions (e.g. Canadian Coalition for Action on Tobacco Control and its Ontario equivalent) continue to play an important role in this work by collectively lobbying government. Members of these coalitions are diverse, ranging from large health charities, representative groups, and organizations that are not government funded. Those that are not government funded can be more aggressive (i.e. play the 'bad' cop), while other organizations that have high level connections to government can take a more measured approach ('good' cop).

One interviewee noted that messages that have resonated with government in today's economic climate include framing the costs of interventions as a proportion of tobacco tax revenues; and identifying manufacturing tax loopholes, which, if closed, could be used to fund a program. Pointing to the overall costs to the health care system is less compelling today with fewer smokers, however advocates can still emphasize cost reductions that could be achieved related to specific conditions. A 2012 report from CCO and Public Health Ontario *(20)* links chronic diseases and prevention to four key risk factors: tobacco, alcohol, unhealthy eating and physical inactivity.

## ENABLERS OF TOBACCO CONTROL

The Smoke-free Ontario Scientific Advisory Committee's report "Evidence to Guide Action" Chapter 9 *(21)* outlines **five enablers of a comprehensive and sustainable tobacco control strategy**: **leadership; support for development and implementation of policies, programs and social media; funding; a learning system; and accountability and performance management.** Many of these elements were put in place in Ontario over the years, but evaluation results suggests some require more attention a different emphasis and/or additional investment going forward.

The BMSG Acceleration discussions *(5)* concluded that a successful food and nutrition movement requires an investment of resources to support work in three areas: **"building infrastructure, conducting research, and cultivating leadership".** These reflect many of the elements identified as enablers of tobacco control.

1. **Leadership**: the capacity to establish a vision, goals, objectives and manage partnerships is critical to the development and implementation of a strategic plan; leadership must be strong and sustained; take a whole of government approach (i.e. inter-ministerial leadership); and leadership must be exercised in partnership (e.g. coalition building with non-governmental organizations (NGOs) and local advocates). *(21)*

"Finding and supporting strong leaders in the obesity prevention movement is important" *(5, p. 34)*. In the tobacco control movement, leaders often emerged at the local level. Strong leaders are needed to elevate the status of an issue – e.g. to frame food and nutrition as an important public health and equity issue; and to respond to aggressive industry opposition that will arise. There is likely a need for different kinds of leaders working visibly and behind the scenes at different levels – the BMSG report *(5)* cites the Advocacy Institute's leadership taxonomy: visionaries, strategists, statespersons, experts, outside sparkplugs, inside advocates, strategic communicators, and movement builders.

2. **Support for development and implementation of policies, programs and social media**: policy interventions have proven the most powerful tool in tobacco control, so continued investments need to be made to build capacity in policy development (e.g. to identify needs, assess costs and effects, prepare policy briefs). Building capacity related to program development (e.g. identify needs, review evidence, conduct evaluation, design for replication, etc.) and the effective use of mass and other social media (e.g. design media strategies, coordinate, evaluate, etc.) will also continue to be important. *(21)*

   In tobacco, the US ASSIST project (American Stop Smoking Intervention Trial, a partnership between the National Cancer Institute and 17 state health departments) **focused on advancing policy in four areas**: clean indoor air; advertising restrictions, pricing policies (tax), and youth access *(5).* **This focus provided direction** for advocates and brought greater cohesion and alignment to the movement, and encouraged experimentation within these areas. Evaluation was then used to determine what worked.

   **Independent research is critical** *(5)* to legitimizing policy changes, evaluating experiments, describing conditions for success, and informing advocates of best practices. It can also be useful in helping gain support to expand programs that work. The publication and promotion of findings is critical to shifting issue contexts and public opinion; researchers may need support in learning how to effectively engage the media. The Ontario Tobacco Research Unit (OTRU) identifies and publishes research priorities that support the tobacco control strategy.

3. **Funding**: evidence from California suggests that sustained, long-term funding for a comprehensive range of strategies delivered a significant return on investment in terms of reducing the prevalence of smoking and the burden of disease. Funding cuts in some US states led to declines in the rate or reversal of progress. Many tobacco control programs such as media campaigns that have played a key role in Ontario's tobacco strategy have been co-funded (and delivered) in partnership with credible health NGOs *(22)*.

4. **A comprehensive tobacco control learning system**: in Ontario key elements of this system include four Tobacco Control Resource Centres (TCRCs) that are housed in provincial agencies and the Ontario Tobacco Research Unit (OTRU). The centres provide training, technical assistance and resource support to help build capacity for tobacco control; they plan together annually. OTRU does much of the monitoring, evaluation and documentation of outcomes needed to inform policy and program development and ensure cost-effectiveness. Research done in Ontario has advanced global understanding. This learning system brings together key members

of the system (e.g. scientists, practitioners, policy-makers and those providing technical assistance) to network, learn, and innovate together.

The BMSG report *(5)* noted that progress by the tobacco control movement was hindered in the 1970s and early 1980s by a lack of infrastructure (the kinds of enablers identified in the Smoke-free Ontario Evaluation). The group concluded that infrastructure is critical to fostering a network of advocates and connecting key players in the food and nutrition movement (e.g. advocates, researchers, communities and policy makers) to engage their creative thinking, deepen relationships, exchange and capture knowledge, and spread lessons learned. They identified several **key infrastructure supports**: advice or training on policy and research; a safe, independent environment/forum in which to meet and connect (e.g. in 1988 a computer bulletin board was introduced to connect tobacco control advocates; regular meetings were held between small numbers of advocates and researchers); and media advocacy assistance.

5. **Accountability and performance management**: ensuring the implementation and enforcement of Smoke-Free Ontario Act.

## FRAMING THE ISSUE

Frames help to organize information and serve as an emotional and/or intellectual hook. They can be used to help the public, journalists, and policy makers think differently about an issue and connect the dots *(23)*. Menashe and Siegel *(2)* provide a definition informed by a variety of researchers, *"A frame is a way of packaging and positioning an issue so that it conveys a certain meaning. … Framing not only defines the issues, but it also suggests the solution" (p. 310)*. They cite work by Wallack et. al in 1993 who argued that "debates over public health policy issues represent battles to frame the issue in the eyes of the public and policy makers" *(p. 311)*. George Lakoff cautions, "if a strongly held frame [i.e. an individual's current thinking about an issue] doesn't fit the facts, the facts [i.e. those you present about an issue] will be ignored and the frame will be kept" *(24, p. 37)*.

Frames used by tobacco control advocates and the tobacco industry have evolved over time and have been an integral part of the evolution and effectiveness of tobacco control efforts. Advocates for tobacco control have used frames to shift public opinion and influence individual behaviour and policy-makers, while the tobacco industry has used frames to legitimize their industry and protect profits. NCI's Monograph 1 reinforces the role of persistent, inescapable messaging in changing social context. In California, they determined that budgets related to tobacco control strategy implementation should ideally be allocated: 1/3 to public health for strategy coordination and leadership; 1/3 to the community (NGOs, coalitions, expert groups); and 1/3 to mass media communications. In Ontario the role and value of mass media was underestimated in the early 1990s. After looking at the impact of media campaigns the U.S., media in Ontario received more attention and funding post-2000. Mass media efforts were ultimately critical in shifting public attitudes (see Appendix B-6), which facilitated the introduction of smoke-free legislation.

Effective, consistent frames related to food and nutrition have not yet been identified. In this section I highlight some of the frames employed by both sides of the tobacco story and identify some possible frames and considerations for food and nutrition policy advocates.

Menashe and Siegel's *(2)* analyzed newspaper coverage of tobacco issues in the U.S. between 1985 and 1996. They found that the tobacco industry's frames were well constructed; linked to core values (i.e. personal freedom, civil liberties, and individual rights); and consistent. Industry frames were only tweaked to *respond* to framing shifts made by tobacco control advocates. In contrast, tobacco control frames used during this period were inconsistent, poorly coordinated and powerful frames (which outlined the clear evidence about the dangers of tobacco use) were diluted. The authors suggested in 1998 that tobacco control advocates "must directly confront the opposition frames… develop their own frames that appeal to the same compelling core values" *(p. 312)*.

- **Tobacco script**: for many years the industry's mantra was "smoking had not been proved to cause cancer". They emphasized moderation, despite evidence that no amount of consumption is safe. A 'playbook' of strategies was used to sustain controversy, delay shifts in public opinion, and cast the industry in a positive light. *(3)*
- **Dominant industry frames** (U.S. media analysis1985-1996 *(2)*): industry as a positive economic force; moralizing/prohibition by 'fascist' antismoking advocates; free speech/legal product; just doing business; big government/civil liberties; accommodation of smokers and non-smokers. The first three frames were the most frequently used to counteract tobacco control frames.
  - The industry uses symbols and metaphors to portray itself as a good corporate citizen, friend of farmers, and protector of free choice.
- **Values used by industry** *(2, p. 318)*: the industry *consistently* engaged social values such as freedom, autonomy, individual rights, economic opportunity, capitalism, democratic principle, fairness, equality. When the non-smokers rights frame was introduced by tobacco control advocates, the industry challenged this by emphasizing the discriminatory nature of policies and the erosion of individual rights.
  - In the 1980s and early 1990s the industry tried to shift emphasis away from the credibility of scientific evidence to the erosion/threat to personal freedom (Menashe and Siegel reference Jacobson et al.'s 1993 work). The tobacco industry emphasized individual choice from early on and continues to use this argument today, in deflecting responsibility for smoking-related diseases - i.e. personal responsibility frame: "individuals have been warned".

- **Dominant control frames** (U.S. media analysis1985-1996 *(2)*): deceitful/ manipulative industry; non-smokers' rights (prevalent from the late 80s); targeting of kids; killer (tobacco kills smokers and non-smokers, suggesting society has a responsibility to create a smoke-free society and that companies must be held accountable: dominant frame in mid-late 80s). Menashe and Siegel *(2)* found these frames changed over time; *none were used consistently* during the period they studied. They noted inconsistency is problematic given the length of time required to change social norms.
  - <u>Death frame</u> *(2)*: Tobacco control advocates in the mid-1980s in the US framed the industry as 'merchants of death' (the killer frame), but gradually moved away from this dominant frame to the idea that "tobacco use is a problem only insofar as it involves the recruitment and addiction of youth smokers" *(p. 309)*. Menashe and Siegel saw this shift as diluting the health message. Framing in

Ontario in the late 1990s and early 2000s re-engaged the powerful 'smoking kills' message.

    - Health frame: Burt and Campbell *(25)* cited research at the University of Waterloo in 1999 that found a health frame (e.g. #1 drug addiction problem, chronic disease links, danger of exposure to second-hand smoke), resulted in a strong smoke-free by-law, whereas an economic frame resulted in a weak or absent by-law. Tobacco advocates in PEI in the early 2000s successfully focused on a health frame and this eventually overshadowed the economic frame being used to oppose smoke-free legislation (e.g. concerns about economic hardship and job loss raised by tobacco farmers and the Canadian Restaurant and Food Association). The health frame was aligned with PEI's shift toward a healthy lifestyle approach to policy.
    - De-normalization of products and companies: focusing on tobacco companies' 'misdeeds' has been key to shifting public opinion to support environmental tobacco controls *(5, p. 15)*. Identifying and publicizing industry behaviour that opposes community values (e.g. abuse of science, targeting of children) has also been helpful in undermining the industry's overall credibility. One interviewee noted that this framing has been particularly effective in mobilizing the youth population in recent years.

- **Values used by tobacco control**: most tobacco control frames primarily engaged the value of health. Menashe and Seigel *(2)* suggested in 1996 that it could be helpful to engage some of the values used by industry such as the 'right' to breathe clean air and the 'economic hardship' that restaurant workers suffer when they contract diseases related to second-hand smoke.

## Media campaigns

In Ontario, the need for a media campaign to shift public attitudes was identified in 2000. The Ministry of Health determined that the messaging might be more powerful if it was delivered by non-governmental actors alongside government; this has since been supported by evidence. The Heart & Stroke Foundation of Ontario (HSFO) took the lead in this work and worked with Ipsos-Reid to analyze attitudes of different groups with a view to identifying segments of the population to focus on. They identified 'complacent libertarians' as the group to shift – complacent because they weren't very concerned about second-hand smoke, and libertarian, because they objected to government intervention/nanny state. HSFO developed a series of TV ads which ran extensively during 2000-2006; the ads were modelled on ads run in the U.S. but one of the most successful featured a Canadian waitress who was dying of lung cancer but had never smoked (a powerful spokesperson). HSFO's sponsorship helped expand public awareness of the connection beyond smoking and cancer to cardiovascular disease. The campaign successfully shifted public opinion in Ontario (see public opinion, B-6). The media budget during this period was approximately $3 million annually.

## Current food frames and possible frames[2]

The examples above illustrate the importance of understanding public attitudes related to an issue in order to identify frames that might trigger shifts. One interviewee observed that,

[2] *Note: Bales' 'Framing the Food System' (26) contains some useful guidelines for reframing issues, the use of causal sequences, and examples of effective food systems frames that are not included here due to copyright restrictions.*

while issues related to food and related health issues are regularly in the news, few recognize themselves and their families in these stories. Research related to current attitudes to food, nutrition and the food industry is needed.

- **Food industry script** *(3)*: this script borrows from the tobacco playbook by focusing on personal responsibility and emphasizing activity over diet; raising concerns about government infringing on personal freedom (food police, nanny state); questioning the legitimacy of peer-reviewed scientific studies and funding science that distorts; emphasizing 'there are no good or bad foods'; and offering to self-regulate.
- **Current food frames and values** *(26*): some of the frames employed by the industry *and* advocates today are problematic.
  - Consumer choice: frames food as a matter of individual choice/responsibility, and reduces eaters to 'purchasers'. Like tobacco, food choices are influenced by advertising and the presence of addictive ingredients *(27)*. This frame obscures systemic issues related to food and tends to keep the focus on the dinner plate and costs.
  - Moderation: the food industry has defended its unhealthy products by emphasizing that individuals appreciate the need for moderation
  - Modernism: industry claims today's 'modern lives demand convenient food'. This frame also suggests there's no possibility of or appetite for going back to natural, traditional, old-fashioned ways. This is sometimes combined with messages such as: scaling back on mass production would harm the 'little guy'. This frame attempts to position big business on the side of the 'everyman'.
  - Obesity: can be a narrow frame as it suggests individual/parental choices are to blame. There is some concern this frame could lead to increased rates of anorexia in children. The goal needs to be broader - focused on "access to healthy foods, the opportunity to practice healthy behaviour and environments that support good health" *(5, p 14)*.
  - Healthy choice: although the frame 'making the healthy choice the easy choice' attempts to bridge the individual-environment spectrum, it still highlights the individual without effectively illustrating the role of the environment.

- **Frames and values for future consideration**:
  - Legacy and protection: Bales *(26)* conducted survey research which suggested the values of 'legacy' - a sustainable food system for future generations - and 'protection' - food as nurturance, sustenance, and health - may promote a sense of collective responsibility for the food system, particularly among new parents.
  - Shared responsibility and institutional accountability: for the effects of food on the health of eaters and society as a whole; these may be relevant frames for those advocating for obesity prevention *(15)*
  - Toxic food environment *(28)*: this highlights the environment and detracts attention from the individual while also linking food and health. This frame provides an opportunity to talk about how the foodscape and food production models needs to be re-designed, and about how poor diets are reducing life expectancy.
  - A delicious prescription *(29):* healthy food could be framed as an appealing and cost-effective way to treat diet-related diseases such as diabetes, high blood pressure and heart disease

  - Children's rights: this frame might draw support from parents on advertising bans; it is aligned with the UN Convention on the Rights of the Child *(30)*
  - Justice: although some have suggested it might be helpful to frame food as an issue of 'fairness' and 'justice' (since the poor often lack access to healthy food and many of the problems related to food disproportionately affect the poor), Bales *(26)* disagrees, saying that values like "social justice, preservation, fairness, etc. can appear non-sequiturs to the public" *(p.11)*.
- **Language**: frames have not yet been solidified in food and nutrition advocacy in part because food is such a complex issue, "the food system is largely invisible" *(26)*, and people lack knowledge. A vocabulary that illustrates the systemic interconnections *(5)* and 'the big picture' *(26)*, is needed. Once relevant language is identified, using consistent language within the movement will be important; training and fact sheets would be helpful.
- **A messaging recipe** *(31, p. 1)*:
  - Lead with an environmental perspective: e.g. "Our health is affected by our communities…. We eat better when healthier foods are more available than junk food…".
  - State/engage a value: e.g. "in some neighbourhoods healthy food isn't readily available and soda is more available than milk ". Engage values that reflect your target audience.
  - Give your solution as much attention (or more) than the problem.

In the conclusion of "Re-framing the great food debate: the case for sustainable food" *(32)*, the authors state, "food is different from other sectors and consumer items and that this difference confers special responsibilities on government. Specifically, it is no longer acceptable to put loosely regulated markets at centre stage and then place the burden of responsibility on the shoulders of individuals to 'choose health', 'eat well' or use their spending power to nudge companies towards more responsible social and environmental behaviour. Rather, a sustainable food policy must make explicit the fact that responsibility for moving towards more sustainable food is shared by government, companies within the food sector, public institutions, and the general public." They suggest the need for a full-scale attack on 'cheap food disease' which externalizes the social and environmental costs related to food and makes food artificially cheap. They credit the local food movement with helping to shift the debate about food in the U.K. over the last 20 years.

Advocates have different interests related to food and nutrition: e.g. nutrition advocates want people to eat healthy; social justice advocates want to reduce health disparities; public health advocates want to prevent disease and promote health; many food advocates want to produce food in a way that is more economically and environmentally sustainable, and healthier for those who produce and consume it. If these groups can find some common ground or agree on which roles each can play in the development and implementation of policies and a comprehensive strategy, they will be a powerful collective force.

## CONCLUSION

In reviewing the evolution of the tobacco control movement, I was struck by the gradual evolution of strategies over the years, as well as the breadth of involvement in the movement – from governments to NGOs to public interest groups. While much progress

has been made over the last 20 years, the work done in the previous 40 years was foundational. This has been a long journey. The range of interventions across the individual behaviour-population-based/environment spectrum provides insight into the complexity of changing social norms. It also speaks to the need for significant investment in infrastructure to enable collective efforts.

Although it was not practical for tobacco control groups to work 'with' the tobacco industry to address public health issues, I think the situation is different for food and nutrition advocates. The food industry cannot be viewed as the enemy, and in fact partnering with some parts of the industry will likely be required moving forward. Industry has a vested interest in the future of food and has substantial resources at its disposal. At the same time I am mindful of, and would like to reinforce, the recommendation that advocates develop food and nutrition strategy independently of large industry players that are the equivalent of 'big tobacco'.

I found tobacco control's efforts to shift public opinion using framing and media not only fascinating, but also instructive. This was a critical strategy element which required a significant investment of resources, ongoing attention and a particular kind of strategy (frame analysis and message framing). I think for food and nutrition the importance of understanding public attitudes in order to frame compelling messages cannot be underestimated. While awareness has grown, messaging food and nutrition issues is more complex as there is a more nuanced story to tell. The public is likely more media savvy today and based on the tobacco industry's example they may be quicker to recognize signs that some members of the food industry are attempting to manipulate eaters. This may help in shifting public opinion and increasing support for the kinds of population-based/environment level interventions required.

The interest in food and its relationship to health, local communities and the environment has never been higher. The number of people potentially affected by food-related diseases likely out-numbers those affected by smoking today. In addition, the Ontario government is paying attention, so it's the opportune time for those interested in food and nutrition policy development to come together to develop a cohesive strategy and policy recommendations.

## REFERENCES

1. Warner, K. Lessons for addressing obesity from the history of tobacco control. Memo prepared for Berkley Media Studies Group's Acceleration Meetings in January 2004.
2. Menashe, C. L., Siegel, M. The power of a frame: an analysis of newspaper coverage of tobacco issues – United States, 1985-1996. Journal of Health Communication, Taylor & Francis, 1998; 3:307-325.
3. Brownell, K.D and Warner, K.E., The perils of ignoring history: big tobacco played dirty and millions died. How similar is big food? The Millbank Quarterly. 87(1) pp. 259-294. 2009
4. Ontario Tobacco Research Unit. Backgrounder - secondhand smoke: smoking in the workplace. 2007.
5. Berkley Media Studies Group. Accelerating policy on nutrition - a summary of reflections on advice gathered from two Acceleration Meetings held in January and October 2004, 2005.
6. Staff report to the Board of Health from the Medical Officer of Health. Toronto Public Health tobacco control plan 2011. February 14, 2011.
7. Rick Cluff interview with Vance Campbell of the Hospitality coalition. Courtesy of choice transcript. CBC radio. June 13, 2000.
8. Centre for Addiction and Mental Health (CAMH). Submission to: The Standing Committee on Finance and Economic Affairs. Bill 164: The Smoke-free Ontario Act. 2005.
9. Engelhard, G., Garson, A., Dorn, S. Reducing obesity: policy strategies from the tobacco wars. University of Virginia and Urban Institute; 2009.
10. Smoke-free Ontario online: http://www.mhp.gov.on.ca/en/smoke-free/default.asp
11. The Ontario Tobacco Research Unit. Smoke-free Ontario strategy evaluation report. Executive summary, evaluation update. October, 2011
12. U.S. Department of Health and Human Services, Public Health Service. Smoking and Tobacco Control Monographs 1. Strategies to control tobacco use in the United States: a blueprint for public health action in the 1990's". National Institutes of Health, NCI. 1991.
13. Report from the Tobacco Strategy Advisory Group to the Minister of Health Promotion and Sport. Building on our gains, taking action now: Ontario's tobacco control strategy for 2011 – 2016. 2010.
14. Rider, D. Toronto to look at expanding outdoor smoking ban now aimed at playgrounds. The Toronto Star, March 8, 2012
15. Berkley Media Studies Group, Accelerating policy on nutrition: lessons from tobacco, alcohol, firearms and traffic safety - Appendix – supporting materials for the two Acceleration Meetings held in January and October 2004, 2005.
16. Ontario Government. Ontario's New School Food and Beverage Policy is available online at: http://www.edu.gov.on.ca/eng/healthyschools/policy.html
17. Hawkes, Corinna. Promoting healthy diets and tackling obesity and diet-related chronic diseases: What are the agricultural policy levers? Food and Nutrition Bulletin. The United Nations University. 28 (2). 2007.

18. Harvie, J., Mikkelsen, L. and Shak, L. A new health care prevention agenda: Sustainable agricultural procurement and agricultural policy. Journal of Hunger and Environmental Nutrition. Taylor & Francis Group. 4:409-429. 2009. *p. 419*
19. The Canadian Environmental Law Association definition of the precautionary principle. Accessed online April 2012: http://www.cela.ca/collections/pollution/precautionary-principle
20. Cancer Care Ontario, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Taking action to prevent chronic disease: recommendations for a healthier Ontario. Toronto: Queen's Printer for Ontario; 2012.
21. Scientific Advisory Committee. Evidence to guide action: comprehensive tobacco control in Ontario – Chapter 9: key system enablers in tobacco control. Smoke-free Ontario. 2010.
22. Ontario government, "TOBACCO: Ontario tobacco strategy fact sheet", undated.
23. Nisbet, Matthew C. Communicating about poverty and low-wage work: A new agenda. The Mobility Agenda - A Special Initiative of Inclusion. Washington, D.C. October, 2007. Accessed online March 2012: www.inclusionist.org/files/USUKPaper.pdf
24. Lakoff, George. Don't think of an elephant! Know your values and frame the debate. Chelsea Green Publishing. 2004.
25. Burt, S., Campbell, H. S. "Policy frames, networks and communities: environmental tobacco smoke legislation in Prince Edward Island", paper prepared for the Annual Meeting of the Canadian Political Science Association, 2007.
26. Bales, Susan Nall. Framing the food system. Washington, DC: FrameWorks Institute; 2006.
27. Patel, Raj. Abolish the food industry. The Atlantic Online. February 6, 2012.
28. Jacobson, M. F. Spending to save on obesity – Memo from MFJ. Centre for Science in the Public Interest. 39.1. 2012.
29. Why Eat Real: Food Day. Eat real 6 food day principles. Accessed online at: http://foodday.org/why-eat-real/six-principles-reduce-disease.php
30. The Public Health Advocacy Institute: A time for action: an obesity agenda for the transition team. Policy recommendations from PHAI's fifth conference on public health, law and obesity. November 2008.
31. Berkley Media Studies Group. "Making the case for prevention – basic messages for health departments". Undated.
32. Sumberg, J. Re-framing the great food debate: the case for sustainable food. nef (new economics foundation), UK; 2009.
33. MacRae, R. A joined-up food policy for Canada. Journal of Hunger and Environmental Nutrition. Taylor & Francis, 2011. 6:424-257.
34. Physicians for a Smoke-free Canada. Tax revenues from tobacco sales. November 2011.
35. De Schutter, O. Obesity epidemic endangers health of millions. The Toronto Star. Mar. 7, 2012.
36. MacRae, Rod. Presentation: Introduction to Food Land and Culture, Background on Canadian food system. September, 2011.

37. Jeffery, B. and Cappello, N. Writing on the wall – time to put nutrition information on restaurant menus. Centre for Science in the Public Interest. 2012.
38. Brownell, K. Interview - Food industry pursues the strategy of big tobacco. Yale environment 360. April 2009. Accessed online at: http://e360.yale.edu/content/feature.msp?id=2136
39. International Markets Bureau. Comparative Consumer Profile Canada and the United States. Agriculture and Agri-Food Canada online: http://www.ats-sea.agr.gc.ca/info/5645-eng.htm. July 2010.
40. Bain, Jennifer. Scarborough Hospital plans to serve patients food that's delicious, local and made from scratch. The Toronto Star. Mar. 21, 2012.
41. Toronto Food Policy Council. Discussion paper # 3: If the health care system believed "you are what you eat": strategies to integrate our food and health systems. 1996.
42. Centers for Disease Control and Prevention. Tobacco industry marketing fact sheet. Accessed online at: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/marketing/index.htm

# APPENDIX A: Interviewees & Acknowledgements

## INTERVIEWEES

Members of the Ontario Food and Nutrition Strategy group recommended I speak to a number of individuals who have helped advance, or who were familiar with, Ontario's tobacco control efforts. Four individuals generously agreed to share their perspectives with me in March-April 2012 and I thank them for their participation. I interviewed three people by telephone and met with Mary Lewis in person. These interviews were not considered Human Participant-style interviews and I did not complete an ethics review; we agreed I would keep their comments anonymous to the extent that is possible. One of the three elected to remain anonymous.

1. John Garcia, Associate Professor & Associate Director, Professional Graduate Programs School of Public Health and Health Systems Faculty of Applied Health Sciences, University of Waterloo. Principal Investigator, Ontario Tobacco Research Unit.
2. Mary Lewis, Vice President of Research, Advocacy and Health Promotion, Heart & Stroke Foundation Ontario.
3. Rebecca Truscott, Senior Analyst, Prevention and Cancer Control, Cancer Care Ontario.

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I would also like to thank Rod MacRae, my professor, and Ravenna Nuaimy-Barker, of Sustain Ontario for helping me identify such an interesting topic as the subject of my course paper (Food Policy Development in Canada). They believed it would be of interest to the Ontario Food and Nutrition Strategy group; I hope it is. The subject of the paper was to relate to one of our core reading for the course, Rod MacRae's 'A joined-up food policy for Canada' *(33)*. In this section I have briefly identified some of the connections.

Like tobacco, food has implications for public health, particularly as the health costs related to food consumption are rising and the rising cost of food of food is making access more difficult for many. 'A joined-up food policy for Canada' *(33)*, outlines the need for a broad, comprehensive, whole of government approach to food policy as a way to link and address the complex issues related to food production, consumption and distribution. In the paper he identifies ten goals, two of which I want to acknowledge as they reflect some of the issues in the food system that food and nutrition advocates should keep in mind as they consider how to adapt strategies used in tobacco control.

> Goal 1: "everyone has the resources to obtain enough food (quality and quantity) to be healthy and the knowledge to optimize nutritional health".
> Goal 3: "the food system provides an essential public service and is linked to other related public services like health care and education".

In examining tobacco control efforts, I found that policy and program interventions used to increase prices reduced access to and consumption of an unhealthy product and to educate the public about the health implications of tobacco (goal 1). In food and nutrition, not only can prices be used to reduce access to unhealthy food, prices can also be used to expand access to healthy options. Tobacco control policies and programs were developed

and delivered through the ministry of health, ministry of education and multiple NGOs (goal 3). Engaging a variety of players and governments will also be critical in food and nutrition policy.

## APPENDIX B: Tobacco and Food - A Tale of Two Industries

This chart illustrates some of the similarities and differences between the two industries, which are both international in scope and have health and economic implications for populations around the world. Recognizing the similarities and differences is important for food and nutrition policies makers who want to build on or adapt successful tobacco control efforts.

| Characteristics | Tobacco Industry | Food Industry |
|---|---|---|
| **Products** | "The only legal product that, when used as intended, kills half of its users prematurely." *(13, Executive Summary)*<br>A small number of legal, addictive products (cigarettes and other smokeless products) with clear negative impacts on health.<br>Consumption not recommended, even in small quantities.<br>Tobacco revenues in US in 2002: $23 billion. *(3)*<br>Tobacco tax revenues in Canada 2011: $7.5 billion *(34)* | Food is essential to life. There are innumerable products, many of which have at least some nutritional value; and some 'junk' foods that have little/no nutritional value (e.g. soft drinks, candies, many snack foods).<br>Moderation is recommended for high calorie, low nutrition foods (even in dietetic food guides).<br>Highly processed, low nutrition foods tend to be the most profitable *(3)* since many cereals, vegetable oils and sweeteners are subsidized *(35)*.<br>Canadian Food System *(36)*: represents 8.1% of Canada's GDP: $50 billion from agriculture; $111 billion spent on food and beverage in stores; $43 billion spent in restaurants and food service. 1 of 8 jobs.<br>Children in the US aged 5-14 spend >$20 billion annually on food and influence spending of $200-500 billion more. *(3)* |
| **Science and health links** | Diseases related to smoking and exposure to second-hand smoke: heart disease, lung cancer, nasal sinus cancer, emphysema, asthma. Effects of second hand smoke on children can be serious.<br>Tobacco companies have been accused of manipulating nicotine levels to increase the addictive quality of cigarettes.<br>Evidence linking tobacco, second hand smoke and diseases became clearer over time. | Diet-related illnesses and disease: food-borne illnesses, obesity, diabetes, high blood pressure, heart disease, stroke, cancers and premature death.<br>60% of men and 45% of women in Ontario are overweight or obese *(20)*. Since 1990 childhood obesity rates in Canada have tripled to about 9%. *(28)* Researchers have concluded that excess caloric intake has been the major contributor. *(37)*<br>Many highly processed foods |

| Characteristics | Tobacco Industry | Food Industry |
|---|---|---|
| | | contain high levels of sugars, fat, sodium, calories, or caffeine, ingredients linked to diseases above. Evidence suggests caffeine is addictive. Some have suggested the industry may be using it as an additive to sell more products. *(38)* |
| **Producers** | Small number of well-organized, highly profitable tobacco companies.<br>Clearly defined 'opposition'/ enemy for the tobacco control movement to focus on. | Large number of producers from field and factory to plate. Producers range in size from very small family operations to multinational agribusinesses comparable in size to big tobacco companies.<br>Many products could be reformulated: some producers have voluntarily introduced healthier options (e.g. Loblaw's 'Blue Menu' line).<br>The 'opposition' is much less clear; advocates may be able to work with some producers and retailers to make change. |
| **Consumption** | Smoke-free legislation has gradually restricted consumption to private spaces and outdoors. This has reduced the visibility of smoking in society.<br>Tobacco products are still disproportionately consumed by people in lower socioeconomic groups. | Food is consumed at home, and in a wide variety of private and institutional venues (e.g. restaurants, workplaces, schools, hospitals, nursing homes). In private and public venues, information about ingredients and nutrition is limited.<br>Canadians spend 10-15% of their annual budget on food *(36, 39)*. Canadians spend $60 billion on restaurant food each year *(37)*.<br>Home consumption is affected by access, schedules, food preparation skills and culture.<br>Less healthy products are disproportionately consumed by lower socioeconomic groups who are often food 'insecure'.<br>Some hospitals and schools have started introducing healthier options *(40)*. |

| Characteristics | Tobacco Industry | Food Industry |
|---|---|---|
| **Social costs** | Smoking and second-hand smoke directly affects the health of individuals and the broader population (see Science and Health Links above).<br>"The use of tobacco products remains the leading cause of preventable disease and death in Ontario." *(6, p. 7)*<br>Ontario social costs *(10)*<br>– 13,000 deaths<br>– $1.6 billion in direct health care costs<br>– >500,000 hospital days annually<br>– $4.4 billion in productivity losses | Nutrition-related diseases (see Science and Health Links above) kill ~48,000 (1/5 of all deaths) Canadians annually and cost the economy >$7 billion. *(37)*<br>Obesity and related chronic diseases affect individuals and their family members (care-givers). Costs to the Canadian economy are estimated at >$5 billion annually. *(28)*<br>Conventional agricultural production methods affect and carry public health costs for eaters, producers and communities (e.g. costs relate to food safety/contamination; reduction in antibiotic efficacy; pollution of water sources, etc.) *(41)* |
| **Advertising and marketing** | Annual marketing budget: $12.4 billion in the US in 2002 *(42)*<br>Seeks to make smoking attractive, particularly for youth.<br>Has used marketing to respond aggressively and creatively to tobacco control efforts; used free speech arguments to sustain advertising presence.<br>The industry aligned itself with social causes (e.g. by making philanthropic contributions to women's organizations, arts and cultural groups) with a view to deflecting attention away from tobacco to other issues. *(3)* | Annual marketing budget: estimated at $30 billion in the US *(Engelhard et. al (9) reference Chopra and Darnton-Hill 2004)*, approximately 1/3 of which is allocated to advertising aimed at children and youth *(Engelhard et. al (9) reference Institute of Medicine, 2006)*.<br>Launch costs for a new candy bar can exceed $30 million *(5, p. 42)*<br>Marketers often over-emphasize a single healthy element – e.g. 'KFC is now trans-fat free'.<br>Some in the industry fund anti-obesity efforts – e.g. school-based education programs and research. |
| **Retail sales** | Tobacco products are somewhat less widely available than in the past, and products are less visible (i.e. stored behind the counter, behind closed doors).<br>Purchase is restricted by age and retailers are responsible for enforcing to this.<br>Cheap contraband products have | Access to healthy food is seen as a key enabler of healthy eating; access varies by income and geography. Many Canadian cities contain food deserts/swamps characterized by limited access to healthy foods (e.g. supermarkets, green grocers) and easy access to cheap, less healthy food options |

| Characteristics | Tobacco Industry | Food Industry |
|---|---|---|
| | become increasingly popular and are more widely available including in some retail outlets.<br>Graphic labels on packages have been highly effective in reducing tobacco purchase/consumption. | (e.g. convenience stores, fast food franchises). Location decisions are driven by industry's profit motive and so may be difficult to influence.<br>Product placement in retail stores is used to promote the sale of high profit food items which tend to be highly processed and low in nutrients.<br>Current nutritional labels on packages are not overly effective and are confusing for purchasers.<br>Some fast food restaurants have voluntarily made nutritional information available online, but in Canada this information is not displayed on menus at point of purchase.<br>Growth of alternative retail: farmers markets, CSAs (consumer-supported agriculture) and co-ops are a reflection of the growing interest in local food and also a recognition of issues related to the industrial food system. |
| **Taxation** | Taxation of tobacco has been recognized at the most effective strategy in reducing consumption.<br>Rates have increased over time and revenues have been used to subsidize tobacco control media, school education and cessation programs.<br>Increasing tax rates and prices contributed to contraband growth. | Some countries (Canada, UK) have introduced taxes on less healthy foods. These are sometimes termed a 'snack' tax; some think rates are not high enough to affect consumption. This appears to be a research gap.<br>Food taxes are sometimes perceived/portrayed as an unfair tax on the poor. Strategies to alleviate economic burdens should be considered if and when taxes are expanded. |
| **Response to regulations and controls** | Their 'playbook' engages a range of strategies to influence public opinion, cast the industry in a positive light, engage supporters (e.g. formation of front groups), and oppose policies which threaten industry profits. | Mixed responses, some of which suggest they too are using a 'playbook'.<br>Defensive: "Used in moderation, our product causes no harm"; "We produce what the market demands". The industry is taking |

| Characteristics | Tobacco Industry | Food Industry |
|---|---|---|
| | For years the industry relied on a consistent message: smoking had not been proved to cause cancer. The industry tried to 'muddy' the discussion by funding scientists to do research that would cast doubt. They also criticized legitimate science as 'junk' science.<br>Aggressively pursued new markets as rates of smoking declined – e.g. youth, international. | advantage of confusion around healthy eating *(15)*.<br>Opposition/Interference: industry has engaged lobbyists to oppose snack taxes and lobby for weaker state/national menu labelling regulations. Funding of front groups such as the "Center for Consumer Freedom" *(3)*.<br>Positive: mandatory trans-fat labelling led some producers to develop trans-fat free products (however some fats were replaced by equally bad substitutes *(3)*). This suggests product reformulation may be an area advocates and industry can collaborate on. |
| **Litigation – by producers and advocates** | Tobacco companies have engaged top law firms to challenge legislation in court, so having evidence in place is important. Government usually wins.<br>Public disclosure of internal industry documents has damaged the industry's credibility. *(3)*<br>A $27 billion class action suit was launched in Quebec (Mar. 2012). | Some think litigation against industry may be premature since 'defendants' are unclear; legal cause has not been clearly defined; and evidence is insufficient. Risk of setting a bad precedent *(5, p. 39)* |
| **Relationship with 'control' movement** | Collaboration efforts were largely unsuccessful. | Researchers and food practitioners have a history of working together – relationships exist.<br>Food industry pays to sponsor and provide input into the American Dietetic Association's nutrition 'fact sheets'. *(3)*<br>Potential for collaboration exists with a portion of the industry where there are overlapping goals (e.g. setting standards). Helping the industry recognize that healthier products are in their long-term best interest may be a challenge.<br>Groups need to consider carefully |

| Characteristics | Tobacco Industry | Food Industry |
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| | | who to work with, when and how. Advocates need independent 'space' (i.e. separate from 'big food' influence) in which to set priorities and develop strategy *(5, p. 24)*. |
| **Public opinion** | Tobacco has more social stigma today but remains a social norm in many communities.<br><br>Attitudinal Shifts in Ontario from 2000 to 2006 *(source: Heart & Stroke Foundation's evaluation of attitudes pre and post-media campaigns)*<br>58→71% Support province-wide legislation that would make all public places 100% smoke-free<br>55→75% Among 16-24-year olds<br>34→41% Support for tobacco regulation among smokers | Public interest in food, cooking and health is growing. Interest in local and organic foods has also grown in recent years. Behaviour change lags behind this interest.<br>Awareness about food industry issues and concerns about health statistics related to food and nutrition are growing. With this, support for taxation of fattening foods seems to be growing, particularly if revenues are reinvested in obesity prevention *(9)*.<br>Obesity has social stigma; blame tends to be levelled at the individual or parent.<br>The introduction of healthier options in Ontario schools in 2011 was met with less resistance than anticipated *(interviewee)* and has been very well received at Scarborough General Hospital *(40)*. |