YANKEE DOODLING **Douglas Kamerow**

Smoking or obesity: must we target only one?

Funds for antiobesity campaigns increase while tobacco programmes languish

In a landmark article published almost 20 years ago McGinnis and Foege showed that the actual leading causes of death in the United States were not cardiovascular disease and cancer, which had long headed the "leading causes" rankings calculated from death certificate analyses (*JAMA* 1993;270:2207-12). Using attributable risk data cobbled together from a number of sources, they estimated that smoking, with 400 000 deaths a year, and disease related to diet and lack of physical activity, with 300 000 deaths, were in fact the leading killers of Americans, between them causing about a third of all deaths in 1990.

The headlines then were all about how smoking was at the top of the list and that almost half of that year's deaths were a result of this and other preventable, behaviour related causes. Many people were also surprised at the huge toll taken by poor diet and lack of physical activity, but it wasn't a focus of discussion.

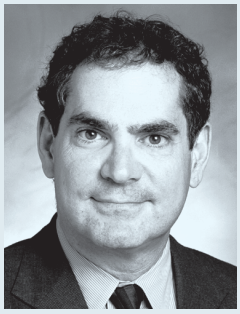
The intervening decades have been a terrific success story for anti-tobacco efforts. As a result of an effective, multitiered campaign, including higher taxes on tobacco, bans on smoking indoors, targeted countermarketing, cessation helplines, drugs, and counselling, the prevalence of smoking in the US has fallen to around 20% of people—less than half what it was in 1955 (*N Engl J Med* 2010;363:201-4).

The past few years have seen increasing attention on another public health problem: obesity. It has threatened to dethrone tobacco as the number one public health catastrophe in the making. Indeed, a redo of the McGinnis and Foege analysis 10 years later found that, while tobacco was still in the lead in 2000, with 435 000 attributed deaths, diet and activity (largely obesity related) deaths had risen to 365 000 a year (*JAMA* 2004;291:1238-45). The authors cautioned that "poor diet and physical inactivity may soon overtake tobacco as the leading cause of death."

Obesity is a huge problem that is probably getting worse. The prevalence of childhood obesity has tripled among school age children and adolescents since 1980, and more than 70 million US adults are now obese (www.cdc.gov/mmwr/preview/mmwrhtml/mm59e0803a1.htm). Obese adults and children have an increased risk of several chronic diseases and incur dramatically increased healthcare costs.

The anti-tobacco strategies were not lost on those trying to combat obesity. The same multifocal approach that worked so well for smokers is being applied to obesity. Interventions currently under way range from regulatory to legislative to clinical. In fact, public health attention and funding have now tilted towards obesity. A recent iconic photo of the first lady, Michelle Obama, says it all. She was shown on the south lawn of the White House vigorously exercising with a group of kids at the kick-off of her antiobesity "Let's move!" campaign (*BMJ* 2010;340:c948). Needless to say, no similar anti-tobacco campaign is being led by her reportedly still smoking husband.

A recent article in the *New York Times* described how public health funding, from both government and private sources, has shifted from tobacco to obesity in the US. The country's largest health charity, the Robert Wood Johnson Foundation, which funded many of the tobacco policy initiatives that have been so successful, has now decreased its anti-tobacco funding in favour of a $500m (£320m; €400m) antiobesity campaign (Wilson D. A shift towards fighting fat. *New York Times* 2010 Jul 28:B1). Federal stimulus money earmarked for prevention has funded both tobacco and obesity efforts, but recently obesity programmes have received more than tobacco. States have had to cut their budgets and have decreased spending on tobacco. All of this has preventionistas like me worried. How do we decide whether to fund anti-tobacco or antiobesity campaigns?



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On the one hand, while tobacco control programmes have been a poster child for success, the war is not over. The downward trend in smoking seems to have stalled: prevalence has hovered around 20% since 2006. Some 450 000 Americans still die each year from tobacco related illness, and more than eight million are sick or disabled because of it (*N Engl J Med* 2010; 363:201-4). Furthermore, smoking and smoking related diseases are now more than ever a class phenomenon. More vulnerable people smoke, including poor people, many ethnic minority groups, and people with chronic mental illnesses. And the tobacco companies are still out there pitching, trying to recruit new smokers to replace those who die or quit.

On the other hand, at least trends in smoking have long been going in the right direction. The obesity problem seems to be getting worse. And anti-tobacco efforts have a new champion now that the Food and Drug Administration has regulatory authority over tobacco and a new office and staff to make and enforce its rules.

One big test for federal funding will come as the new Patient Protection and Affordable Care Act (healthcare reform) goes into effect. One provision of the law calls for increasingly large amounts of public funding for public health and prevention, starting with $500m in 2010 and rising to $1bn a year by 2012. How much of this investment, totalling $15bn, will go to antiobesity efforts and how much to tobacco?

The lobbyists are lining up, but in this case they are all lobbyists for the "good guys." Maybe there will be enough money to go around for both worthy causes. Funding to combat the two leading causes of death in America—whatever their rank order—should not have to be a zero sum game.

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