Reducing Deaths by Diet: A Call for Public Policy to Prevent Chronic Disease

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Introduction

Chronic diseases including cardiovascular disease and cancer are the leading causes of disability and death in Canada.^{1,2} The majority of chronic diseases are caused by physical inactivity, tobacco use, excess alcohol consumption and unhealthy diet.³⁻⁶ In particular, unhealthy diet is the leading risk factor for death and disability in Canada resulting in an estimated 64,000 deaths and over 1 million years of disability (DALYs) in 2010 alone.⁷ Worldwide, a staggering 11 million deaths and over 200 million DALYs were attributed to unhealthy eating in 2010.

The usual Canadian diet is unhealthy, high in saturated fat, trans-fats, free sugars, and salt and low in fresh fruit, whole-grains, and vegetables (including legumes /beans).⁸⁻¹² An estimated 30,000 deaths could be delayed annually if our diets complied with Canadian dietary recommendations, particularly for fruit, and vegetable intake.¹³ In fact, the estimated risk of cardiovascular disease is reduced by about 4% and total premature death rate reduced by 6-7% for each additional serving of fruit and vegetable daily.¹⁴

The World Health Organization (WHO) advocates population approaches to achieve healthy diets as being critical to reduce non-communicable diseases (NCDs). The United Nations has established 9 targets to halt the rise in chronic disease including stopping the increase in obesity, reducing uncontrolled hypertension by 25% and reducing dietary salt by 30% by 2025.⁵ Many countries are implementing population-based policies to reduce dietary risk with success; however, Canadian approaches focus largely on individual behavior change.⁶ In contrast, Canadian governmental and non-governmental chronic disease strategies strongly recommend population-based interventions to improve diet.¹⁷⁻²⁰ However, few effective population-based interventions to improve diet have been implemented to date. While individual behaviour

choices are clearly important, it is unlikely that substantive progress will be made without a comprehensive set of population-based interventions to facilitate healthy choices being feasible and easy for individuals to make.¹⁶

Introduction

Les maladies chroniques, dont les affections cardiovasculaires et le cancer, sont les principales causes d'incapacité et de mortalité au Canada^{1,2}. La plupart des maladies chroniques résultent de l'inactivité physique, de l'usage du tabac, de la consommation excessive d'alcool ou d'une mauvaise alimentation³⁻⁶. Plus particulièrement, en 2010 seulement, la mauvaise alimentation a été le principal facteur de risque de mortalité et d'incapacité au Canada, en causant environ 64 000 décès et plus d'un million d'années de vie ajustée en fonction de l'incapacité (AVAI)⁷. À l'échelle mondiale, toujours en 2010, on attribue les nombres ahurissants de 11 millions de décès et de plus de 200 millions d'AVAI en raison de la mauvaise alimentation.

Le régime alimentaire canadien courant s'avère malsain, riche en gras saturés, en gras trans, en sucre libres et en sel, en plus d'être pauvre en fruit frais, en grains entiers et en légumes (incluant les légumineuses)⁸⁻¹². Environ 30 000 vies pourraient être prolongées annuellement si notre alimentation respectait les recommandations du Guide alimentaire canadien, notamment en matière de consommation de fruits et de légumes¹³. En fait, on estime que l'ajout quotidien d'une portion de fruits ou de légumes au régime alimentaire fait diminuer le risque de maladie cardiovasculaire d'environ 4 % et le taux de décès prématuré de 6 à 7 %¹⁴.

L'Organisation mondiale de la santé (OMS) défend l'idée que les méthodes axées sur la population pour instaurer de saines habitudes alimentaires sont essentielles à la réduction du nombre de cas de maladies non transmissibles. Dans le but de freiner l'augmentation des maladies chroniques, l'Organisation

des Nations Unies a fixé neuf objectifs à atteindre d'ici 2025, dont l'arrêt de la progression de l'obésité, la réduction de 25 % du nombre de cas d'hypertension non normalisée et une baisse de 30 % de la consommation de sel⁵. En vue de réduire les risques liés à la mauvaise alimentation, nombre de pays instaurent avec succès des politiques axées sur la population, pendant qu'au Canada les méthodes actuelles se concentrent plutôt sur le changement des comportements individuels⁶. En revanche, les stratégies canadiennes gouvernementales et non gouvernementales relatives aux maladies chroniques recommandent fortement la mise en œuvre de politiques de population pour favoriser une meilleure alimentation¹⁷⁻²⁰. Par contre, peu de ces interventions ont été mises en place à ce jour. Il est clair que les choix de comportements individuels sont importants, mais il est peu probable que les choses s'améliorent de façon significative sans l'instauration d'un ensemble de mesures axées sur la population en général et permettant aux individus de faire des choix sains plus facilement¹⁶.

A National Health Sector Response

Over 15 Canadian health-related organizations, including the Canadian Society of Internal Medicine, have supported a Call to Action to Implement a Healthy Food Policy Agenda.²¹

Based on international recommendations, the Call advocates key components of a comprehensive food strategy that could meaningfully reduce the diet-related chronic disease including:^{3,5,6,8,15,21,22}

- restricting the marketing of foods and beverages to children.
- regulating the additions of sodium, free-sugars, and trans-fats in processed foods.
- promoting intake of whole grains, fruits and vegetables including legumes/beans.
- promoting the reduction of saturated fats in our diet.
- establishing simple easy-to-understand nutrition labeling on processed food products and in dining establishments
- introducing targeted subsidies for healthy food products combined with taxation of unhealthy food/beverage products.
- implementing healthy food and beverage procurement policies in publicly-funded and private sector settings.
- developing standards to reduce conflicts of interest in nutrition policy development, research and education.

Advocacy Opportunities

General Internists are important opinion leaders and can play strong advocacy roles. All levels of Canadian government have the authority to impact healthy and unhealthy diets through public policy; however, Canada's health and scientific organizations, the private sector, and individuals all need to play important roles.

To the extent that chronic disease represents the greatest burden of diet-related disease managed in adults by General Internists, we have an important opportunity to advocate at the clinical and public health level. This can start by supporting national calls to action for governments to respond and act. The impact of poor diet on premature morbidity and mortality should be a focus in all internal medicine academic and education-related endeavors, including publications. Likewise, Internists can advocate for more research funding to assess and monitor dietary trends and the impact of nutrition policy on public health outcomes to inform future research and policy priorities.

Canadian policy responses to diet-related death and disability are inadequate and are falling behind those of other countries. Recently five key messages were proposed to be the basis for unified action on obesity.¹⁶ The messages recognize:

- 1) that the epidemic of diet-related chronic disease will not be reversed without strong government leadership.
- 2) the status quo will be costly in terms of population health, health care expenses, and loss of productivity.
- 3) there is limited impact and low sustainability of education efforts aimed at the individual level.
- 4) there is a need to accurately monitor and evaluate population nutrition data and intervention outcomes.
- 5) that a multi-sectoral systems approach is needed.

Canadian policies are lagging behind the global community in response to the increasing burden of chronic disease. The time is now for Canadian General Internists to play a stronger role in reversing this trend.

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