Association of Directors of Public Health North East

Position Statement on Commercial Determinants of Health

March 2024

What are the commercial determinants of health?	The commercial determinants of health (CDoH) are *the conditions, actions and omissions by corporate bodies that affect our health*[1]. They are the activities of private sector industries that impact us both positively and negatively by shaping the environments in which we're born, grow, live and work. The positive contributions of these industries include economic growth, job creation in our local communities and improved standards of living. In addition, the North East Better Health at Work Award supports businesses and employers across the region to improve the health and wellbeing of their employees. Unhealthy commodity industries (UCIs) are for-profit and commercial enterprises/businesses delivering commercial products that lead to significant associated negative health consequences. Key examples include the tobacco, alcohol, gambling and ultra-processed food industries. There are other UCI's such as the fossil fuel industry but the focus of this paper will initially be on the first four. The products of these industries are linked to many chronic, non-contagious diseases (non-communicable diseases – NCDs), as well as other health and social issues: • Cancers • Heart disease • Stroke • Respiratory disease • Overweight and obesity • Liver disease • Mental health disorders • Suicide • Global heat-related deaths • Spread of infectious disease • Accidents • Social problems In 2019, NCDs accounted for 88.8% of all deaths in England[2] and they make a significant contribution to disabilities and worsening health-related quality of life alongside driving inequality; not all harmful products are consumed equally, and some groups are more vulnerable to the negative impacts. For example, people living in the most deprived communities are four times more likely to die from cardiovascular disease (CVD) as those in the least deprived. Tobacco causes one in 5 cancers and alcohol and unhealthy food cause one in 20. We know that people from the most disadvantaged areas are more likely to smoke, be overweight and experience greater levels of harm from alcohol (even when they consume less).

Common industry tactics	There are common tactics used across UCIs to target consumers and vulnerable populations. Broadly, these are: • **Lobbying and political party donations** This leads to the impeding of policy and legislative decisions that would support public health. Gambling firms have been a leading source of donations to MPs in recent years[3]. • **Manufacturing doubt and shifting blame** UCIs contradict and cast doubt on the scientific evidence that reveals the harm caused by their products and instead promote their own (industry-funded) research. For example, the tobacco industry promotes alternative causes for lung cancer to distract from the link to smoking[4]. • **Aggressive marketing and advertising** There is product placement and promotion across all mediums, often particularly concentrated in areas of greater deprivation and/or towards vulnerable groups. A recent study in Scotland found that children from more deprived areas were more likely to be exposed to unhealthy food and unhealthy food and drink product advertising compared to those living in less deprived areas[5]. • **Self-regulation and corporate social responsibility** There is a strong push by industry to avoid mandatory regulation by self-regulation instead, but research suggests this does not lead to any public health benefits[6,7]. A review of the Public Health Responsibility Deal found that pledges to improve health were driven by the interests of industry and were not drawn from the most effective interventions available (instead focusing on information giving and individual choice) – and this was particularly the case for the alcohol pledges[8,9]. UCIs also invest in charities, good causes and training / educational initiatives to distract from evidence of harm. The personal responsibility narrative is central to their approach; they argue that as individuals, we must take responsibility for what we choose to consume and how regularly we do that. UCIs argue that public health interventions are akin to a 'nanny state', unduly interfering in personal choice. What they fail to acknowledge is the significant role they have in shaping our environments and ultimately influencing our choices through their own activities. Industry-sponsored education and awareness raising in schools is also a common occurrence but has been shown to be biased towards industry interests (for example, promoting moderate alcohol consumption[10]).
A public health approach to CDoH	The harms driven by the CDoH occur at a population level, not just at an individual level. Focusing only on those with acute issues overlooks the significant proportion of the population who are at risk of harms and also contributes to the personal responsibility narrative. There are health, financial and relationship harms alongside significant monetary costs to society. Therefore, our response needs to be at all levels of prevention – primary, secondary, tertiary.

	Work to tackle the effects of UCIs is at different stages; the tactics of the tobacco industry are well-known and programmes of work to reduce smoking prevalence are advanced, with legal frameworks in place. Gambling-related harms work is at an earlier stage and requires development. However, there are key principles that apply regardless of which UCI is being considered. A conflict-of-interest toolkit is currently being developed by public health specialty registrars for use by local authorities.
Key principles	1. UCIs should not influence health policy, health services or education/awareness-raising initiatives, particularly those aimed at young people. 2. Children and young people are a priority group to protect from the tactics of UCIs, particularly those living in our most deprived communities 3. UCI marketing drives harmful consumption and health inequalities and needs to be tackled 4. Reframing the narrative from personal responsibility to the actions of industries and their harmful products is a legitimate intervention
Actions	1. Develop a toolkit for how we frame CDoH with the public and press – including FAQs and responses to anticipated challenges 2. Up-skill our public health teams and wider stakeholders on the commercial determinants of health through training/workshops 3. Work with other regions to influence national policy and action on the CDoH 4. Secure endorsement for the principles outlined in this document at local Health and Wellbeing Boards

Version control

Author: Association of Directors of Public Health North East

Version: FINAL v1

Date Reviewed & Agreed: 15-03-2024

Review Due Date: 15-03-2025

References

[1] World Health Organization (2023). *Commercial determinants of health*. Available from: https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health.

[2] Office for Health Improvement and Disparities (2021). *Annex C: data on the distribution, determinants and burden of non-communicable diseases in England*. Available from: https://www.gov.uk/government/publications/nhs-health-check-programme-review/annex-c-data-on-the-distribution-determinants-and-burden-of-non-communicable-diseases-in-england#summary

[3] The Guardian (2021) *Almost £225,000 in wages and freebies taken from gambling industry by 28 MPs.* Available from: https://www.theguardian.com/society/2021/nov/15/almost-225000-in-wages-and-freebies-taken-from-gambling-industry-by-28-mps

[4] Maani N., van Schalkwyk MCI., Filippidis FT., Knai C., Petticrew M. (2021) *Manufacturing doubt: Assessing the effects of independent vs industry-sponsored messaging about the harms of fossil fuels, smoking, alcohol, and sugar sweetened beverages.* SSM Popul Health. Available from: https://www.sciencedirect.com/science/article/pii/S2352827321002846?via%3Dihub

[5] Olsen, J., Patterson, C., Caryl, FM., Robertson, T., Mooney, SJ., Rundle, AG., Mitchell, R. & Hilton, S. (2021) *Exposure to unhealthy product advertising: Spatial proximity analysis to schools and socio-economic inequalities in daily exposure measured using Scottish Children's individual-level GPS data.* Available from: https://www.sciencedirect.com/science/article/pii/S1353829221000319

[6] Seferidi, P., Millett, C. & Laverty, AA. (2021) Industry self-regulation fails to deliver healthier diets, again. BMJ; 372. Available from: https://doi.org/10.1136/bmj.m4762

[7] European Public Health Alliance (2016) *Self-regulation: a false promise for public health?*. Available from: https://epha.org/wp-content/uploads/2016/12/Self-Regulation-a-False-Promise-for-Public-Health_EPHA_12.2016.pdf

[8] Knai, C., Pettigrew, M., Douglas, N., Durand, MA., Eastmure, E., Nolte, E. and Mays, N. (2018) *The Public Health Responsibility Deal: Using a Systems-Level Analysis to Understand the Lack of Impact on Alcohol, Food, Physical Activity, and Workplace Health Sub-Systems.* Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6313377/

[9] Knai, C., Pettigrew, M., Durand, MA., Eastmure, E and Mays, N. (2015). *Are the Public Health Responsibility Deal alcohol pledges likely to improve public health? An evidence synthesis*. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/add.12855

[10] van Schalkwyk, M., Pettigrew, M., Maani, N., Hawkins, B., Bonell, C., Vittal Katikireddi, S. & Knai, C. (2022) *Distilling the curriculum: An analysis of alcohol industry-funded school-based youth education programmes*. Available from: https://doi.org/10.1371/journal.pone.0259560.