Annex A:

# Commercial Determinants of Health Position Statement

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## 1. What are the commercial determinants of health?

The commercial determinants of health (CDoH) are private sector activities which impact public health, either positively or negatively, directly or indirectly, and the enabling political economic systems and norms (WHO*).* The Lancet series broadens this definition to include '*the systems, practices, and pathways through which commercial actors drive health and equity'* (Lancet). These actions and omissions play a significant role in shaping the environments in which we are born, live, grow, and work.

As DsPH we affirm the importance of inclusive wellbeing economies that serve the wellbeing of people and the planet, making life better for all (ADPH Y&H). Along with the WHO, we recognise that '*commercial activities shape the physical and social environments in which people are born, grow, work, live and age – both positively and negatively*.' We also echo the Lancet series on the CDoH by acknowledging the diversity of the commercial world ranging from '*transnational and multinational corporations with revenues larger than the gross domestic product of some countries to small-scale, locally owned businesses*' (The Lancet). We start by noting some of the positive impacts that commercial entities can have for society (such as creating ethical employment) and the necessary role that specific industries can play in improving health (such as the cycle industry in active travel). Our work to improve the health of the public and drive equity must also recognise the substantial harms that commercial entities can cause. Again, as the second paper in the Lancet series on CDoH points out '*few commercial entities, if any, are wholly good or bad for public health*' and our concerns are directed at specific forms of commercial activity that harm health (The Lancet). Unhealthy commodity industries (UCIs) are companies who manufacture, produce, process, distribute, import, sell and/or market other products or services (including any company that derives significant revenues from producing, selling, or marketing such products or services) that could be considered detrimental to physical or mental health and, as a result, profit from their sale (Spectrum). Some of this paper starts with a focus on the key UCIs: the tobacco, alcohol, gambling, unhealthy food (such as ultra-processed food and food high in salt, sugar, and fat), and fossil fuel industries - but we recognise activities that harm health can be caused by any industry.

## 2. Why do they matter?

**2.1 CDoH cause significant morbidity and mortality, and people are dying before their time**

- The products and associated commercial practices from just four UCIs (fossil fuel, tobacco, alcohol and ultra-processed food) have been estimated to cause *at least* one-third (36%) of

global deaths, and over 4 in 10 (45%) deaths from noncommunicable disease (NCD). *Note: these are likely to be significant underestimates as they take no account of products such as lead or prescribed opioids, or practices such as dumping of toxic substances in water courses, and a more likely figure is that CDoH contribute to 78% of NCD deaths (GBD/Lancet).*

- NCDs accounted for almost 9 in 10 (88.1%) of the premature deaths in England in 2019 (GBD/IHME).

**2.2 People are spending many years in ill-health**

- Many of the leading risk factors for the commonest NCDs are exacerbated by CDoH, and these are responsible for significant disability in England. For example in 2017 in England the top three risk factors for YLD (years lived with disability) were high BMI (622 per 100,000), smoking (508), and high blood glucose (490) (GBD/ONS).
- Healthy life expectancy at birth in England in 2018–20 was 63.8 years for males and 63.6 years for females, meaning that more than one-fifth of life will likely be spent in ill health (ONS).
- Healthy life expectancy (HLE) at birth in the UK showed no significant change between 2015-17 and 2018-20 and disability-free life expectancy at birth decreased significantly. In Yorkshire and Humber, HLE decreased by 0.6 years for males to 61.1 years, and increased slightly by 0.5 years for females to 62.1 years (ONS).
- Both sexes saw significant declines in HLE if living in deprived areas; especially females in the most deprived areas who were expected to live less than two-thirds (66.3%) of their lives in good health compared to more than four-fifths (82%) in the least deprived areas (ONS).

**2.3 Inequalities are substantial**

This significant contribution to mortality, disability, and worsening health-related quality of life occurs alongside driving inequality. Not all harmful products are consumed equally, and some groups experience disproportionately more negative impacts.

- People from disadvantaged groups are more likely to smoke, be overweight, and experience greater levels of harm from alcohol (even when they consume less). (ASH, Lancet, Obesity).
- The health harms from UCI products are much higher when risk factors are combined, which is more common in disadvantaged groups (Kings Fund).
- This contributes to people from more disadvantaged groups living shorter lives, and spending a smaller proportion of their lives in good health (ONS).
- People living in the most socio-economically deprived communities are four times more likely to die from CVD as those in the least deprived (UKHSA).
- Climate change impacts have key inequalities dimensions: lower income and disadvantaged groups often live in poorer-quality housing in locations that are vulnerable to flooding or other climate impacts. Low-income households in the UK are more likely to be affected by flooding, and their homes are more likely to be prone to overheating and lack green space (Environment Agency).

**2.4 There is evidence of deliberate targeting of those who will be harmed the most**

There is evidence to show that parts of the private sector target groups who are vulnerable to the most harm from their products and activities in order to drive higher consumption and maximise profits.

- Examples from the USA include predatory loans such as subprime mortgages that disproportionately disadvantaged Americans of colour, employer organisations increasing worker vulnerability by keeping wages low during the COVID-19 pandemic, and the meat industry increasing marketing to force re-opening of processing plans when workers in such environments had twice the fatality rate of those in the EU (Milbank Quarterly).
- Cigarette brands and products have also been developed and marketed to specifically target ethnic minorities and women. People who are homeless and who have mental health issues have also been targeted (Tobacco Control).
- Marketing of unhealthy foods to ethnic minority children (Berkeley Media Studies Group).
- Infant formula has also been previously targeted at ethnic minority women with accompanying reduced breastfeeding rates (Milbank Quarterly).
- Here in the UK, organisations are uncovering how the food and drinks industry is specifically targeting young people, for example through sports sponsorship, misleading food labelling, and online marketing (BiteBack).

**2.5. As well as the human cost, there is a substantial economic cost**

The premature disability, disease, and death from NCDs linked CDoH (as discussed previously) is increasingly affecting those of working age and thereby affecting the economic productivity of our society.

- Sales of health-harming products are enormously profitable for industries. Recent economic analysis has found that, after tax, £53 billion combined industry revenue is made from sales from smoking (£7.3 billion), alcohol (£11.2 billion) and food (£24.2 billion) at levels harmful to health. These profits come at huge expense for society, with billions spent on health and social care detailed below, and £31 billion lost in wage penalties, unemployment, and economic inactivity due to tobacco, alcohol and obesity (ASH/OSA/AHA 2023).

- **Tobacco** kills up to half of its users who are unable to quit (WHO). Many of these are due to the cancers, cardiovascular disease, and respiratory disease it causes. In 2022, 12.7% of England's adult population smoked (ONS), and there were over half a million related hospital admissions in 2020 (NHS Digital). ASH estimates that each year, smoking costs England £17.3 billion (ASH).

- Over 1 in 5 (21%) of people in England drink above the recommended levels of **alcohol** (14 units per week) (Alcohol Change UK), and there were almost one million related hospital admissions in 2021 (NHS Digital). Alcohol has been estimated to cost society £21 billion per year (PHE).

- Nearly 2 in 3 adults (63.5%) in England are living with **overweight or obesity** (OHID), and nearly 1 in 4 (23%) children (OHID). There were over 1 million weight-related hospital admissions in 2020 (NHS Digital). The direct and indirect cost of obesity in the UK was estimated to be £58 billion annually (Frontier Economics).

- In England, over half the adult population (54%) **gambled** in 2018 (OHID) with 1.76 million participating in harmful gambling (OHID). We also know that gambling-related harms are felt broadly across families and communities, not isolated to individuals (van Schalkwyk et al). Most (86%) of online betting profits come from just 5% of those gambling, usually from those already experiencing harm (Gambling With Our Lives). Gambling costs society over £1 billion annually (OHID).

- **Climate change** has been called the biggest threat to global health of this century, and emissions from fossil fuels are the main driver. In the UK, outdoor air pollution is estimated to cause 28,000-36,000 deaths each year, and has been described as a 'public health emergency' (BMJ). A high proportion is caused by the fossil fuel-dependent nature of our economic and social systems. This includes their use for energy generation, industrial processes, and especially transport which causes over a quarter (26%) of UK carbon emissions (Our World in Data), as well as indoor air pollution in our homes (for heating and cooking).

  Heatwaves, flooding and wildfires and other extreme weather events are becoming more common, posing a significant health concern. An estimated 1.8 million people in the UK are at significant risk of flooding (Climate Change Committee). Increasing invasive mosquito numbers and rising Lyme disease cases are being observed in the UK, and impacts on multiple infectious diseases are of global concern. Climate-related crop failures and reduced yields worldwide are likely to impact food availability and pricing, with consequences for dietary quality and nutrition in the UK. Climate change and related economic impacts can also undermine security, potentially driving conflict and instability. Increasing population movement is likely, and will demand a humane and ethical collective response that centres health, particularly in view of the historical responsibility of countries in the Global North.

**2.6. This harm is preventable, and we can do something about it**

- Around 1 in 5 (22.8%) deaths in Great Britain were considered avoidable in Great Britain in 2020, that is, preventable or treatable in those aged under 75 (ONS). Since 2011, this figure has been 22-24% for the UK.
- Evidence based on individual industries gives us an indication of what is likely to be needed and effective across different industries and at cross-industry level. We have seen substantial success (albeit more still needed) from comprehensive tobacco control. We will need to rapidly test out these approaches at a CDoH level. We will also need to ensure our approaches are informed by power analysis and systems thinking - otherwise we risk our actions being undermined by organised and well-resourced opposition to the most effective actions, or intervening only with actions rather than trying to shift the system.

Transport for London's food **advertising policy**, and support from Sustain, have led to other councils implementing similar policies. Early evidence indicates reductions in energy, sugar, and fat purchased from High in Fat Salt and Sugar (HFSS) products is likely to result in improved health (PLOS Medicine). Bristol's Advertising and Sponsorship Policy includes guidance and principles for the content of adverts on Council-controlled spaces and sponsorship deals. It prohibits advertising for tobacco, gambling, payday loans (high cost short-term credit), organisations who offer ways to avoid paying UK tax, HFSS Foods, alcohol, and promotion of food and drink brands that are not advertising specific foods or drinks (Bristol City Council).

**Fresh and Balance** is a regional programme in the North East of England working on a population level to reduce harm from tobacco and alcohol. Their comprehensive approach is based on international evidence for effective Tobacco Control and includes highlighting the practices and activities of industry and working to limit their influence, as well as advocating for population-level interventions (FRESH-BALANCE).

## 3. Commercial practices and common industry tactics

**The 'systems, practices, and pathways through which commercial actors drive health and equity'**

The Lancet series on CDoH covers several commercial sector practices, some of which are outlined below but a more comprehensive set is available here. Many of these practices currently shape the system in the interests of the commercial sector so that, as the Lancet outlines, we have:

- 'Political and economic system that increases commercial sector power, sales, and involvement in, and influence on all aspects of society
- Regulatory approaches and upstream policies that enable and embed commercial sector influence and misconduct and limit options for public interest policy making'

There are common tactics used across UCIs:

**3.1 Preventing, undermining, or circumventing public policy**

This leads to the impediment of evidence-based policy decisions that would support public health. For example, there is a strong push by industry to avoid mandatory regulation by suggesting self-regulation instead, but research suggests this does not lead to any public health benefits (BMJ, EPHA). A review of the Public Health Responsibility Deal found that pledges to improve health were driven by industry interests and not by the most effective interventions available (instead focusing on providing information and individual choice) – especially for alcohol (Int J Environ Res PH, Addiction).

In a further example, 82 third parties with tobacco industry links opposed the UK's product standardisation policy, giving the impression of widespread opposition (BMJ Open). Legal threats and challenges (which are almost always unsuccessful) from the tobacco industry can also be prohibitive to people taking action, due to fear over legal costs (Journal of Public Health).

**3.2 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 (PLoS One, Lancet). For example, the tobacco industry promotes alternative causes for lung cancer to distract from the link to smoking (SSM - Population Health).

**3.3 Aggressive marketing and advertising**

There is product placement and promotion across all media, 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 drink product advertising compared to those living in less deprived areas (Health & Place). In 2020, over one fifth (21%) of England's gambling outlets were concentrated in areas in the most deprived decile (University of Bristol).

**3.4 Shaping social norms around personal responsibility**

The personal responsibility narrative is central to this approach; industry framing argues that as individuals, we must take responsibility for what we choose to consume and when. UCIs argue that public health interventions are akin to a 'nanny state', unduly interfering in personal choice. They fail to acknowledge their significant role in shaping our environments and ultimately influencing our available options and choices through their own activities.

One example is British Petroleum's creation of the term 'carbon footprint' (Mashable) and further framing around individual responsibility from the fossil fuel industry (One Earth). A further example is a tobacco industry-funded smoker's rights group likening England's proposed smoke-free generation tobacco sales ban to 'creeping prohibition' (Forest).

The targeting of children and young people is an established tactic for UCIs. Industry-sponsored education and awareness raising in schools is a common occurrence and has been shown to be biased towards industry interests (for example, promoting moderate alcohol consumption (PLoSOne), and shifting the blame for gambling onto individuals (SSM Popul Health)). There is growing recognition of these tactics amongst this population group and advocacy from young people against the tactics and the harm caused by UCIs (BiteBack, UK Youth Climate Coalition).

**3.5 Public-private partnerships (PPPs)**

Partnerships between the public sector and industry can provide commercial actors opportunities to exert undue influence over decision-making and public policy processes, such as weakening of enforcement mechanisms (J Ac Man Rev) and narrative-shaping.

An evidence review of effectiveness found that PPPs in health promotion were more frequently classed as "not independent" and of poor quality. Negative evaluations were more common when the private partner involved had a high potential for competition between the health promotion activity undertaken and their financial interests (BMC Public Health)

An evaluation of the 'Public Health Responsibility Deal' suggested that it did not result in much added value to the government due to most industry pledges being already planned (Health Policy). A study of negotiations over a calorie reduction 'pledge' showed that more informal governance approaches prioritised commercial interests over public health (University of Edinburgh)

*(above examples from the Good Governance toolkit for local authorities, Brook & Körner, in progress)*

**3.6 Reputational management, including through corporate social responsibility**

UCIs commonly invest in charities, 'good causes', and training/educational initiatives to distract from evidence of harm from their activities. For example, "Keep Britain Tidy" was a media campaign to encourage individuals, companies, and local groups to clean up after themselves, with the UK government involved as a partner until 2015. It was founded by three major waste and litter producers (Imperial Tobacco, McDonalds, Wrigleys), and would now be construed as "greenwashing" (Tobacco Tactics). "Safer Gambling Week" is an industry-funded initiative aimed at awareness-raising and encouraging individuals to gamble more safely and responsibly.

## 4. A public health approach to CDoH is needed

A 'Public Health Playbook' has been developed with strategies that utilise the assets of the public health system and create opportunities to counter the commercial tactics previously discussed (The Lancet Global Health).

A public health approach is a population-focused approach based on intelligence and evidence, to advance the public good. It does this by promoting health, equity, and social justice, collectively through partnership between organisations and communities and through system leadership (Lancet). The scope of the public health approach begins with the causes of the causes of ill-health and spans the whole life course. In this section we sketch out what a public health approach to CDoH could look like.

**4.1 Population level**

The harms driven by the CDoH occur at a population level, not just at an individual level. Private sector activities play a significant role in shaping our environments to ultimately influence our choices. Focusing only on individual behaviour overlooks the ongoing drivers of that behaviour which we encounter throughout our lives. Focusing only on those with acute issues overlooks the significant

proportion of the population who are at risk of harm and could benefit from preventive intervention. Furthermore, focusing on individuals perpetuates the personal responsibility narrative which can be stigmatising and result in a narrow and less effective set of responses and solutions. The increasing burden of related NCDs despite investment in related health services shows that individual treatment is not the sole solution.

### 4.2 Promoting health equity and social justice through partnership and systems leadership

There are health, financial, and relationship harms alongside significant monetary costs to society. As a society we are paying for private sector products, and for responding to the harms they cause to our health and planet. Industry is enabled by the current system to make profit that causes harm with the costs externalised to society, including the public sector. Our ability to promote health and equity is diminished as we try to respond to those harms and meet the resulting health needs, and the private sector's wealth and power increases (The Lancet). We need to shift the system so that it prioritises public and planetary health and equity over a narrow focus on profit from products and practices that harm health. Our society needs regulating and organising in line with these priorities so harms are reduced and benefits amplified – this also levels the playing field for businesses and organisations that want to work in health-promoting ways by incentivising practices that benefit health and equity rather than relying on individuals and organisations to go against the grain (The Lancet). For example, inclusive wellbeing economies aim to reduce inequality through improving the health of people, communities, and the planet, and ensure that economic activity is sustainable (Y&H Public Health Network).

### 4.3 Evidence and intelligence led

The public health approach is rooted in the best available evidence and intelligence. For CDoH, there is clear and increasing evidence of the harm caused by industry tactics (*see section 3*). An effective public health response requires the development of practice-based evidence through public health action. For CDoH, these actions are based on the theory of applying what we know has worked in individual industries (such as for the tobacco industry) to practices and/or commercial entities in combination.

### 4.4 Causes of the causes

CDoH are increasingly recognised as a part of the wider determinants of health so addressing them becomes a critical aspect of any public health focus on fundamental causes of ill-health (Freudenberg, Lee et al 2021). Emphasis is needed on re-balancing power and shifting the practices that currently shape the system in the interests of the commercial sector so that they 'prioritise public interests over commercial profit.' This is what the Lancet series framework describes as the underlying drivers which are shaping the whole system but especially levels 1 and 2 (see Lancet, and Lancet). This is about collective leadership to develop, describe, and influence for alternative systems that enable benefits over harms and will include strategic work to shift public perceptions and norms.

### 4.5 Community-led approaches

Fundamental to a public health approach is understanding what matters to our communities and working to redistribute power away from vested interests and towards community interests. Commercial practices and influences can harm all of us so our understanding of community needs to remain broad, whilst recognising the importance of hearing from population groups who are harmed the most by CDoH. We must ensure that evidence and intelligence includes insights from our population. Our recognition of 'the causes of the causes' must take note of the shifting and growing power imbalances between commercial entities and communities. We need to work with communities

to shape the Public Health agenda on CDoH through meaningful approaches suitable for complex work such as deliberative democracy.

### 4.6 Key principles

System-wide collective action focused on the methods and tactics of industry is a legitimate and direct target for public health intervention. There are key principles that apply, agnostic of the specific industry, which elevate into a general approach to CDoH:

1. People with relevant expertise (and whose goals align with public health) should primarily influence health policy, health services, education (including health messaging and risk information) and awareness raising. UCIs should not have any influence over decisions and processes related to health policy due to a clear conflict of interest.

2. UCI marketing drives harmful consumption and health inequalities and needs to be tackled (restricted through regulation)

3. Reframing the narrative from personal responsibility to the actions of industries and their harmful products is a legitimate public health intervention

4. Children and young people and other groups in vulnerable circumstances who are the most harmed, are priority groups to protect from the tactics of UCIs

5. Tackling CDoH has high public support. Protecting the rights of children (and adults) to be free from harmful commercial environments is more important than the right of corporations to profit at the expense of the health of current and future generations.

6. A public health approach to tackling the CDoH must work to shift power and rebalance the system to prioritise health, equity, and the environment over commercial profits.

## 5. Actions

*We recognise that different areas are at different stages in their CDoH work. In some places this may begin with awareness raising internally and progress to other actions with partners at place and system level. Different areas will need to tailor their approach for their local context.*

1. **Implement a '*CDoH in all policies*' approach: in the absence of government regulation, use the tools and policy levers available locally to adopt a CDoH approach to licensing, planning, advertising, and marketing, event sponsorship, and partnership working with those parts of the commercial sector purveying harmful products.**

A report from The Health Foundation "*Addressing the leading risk factors for ill health – a framework for local government action"* can assist local government in taking a 'CDoH in all policies' approach locally

2. **Develop materials for framing CDoH with the public and press, including FAQs and responses to anticipated challenges. Use these to assist public health teams in responding to industry arguments, as well as raising awareness of private sector tactics in communities.**

3. **Up-skill our public health teams and wider internal colleagues including Councillors through training and/or workshops. Training will include understanding industry tactics, and how to**

**scrutinise stakeholders and sources. It will be important to develop robust methods to address issues identified through such scrutiny - for example what to do about conflicted evidence or funding. Build on this over time to include partners at place and system level.**

4. **Work with other regions to influence national policy and take collective action on the CDoH**

5. **Secure endorsement for the principles outlined in this document at local Health and Wellbeing Boards, and relevant partnership groups such as Scrutiny Committees**

6. **Commit to finding opportunities for funding and capacity for proper work with the public to shape this agenda. The most helpful way to do this on system-level issues like CDoH is likely through deliberative democracy approaches. This requires time and resources. We can build on and learn from the SPECTRUM approach being tried in Scotland.**

7. **Use good governance and organisational conflict of interest policy development resources to implement policies on partnership with industry and using harmful product industry funding for interventions. Focus not just on policies for specific industries or products but on corporate political activity and the systematic exclusion of health-harming industries from the policy process.**

8. **Develop networks for sharing knowledge and best practice between relevant staff working in public health through a seminar series focused on key CDoH issues.**

9. **Develop champions and networks amongst local politicians and other partners beyond public health to drive action forward.**

10. **Commit to seek opportunities for, and develop over time, more shared leadership and capacity for shared delivery mechanisms (building towards an expanded Fresh and Balance model for the region).**