



World Health
Organization

European Region

+++ Commercial determinants of noncommunicable diseases in the WHO European Region +++

Abstract

This report highlights the substantial impact of commercial determinants on noncommunicable diseases (NCDs) in the WHO European Region. Nearly 7500 deaths per day in the Region are attributed to commercial determinants, such as tobacco, alcohol, processed food, fossil fuels and occupational practices. These commercial products and practices contribute to 25% of all deaths in the Region. The report's chapters systematically explore various facets of how commercial interests exacerbate NCDs and key strategies used by commercial actors to negatively influence NCD-related policies at the national and international level. The report also provides selected case studies from the Region to illustrate key strategies and outcomes of industry influence on health policies.

The report then calls for urgent and coordinated action to address the commercial determinants of NCDs. It advocates for building coalitions based on the values of equity, sustainability, and resilience. Public health actors are urged to develop competencies in economic and legal frameworks, enforce transparency, and manage conflicts of interest effectively. The report underscores the need for robust financial reforms and strict regulation to curb industry power and protect public health. By implementing these strategies, the Region can accelerate progress towards global NCD targets and Sustainable Development Goals by 2030.

Key words:

COMMERCIAL DETERMINANTS, COMMERCIAL ACTORS, NONCOMMUNICABLE DISEASES, NONCOMMUNICABLE DISEASE RISK FACTORS.

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FOREWORD

Delays in implementing essential policies and regulations to prevent noncommunicable diseases (NCDs) in WHO Member States and the European Union (EU) are alarming. Most countries are off track in achieving Sustainable Development Goal (SDG) target 3.4 by the 2030 deadline: to reduce by one third premature mortality from NCDs through prevention and treatment, and to promote mental health and well-being. This is despite the potential of countries in the WHO European Region, with existing public health capacity and the availability of leading experts.

One major barrier causing delays in implementing NCD-related policies and regulations is the influence of major commercial industries. Commercial determinants of health (CDoH) are present in everyone's lives, sometimes visible, but often covert. Due to the huge impact commercial entities have on the global market and politics, their influence on peoples' lives is immense. It's not only the products these industries manufacture, promote, and sell, but also their profit-generating mechanisms which can negatively impact people's health.

WHO aims for health for all. This can only be achieved if the environment people are living in is health-promoting rather than health-harming. The Special Initiative on NCDs and Innovation (SNI) of the WHO Regional Office for Europe works with a dual track system, supporting Member States to reduce premature mortality by 2030 to achieve SDG target 3.4, and looking at longer term issues under the vision 2050 workstream, which, among others, prioritizes addressing commercial determinants, thereby protecting future generations from vested interests.

For a long time, commercial growth and revenues have been seen as the primary indicator and measure of success for companies or countries. New models are now being explored, which put people's health and well-being first.

This publication looks at how commercial determinants impact NCDs. This can happen through several mechanisms and on different levels across industries. Despite the diversity in products, from health-harming products, such as tobacco, alcohol or sugar-sweetened beverages, to lifesaving medications, industries use a similar playbook to maximize profits, increase market power and create the best environment within which they can further grow. Attempts to control the negative health impact of those industries' activities, by policies aiming to prevent NCDs, are continuously challenged, delayed, weakened or stopped.

Health is a common good and we need to protect it. We hope this report will be a useful tool to understand the commercial determinants of NCDs better and to enable the start of a wider discussion in the public health community followed by concrete action. To address commercial determinants and successfully prevent and control NCDs, we need to work together with all public health stakeholders towards a health-promoting future for all.

Dr Gauden Galea

Strategic Adviser on NCDs and Innovation
WHO Regional Office for Europe

Dr Hans Henri P. Kluge

Regional Director
WHO Regional Office for Europe

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Contributors

Authors

The lead authors were responsible for drafting and reviewing, and attending consultation meetings. The co-authors assisted in all of these functions. All authors have submitted a declaration of interest form.

Introduction

Lead author: Sumudu Kasturiarachchi (WHO Regional Office for Europe)

Co-authors: Ivo Rakovac (WHO Regional Office for Europe), Kathrin Hetz (WHO Regional Office for Europe), Kremlin Wickramasinghe (WHO Regional Office for Europe)

Chapter 1

Lead author: Anna B Gilmore (University of Bath)

Co-authors: Mark Petticrew (London School of Hygiene and Tropical Medicine), Benjamin Hawkins (University of Cambridge), Mélissa Mialon (INSERM), May van Schalkwyk (London School of Hygiene and Tropical Medicine)

Chapter 2

Lead author: Kathryn Backholer (Deakin University)

Co-authors: Emma Boyland (University of Liverpool), Fiona Sing (University of Auckland)

Additional case study authors: Marie-Laurence Lambert (Temporary Advisor, WHO Regional Office for Europe), Marilys Corbex (WHO Regional Office for Europe), Ajay Aggarwal (London School of Hygiene and Tropical Medicine) and Richard Sullivan (King's College London).

Chapter 3

Lead author: Jappe Eckhardt (University of York)

Additional case study authors: Marie-Laurence Lambert (Temporary Advisor, WHO Regional Office for Europe), Marilys Corbex (WHO Regional Office for Europe)

Chapter 4

Lead author: Benjamin Hawkins (University of Cambridge)

Co-authors: May van Schalkwyk (London School of Hygiene and Tropical Medicine), Kathrin Lauber (University of Edinburgh), Anna B Gilmore (University of Bath)

Additional case study authors: George Bakhturidze (Georgia State University), Marie-Laurence Lambert (Temporary Advisor, WHO Regional Office for Europe)

Chapter 5

Lead author: Benjamin Hawkins (University of Cambridge)

Co-authors: May van Schalkwyk (London School of Hygiene and Tropical Medicine), Courtney McNamara (Newcastle University)

Chapter 6

Lead author: Mark Petticrew (London School of Hygiene and Tropical Medicine)

Co-authors: Alice Fabbri (University of Bath), Tess Legg (University of Bath), May van Schalkwyk (London School of Hygiene and Tropical Medicine)

Chapter 7

Lead author: May van Schalkwyk (London School of Hygiene and Tropical Medicine)

Co-authors: Mark Petticrew (London School of Hygiene and Tropical Medicine), Nason Maani (University of Edinburgh)

Chapter 8

Lead author: Courtney McNamara (Newcastle University)

Co-authors: Amanda Aronsson (Norwegian University of Science and Technology), Gábor Scheiring (Georgetown University Qatar)

Chapter 9

Lead author: Benjamin Wood (Deakin University),

Co-authors: J Robert Branston (University of Bath), Gary Sacks (Deakin University)

Chapter 10

Lead author: Benjamin Hawkins (University of Cambridge)

Co-authors: May van Schalkwyk (London School of Hygiene and Tropical Medicine), Sheila Gilheany (Alcohol Action Ireland)

Chapter 11

Lead author: Clare Patton (University of Leeds),

Co-authors: Laura Dryburgh (Blavatnik School of Government - University of Oxford) and Samantha Hopkins (Queen's University Belfast)

Chapter 12

Lead author: Méliissa Mialon (INSERM)

Co-authors: Oskonbek Moldokulov (Temporary Advisor, WHO Regional Office for Europe)

Additional case study authors: Cervantée Wild (University of Oxford), Elena Tsoy (WHO Regional Office for Europe) and Nino Maglakelidze (SNI, WHO Regional Office for Europe).

Chapter 13

Lead author: Alessandro Gallina (European Public Health Alliance)

Co-authors: Méliissa Mialon (INSERM)

Additional case study authors: Mihaela Lovše (Slovenian Coalition for Public Health, Environment and Tobacco Control), Cervantée Wild (University of Oxford), Ainuru Altybaeva (National Academy of Science of Kyrgyz Republic) (Ayaldar Kenesh), Aliina Altymysheva (WHO Regional Office for Europe), Rosalind Turkie (Pharmaceutical Accountability Foundation), Wilbert Bannenberg (Pharmaceutical Accountability Foundation), Kaitlin Mara (Pharmaceutical Accountability Foundation), Alba Gil (European Public Health Alliance)

Conclusion

Lead authors: Gauden Galea (WHO Regional Office for Europe) and Sandro Galea (Boston University)

Overall reviewers

Ajay Aggarwal (London School of Hygiene and Tropical Medicine)
Wilbert Bannenberg (Pharmaceutical Accountability Foundation)
Florence Berteletti (Eurocare)
Norah Campbell (Trinity College Dublin)
Angela Ciobanu (Special Initiative on NCDs and Innovation (SNI), WHO Regional Office for Europe)
Adriana Isabel Pinedo Carrillo (SNI, WHO Regional Office for Europe)
Marilys Corbex (SNI, WHO Regional Office for Europe)
Caroline Costongs (Eurohealth Net)
Allison Ekberg (SNI, WHO Regional Office for Europe)
Urska Erklavec (National Institute for Public Health Slovenia)
Carina Ferreira-Borges (SNI, WHO Regional Office for Europe)
Hannah Forde (University of Oxford)
Sharon Friel (Australian National University)
Gauden Galea (SNI, WHO Regional Office for Europe)
Sandro Galea (Boston University)
Narmin Guluzade (SNI, WHO Regional Office for Europe)
Kakha Gvinianidze (WHO Country Office Georgia)
Triin Habicht (WHO Regional Office for Europe)
Kathrin Hetz (SNI, WHO Regional Office for Europe)
Stuart Hogarth (University of Cambridge)
Daniela-maria Madan (SNI, WHO Regional Office for Europe)
Tifenn Lucile Marie Humbert (WHO Regional Office for Europe)
María Lasiera Losada (SNI, WHO Regional Office for Europe)
Sumudu Kasturiarachchi (SNI, WHO Regional Office for Europe)
Knut-Inge Klepp (Joint Action Prevent Non-Communicable Diseases)
Monika Kosinska (WHO headquarters)
Kristina Köhler (WHO Country Office Estonia)
Marie-Laurence Lambert (Temporary Advisor, WHO Regional Office for Europe)
Elizaveta Lebedeva (SNI, WHO Regional Office for Europe)
Kaitlin Mara (Pharmaceutical Accountability Foundation)
Maria Neufeld (SNI, WHO Regional Office for Europe)
Catherine Paradis (SNI, WHO Regional Office for Europe)
Ivo Rakovac (WHO Regional Office for Europe)
Lieven De Raedt (Federal Public Service Health, Food Chain Safety and Environment Belgium)
Tomáš Roubal (WHO Country Office Georgia)
Franco Sassi (Imperial College London)
Dorota Sienkiewicz (WHO European Office for Investment for Health and Development)
Richard Sullivan (King's College London)
Takwa Tissaoui (University of Sydney)
Anne-Marie Thow (University of Sydney)
Alena Tokareva (SNI, WHO Regional Office for Europe)
Fonthip Watcharaporn (Johns Hopkins Bloomberg School of Public Health)
Cervantée Wild (University of Oxford)
Kremlin Wickramasinghe (SNI, WHO Regional Office for Europe)

Julianne Williams (SNI, WHO Regional Office for Europe)
Wendy Yared (Association of European Cancer Leagues)
Olga Zhiteneva (SNI, WHO Regional Office for Europe)

WHO Regional Office for Europe

Angela Ciobanu (SNI, WHO/ Regional office for Europe)
Adriana Isabel Pinedo Carrillo (SNI, WHO/ Regional office for Europe)
Marilys Corbex (SNI, WHO Regional Office for Europe)
Allison Ekberg (SNI, WHO Regional Office for Europe)
Carina Ferreira-Borges (SNI, WHO Regional Office for Europe)
Gauden Galea (SNI, WHO Regional Office for Europe)
Narmin Guluzade (SNI, WHO Regional Office for Europe)
Triin Habicht (Division of Country Health Policies and Systems)
Kathrin Hetz (SNI, WHO Regional Office for Europe)
Tifenn Lucile Marie Humbert (Division of Country Health Policies and Systems)
María Lasiera Losada (SNI, WHO Regional Office for Europe)
Sumudu Kasturirachchi (SNI, WHO Regional Office for Europe)
Elizaveta Lebedeva (SNI, WHO Regional Office for Europe)
Catherine Paradis (SNI, WHO Regional Office for Europe)
Ivo Rakovac (WHO Regional Office for Europe)
Alena Tokareva (SNI, WHO Regional Office for Europe)
Kremlin Wickramasinghe (SNI, WHO Regional Office for Europe)
Julianne Williams (SNI, WHO Regional Office for Europe)
Olga Zhiteneva (SNI, WHO Regional Office for Europe)

WHO headquarters, WHO country offices and geographically dispersed offices

Aliina Altymysheva (WHO Country Office Kyrgyzstan)
Christine Elisabeth Brown (WHO European Office for Investment for Health and Development)
Silviu Domete (WHO Country Office Georgia)
Kakha Gvinianidze (WHO Country Office Georgia)
Monika Kosinska (WHO headquarters)
Kristina Köhler (WHO Country Office Estonia)
Juliette McHardy (WHO headquarters)
Tomáš Roubal (WHO Country Office Georgia)
Amanda Marie Shriwise (WHO Country Office Kyrgyzstan)
Dorota Sienkiewicz (WHO European Office for Investment for Health and Development)
Livi Vedrasco (WHO Country Office Kyrgyzstan)

ABBREVIATIONS

CAP	Common Agricultural Policy (European Union)
CDoH	commercial determinants of health
CEO	chief executive officer
CJEU	court of justice of the European Union
CME	continuing medical education
COI	conflict of interest
CPA	corporate political activities
CPTPP	Comprehensive and Progressive Agreement for Trans-Pacific Partnership
CSO	civil society organization
CSR	corporate social responsibility
DTCA	direct-to-consumer advertising
EMA	European Medicines Agency
ENDS	electronic nicotine delivery system
EU	European Union
FCTC	WHO Framework Convention on Tobacco Control
FDA	Food and Drug Administration (the United States)
GGTC	Global Centre for Good Governance in Tobacco Control
HFSS	foods and beverages high in fats, salt and/or sugar
HHI	health-harming industry
HTA	health technology assessment report
HTP	heated tobacco products
IAs	impact assessments
ISDS	investor-state dispute settlement
ICAP	International Center for Alcohol Policies
ICS	Investor Court System
IPR	own intellectual property rights
IQWiG	Institute for Quality and Efficiency in Health Care
LMICs	low- and middle-income countries
MOU	memorandum of understanding
M&As	mergers and acquisitions
MUP	minimum unit price
NCDs	noncommunicable diseases
OHA	Obesity Health Alliance
PhRMA	Pharmaceutical Research and Manufacturers of America

ABBREVIATIONS (CONTINUED)

PPE	personal protective equipment
PR	public relations
RCT	randomized controlled trial
SSB	sugar-sweetened beverage
SPM	Science for Profit Model
TfL	Transport for London
TIAs	trade and investment agreements
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNGPs	United Nations Guiding Principles
UNICEF	United Nations Children's Fund
WTO	World Trade Organization

EXECUTIVE SUMMARY

Advances in public health research and practice have contributed to a growing recognition of the role of commercial actors as powerful determinants of people's health, safety and well-being the world over. For too long, the ways that commercial practices and products threaten and undermine public health policymaking and goals have not received the attention they demand. Applying a new commercial determinants lens to the pressing public health issues of our time is urgently needed to prevent unnecessary harm and health inequities. This report aims to catalyse new thinking and action to help ensure health and equity throughout the WHO European Region.

Introduction. The importance of addressing commercial threats to noncommunicable disease (NCD) policies in the WHO European Region

This chapter provides an overview of the noncommunicable disease (NCD) burden in the Region driven by commercial practices and products. It examines the key challenges in reaching the global NCD targets in the Region and the current concerns with unsatisfactory implementation of NCD "best buy" policies. It then sets out the goals of the publication, which are to explain the common practices used by commercial actors and to seek to mobilize policy actors to recognize undue commercial influence and take action.

Chapter 1. Conceptualizing commercial determinants of health related to NCDs

This chapter introduces the concept of the commercial determinants of health (CDoH), highlighting how commercial sector actors and their practices impact health, particularly NCDs. The chapter defines what commercial determinants entail, and discusses the diversity of commercial actors, their profit driven motives, and the shared strategies that may harm public health. It calls for urgent recognition and regulation of CDoH to mitigate these health impacts and address growing health inequalities.

Chapter 2. Marketing strategies increase exposure to NCD risk factors and negatively affect NCD care

This chapter focuses on how marketing strategies increase exposure to NCD risk factors and negatively affects the burden of disease from NCDs, and often their prevention, clinical treatment and management. It details how industries, such as tobacco, alcohol, food, pharmaceuticals, and the healthcare industry, integrated marketing campaigns to glamourize and normalize the use of harmful products, including harmful ones often targeting children and socioeconomically disadvantaged groups and others. The chapter highlights the pervasive role of digital marketing and the challenges in regulating it due to advanced technologies and algorithmic targeting. It also includes case studies on industry opposition to the United Kingdom's food marketing restrictions and the French alcohol law *Loi Évin* on advertising and promotion restrictions, and how the public health and civil society organizations sought to overcome it, as well as a case study exploring the consequences of marketing surgery robots in the United Kingdom. The chapter then discusses potential regulatory actions, barriers created by industry opposition, and the importance of strong legal measures to protect public health from harmful marketing practices.

Chapter 3. Industry structure and market power negatively influence policies

Chapter 3 explores how industry structure and market power negatively influence public policies related to NCDs. It examines the ways in which industries, such as meat production, nonalcoholic beverages, and pharmaceuticals, use their market dominance to maintain monopolistic positions, extend product lines into

new sectors, and manipulate pricing. The chapter includes case studies illustrating these practices, such as the high costs of innovative medicines and the battles over access to affordable medicines. It highlights the detrimental effects of commercial actors' strategies on public health policies and the need for regulatory frameworks to curb their power and protect health outcomes.

Chapter 4. Industry lobbying and its impact on NCD policies

This chapter examines the impact of industry lobbying on NCD public policies. The chapter illustrates how commercial industries, including tobacco, food, and pharmaceuticals, engage in political practices to prevent, weaken, and delay public health regulations. It presents case studies, such as industry opposition to the regulation of electronic cigarettes in Georgia, opposition to sugar-sweetened beverage taxes, and an example of pharmaceutical industry lobbying using patient associations and families. It emphasizes the pervasive nature of industry interference in policymaking, which often prioritizes commercial interests over public health, and calls for stronger regulatory measures to counteract these lobbying efforts and protect NCD policies.

Chapter 5. The impact of international trade and investment agreements on policy

Chapter 5 addresses the impact of TIAs on NCDs and related policies. It discusses how these agreements can constrain governments' ability to implement public health measures by prioritizing commercial interests within trade and investment interests over health concerns. The chapter highlights examples of the tobacco industry challenging tobacco packaging laws, the potential health impacts from changes to trade agreements following the United Kingdom's withdrawal from the European Union (EU), and how the pharmaceutical industry influences trade agreements, illustrating the tension between commercial interests and public health objectives. It calls for careful consideration of health impacts in trade negotiations and the need for policies that ensure health priorities are considered and governments maintain their ability to effectively address NCDs.

Chapter 6. Casting doubt on evidence: manipulating research evidence related to NCD causes, prevention and management

This chapter investigates the use of scientific practices by commercial actors, highlighting the systemic problem of disinformation and misinformation related to NCD prevention and management. It describes five key strategies used by commercial actors, particularly in health-harming industries (HHIs), to influence scientific research and public understanding of health issues and to favour their commercial interests, such as funding industry-favourable research, spreading misinformation, and undermining public health guidelines. The chapter provides examples of how the industry influences the interpretation of evidence, and how industry-funded youth education programmes distort evidence in the United Kingdom. It then emphasizes the need for robust measures to counteract these manipulative practices, prevent conflict of interest, ensure transparency, and promote independent, evidence-based knowledge in the field of NCD prevention and management.

Chapter 7. Corporate social responsibility (CSR) and its negative impacts

Chapter 7 focuses on CSR as a strategy for corporate reputation management. It discusses how companies, especially those in HHIs, use CSR initiatives to improve their public image and gain influence, often at the expense of public health. The chapter highlights that, while these activities may appear benevolent, they frequently serve to deflect criticism and avoid regulation. It provides two case studies: one on pinkwashing, where the alcohol industry associates with breast cancer charities, and the other on artwashing, where the pharmaceutical industry and gambling industry promote arts and culture. It then emphasizes the need for critical scrutiny of CSR practices and suggests that true accountability mechanisms and regulation are necessary to ensure that corporate actions align with public health interests rather than merely serving profit-driven motives.

Chapter 8. Employment and health: the role of commercial economic narratives and shifting labour markets

This chapter examines the relationship between employment, health, and the role of commercial economic narratives in shaping labour markets. The chapter presents case studies on the mental health effects of precarious employment in Sweden and labour market shocks. It also underscores the importance of addressing the economic and employment conditions that contribute to health inequities and NCDs, advocating for policies that promote stable, fair employment and protect workers' health.

Chapter 9. Financial practices and the extraction of wealth: increasing inequity and undermining NCD prevention and control

Chapter 9 explores how financial practices and the extraction of wealth by commercial actors increase inequity and undermine NCD prevention and control. It highlights the role of tax avoidance, profit shifting to tax havens, and aggressive financial planning strategies that deprive governments of revenues needed to fund public health. The chapter includes case studies on British American Tobacco's tax avoidance and on COVID-19 vaccine manufacturers' share buybacks. It emphasizes the need for financial reforms and stricter regulation to ensure that commercial entities contribute fairly to public finances and do not exacerbate health inequities.

Chapter 10. The Economic union and European Union's single market laws: how health-harming industries undermine policies to reduce NCDs

This chapter examines how economic union and EU single market laws are used by commercial actors to oppose policies aimed at addressing the NCD burden. The chapter highlights how industries can leverage legal frameworks to challenge national public health regulations, often arguing that such policies impede free trade and competition. The chapter provides examples of how the tobacco and alcohol industries are exploiting EU laws to prevent the implementation of health measures at the EU level, thus prioritizing commercial interests over public health. It calls for stronger regulatory mechanisms and a more health-oriented interpretation of these laws to effectively address the NCD crisis within the EU context.

Chapter 11. The commercial industry taking advantage of crises and emergencies

Chapter 11 discusses how commercial actors may exploit crises and emergencies to advance their commercial interests, which might again be at the expense of public health. It presents case studies illustrating how companies, such as McDonald's, Philip Morris International, and the commercial milk formula industry, have used events, such as the cost-of-living crisis, COVID-19 pandemic, and Ukraine war, to promote their products and influence public policies. These actions can exacerbate NCD risks and undermine public health responses. The chapter calls for vigilance of these practices and stronger regulations to prevent industries from leveraging crises for commercial gain, ensuring that public health remains a priority during emergencies.

Chapter 12. Taking action to address the commercial determinants of NCDs in Europe

This chapter outlines actions to reduce the burden of NCDs by addressing CDoH. It emphasizes the need for coordinated efforts involving governments, civil society, and international organizations to implement effective policies and regulations. The chapter presents case studies of Kyrgyzstan's Joint Annual Review for NCD coordination and Estonia's success with a sugar-sweetened beverage tax through coalition-building. It advocates for comprehensive approaches, including coalition-building, policy dialogues, and regulatory mechanisms, and addressing the limitations of the political economic system to counteract the CDoH and effectively address and prevent NCDs.

Chapter 13. The power of people's voice matters: the actions that citizens and civil society can take to reduce commercial determinants of NCDs

Chapter 13 emphasizes the importance of civil society's action in addressing the commercial determinants of NCDs. It highlights actions that civil society can take to advocate for stronger public health policies and regulations. The chapter presents case studies demonstrating effective civil society interventions, such as the adoption of tobacco legislation amendments in Slovenia and the role of the Women's Council of the Kyrgyz Republic in supporting tobacco control legislation. It underscores the power of collective action, adequate funding, and strategic alliances in influencing policy and responding to the influence of commercial actors.

Conclusion. A stepwise approach to addressing the commercial determinants of NCDs in Europe: an agenda for action

The conclusion of the report emphasizes the urgency to take action to mitigate commercial determinants related to NCDs to address the rising NCD burden in the Region. It calls governments, civil society and academia to action, by building coalitions, emphasizing well-being and developing a clear NCD policy agenda based on the core values of equity, sustainability, and resilience. It calls for public health actors to: develop their competencies in identifying, preventing and managing CDoH and conflicts of interest; identify and critically assess industry-funded research, as well as develop skills in leveraging evidence to support stronger regulations; engage more effectively in debates and policy developments on the economy and trade; and support governments in opposing litigations that block or delay effective NCD policies. Governments in Europe are also called to enforce the regulations that already exist to protect people from NCDs, and to advocate for stringent and effective measures to curtail the effects of commercial actors.

Introduction.

The importance of addressing commercial threats to noncommunicable disease (NCD) policies in the WHO European Region



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Key highlights

- NCDs are responsible for 90% of deaths in the WHO European Region and almost two thirds of these deaths are directly attributed to risk factors.
- Four major commercial products – alcohol, tobacco, processed food and beverages, and fossil fuels – and commercial practices, such as exposure to occupation-related carcinogens, asthmagens, and injuries, cause an estimated 2.7 million deaths annually (that is 7400 deaths daily) which is nearly one quarter (24.5%) of all deaths on average in the WHO European Region.
- The Region is falling behind in reaching the global NCD target of reducing premature mortality risk by a third by 2025 from the base levels in 2010, and there are considerable subregional disparities. The countries in the Region are not implementing even half of the WHO “best buy” policies which have consistently shown to be beneficial.
- This report aims to address this through supporting and mobilizing the policy stakeholders to identify, prevent and mitigate commercial industry influence on NCD-related policies.

The commercial industry contribution to the NCD burden in the WHO European Region

NCDs are responsible for 90% of deaths and 85% of years lived with disability in the Region. Two thirds of all deaths before 70 years of age in the Region are caused by four major NCDs: cardiovascular diseases, cancer, chronic respiratory diseases and diabetes. Cardiovascular diseases and cancer account for a significant proportion of deaths with 51.4% and 46.4% of deaths, respectively (1).

Almost two thirds (61.3%) of the deaths caused by NCDs in the Region can be attributed directly to risk factors and therefore also prevented by minimizing exposure (2). Behavioural risk factors, such as alcohol and tobacco consumption, unhealthy diet, and insufficient physical activity, are preventable causes for these diseases. They also lead to metabolic risk factors, such as overweight and obesity, high blood pressure, high blood sugar, and high cholesterol level, which would then be preventable. Exposure to air pollution following fossil fuel combustion leads to respiratory and cardiac diseases, among many other illnesses in adults; this also poses a particular concern with exposure to young children with their growing brains and lungs. Additionally, non-optimal temperatures and occupational risks also contribute to the NCD burden.

In the Region, four major commercial products – alcohol, tobacco, processed food and beverages, and fossil fuels – and commercial practices, such as exposure to occupation-related carcinogens, asthmagens, and injuries, cause an estimated 2.7 million deaths annually, which is nearly one quarter (24.5%) of all deaths on average (Table 1) (2). In other words, more than 7400 people are dying every day in the Region due to harmful commodities and practices driven by commercial industry. This number can also be an underestimate of the impact. For example, the WHO estimates that 8.8% of total deaths in the Region are attributable to alcohol use (3) which is more than two times higher than Global Burden of Disease estimates due to including more than one dimension of alcohol use and a higher number of attributable diseases among other reasons. Vohra et al estimate 7.6% of global deaths are due to fossil fuels pollution (4). Further, the estimates in Table 1 also do not account for deaths from metabolic risk factors that arise from consuming or using these unhealthy commodities.

Table 1. Estimated annual number of deaths attributed to four commercial products (tobacco, alcohol, food and fossil fuel) and commercial practices in the WHO European Region, 2021

Industry sector	All causes of deaths (mean value)	
	Number	Percentage
Tobacco	1 151 575	10.37
Alcohol	426 857	3.84
Diet high in processed meat	117 290	1.06
Diet high in sodium	252 187	2.27
Diet high in sugar-sweetened beverages	15 606	0.14
Diet high in trans fatty acids	6 056	0.05
Fossil fuel (ozone pollution and particulate matter pollution)	578 908	5.21
Occupational risks	174 732	1.57
Total deaths attributed to commercial products and practices in the WHO European Region	2 723 211	24.5

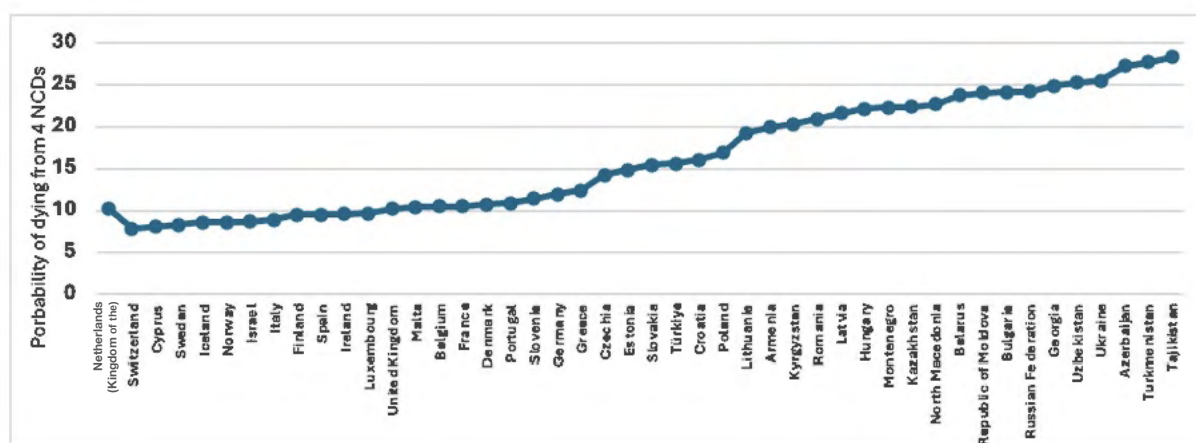
Source: Global burden of diseases, 2021 estimates (2)

Health-harming industries (HHIs) not only causes death and disability but also widen health inequities. Evidence has consistently shown that socially and economically vulnerable populations are at a higher risk of death and disability from diseases arising from consuming these products. For example, Children's Obesity Surveillance Initiative (COSI) data has shown that the prevalence of obesity was higher among children whose parents had a low level of education relative to children whose parents had a high education. The level varied as much as 11% (5). The European Health Equity Status report highlighted further inequalities in NCDs and their risk factors (6). Consequently, inequalities have been shown to decline with reduced consumption. Evidence from Lithuania has shown that, following the taxation of alcohol, inequalities in all-cause mortality by education declined by 18% among men and 14% among women (7).

Key NCD challenges in the Region

As the fourth United Nations High-Level Meeting on Noncommunicable Diseases approaches in 2025, the Region has a unique challenge in reaching its global NCD targets by 2025 and SDGs by 2030. There are considerable subregional disparities in health as well as inequities within countries. While the Region as a whole is not on track to achieve the SDG goal of a one third reduction of premature mortality due to NCDs between 2015 and 2030, there is almost a threefold difference in the risk of premature mortality by NCDs between countries (Fig. (1)).

Fig. 1. Probability of dying between 30–69 years of age from the four main NCDs (cardiovascular disease, cancer, chronic respiratory disease, and diabetes)



Source: WHO, 2021 (8).

Despite consistent evidence that NCD “best buy” policies are cost-effective and provide quick health gains for Member States from policies, such as for taxation, preventing unhealthy marketing, and sale restrictions, the level of implementation remains low. Countries in the Region are implementing, on average, less than half of these recommended interventions to tackle NCDs.

None of the countries in the Region are on track to halt the rise in obesity to meet global NCD targets by 2025 (9). The Region is projected not to reach the global NCD target of a 30% relative reduction of tobacco use among 15+ year-olds. The Region also remains the only region globally not expected to reach the target of a 30% relative reduction of tobacco use among women by 2025 (10). The rising uptake of electronic nicotine delivery systems (ENDS) and smokeless tobacco products among young people are also a major concern for many Member States. The Region remains the highest consumer of alcohol globally (3). While a few leading countries in the central and eastern part of the Region showed significant reductions in consumption levels following strong implementation of WHO “best buy” policies, there has been no change in alcohol consumption in the EU since 2010 (3).

Industrially produced trans fatty acids (TFA) contribute to a high prevalence of cardiovascular diseases in the Region, making elimination of TFA a priority. While significant progress has been made in the EU, thanks to legislation aimed at removing industrially produced TFAs from foods, countries in the Eurasian Economic Union have not met WHO best practice criteria covering all food groups (11). Forty-three of the 53 countries in the Region are consuming an estimated average of over 7.5 g of salt per day; this is 50% more than the recommendation by WHO, which is 5 g of salt per day, thus further increasing the risk of increased blood pressure, a major risk factor for cardiovascular diseases, such as heart disease and stroke (12). Taxes on sugar-sweetened beverages are implemented in only 19 countries in the Region (13).

Alcohol taxation policies are the least implemented and yet are one of the most effective policies for alcohol control in the Region (14). Regarding cigarettes, despite 53% of countries having a tax rate of over 75% of retail price, the affordability of cigarettes has only been reduced among 36% of the Member States in the Region. Only 34% of Member States have banned smoking in public places (15). The labelling of alcohol and food with detailed ingredients and health warnings, and plain packaging for tobacco products, prevent undue marketing and consumers from being misled; however, implementing these policies has faced significant delays and challenges at the regional and national level.



While there are multiple reasons for these delays, industry interference is often cited as one of the main barriers. The Region is home to five of the world's largest alcohol manufacturers. The alcohol market value is estimated to be €200 billion, estimated to be 20% of the global alcohol market (16). The tobacco market is estimated to be €256 billion, with an estimated growth rate of 2.6% annually (17). The pharmaceutical and medical device industry exerts a significant influence on health policy due to the size and market power created by the diseases; their practices, such as poor-quality medical interventions and unnecessary treatments, which are not evidence-based, lead to wasteful spending on already stretched health budgets.

If the Region is to reach the global NCD targets and SDGs as one unified Region, there is an urgent need to address the barriers to and accelerate the implementation of key “best buy” policies that can deliver quick gains and reduce inequities within the Region.

Goals of this report

This publication on the commercial determinants of NCDs aims to raise the awareness of policy-makers in the Region about:

- the need for the Region to accelerate its progress towards reaching the NCD global targets;
- the role of the harmful influence of commercial industry – with a focus on alcohol, tobacco, food and beverage industries – in delaying the implementation of NCD “best buy” policies by explaining the common practices used; and
- to mobilize policy stakeholders to recognize industry influence and take action to free the policy environment from this influence.

This publication also presents 35 case studies from a range of policy areas across the Region to demonstrate the extent of the commercial determinants of NCDs and their relevance to today's policy discussions. These case studies are selected based on the availability of published materials and do not necessarily comprise the most comprehensive list. While there may be many examples, there is a significant gap in documented literature on commercial industry influence from the eastern part of the Region. The final chapter provides a summary of each section and clear actions for different types of stakeholders.

Despite recognizing the key role played by the fossil fuel industry and gambling industry on NCDs, including on mental health, this is not addressed in this publication due to time and resource limitations.

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Chapter 1.

Conceptualizing commercial determinants of health related to NCDs



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Key highlights

Commercial sector actors are diverse, ranging from small entities to major transnational corporations, and their impacts on health vary widely.

- Unfortunately, over recent decades the negative impacts of the commercial sector on health have been growing rapidly. The obesity and NCD epidemics and the climate crisis are key examples, but avoidable harm also occurs across many industry sectors when the pursuit of profit is prioritised over the public interest.
- These links between the commercial sector and health are now referred to as “the commercial determinants of health” which has been defined as the systems, practices and pathways through which commercial actors drive health and equity.
- This chapter details the diverse ways in which commercial actors and their practices can cause harm, including by shaping political and economic systems, regulatory and sectoral policies, and physical and natural environments in ways that favour their interests.
- By doing this, the commercial actors harming human and planetary health are largely able to externalise the costs of the harm they cause, incentivising further harm: a system problem. This must urgently be addressed if we are to improve health in the long-term.

What are commercial determinants of health

Broadly speaking, commercial determinants of health (CDoH) refer to the ways in which commercial sector actors and their products and practices impact on health. These actors are, of course, diverse (see Box 1), as are their impacts, which can be positive – for example, through the creation of products and services that are beneficial to health (1). However, there is growing recognition that the negative impacts of the commercial sector on health, particularly on NCDs, including mental health, and health inequities are significant, growing and often under-recognized. For example, it is estimated that at least one third of total global deaths and 41% of NCD deaths are attributable to just four commercial products: tobacco, ultra-processed foods (UPFs), fossil fuels, and alcohol (1). (Introduction provides details of the scale of commercially driven health harms in WHO European Region)

To compound this problem, while many of the public sector interventions needed to reduce the NCD burden arising from commercial products and practices have been known for many years (2), their implementation has been consistently and repeatedly limited due to opposition from commercial actors (3, 4).

Even for commercial products intended to be beneficial to health, such as pharmaceuticals and medical devices, there is clear evidence that their over-use and inappropriate use are often deliberately encouraged in the pursuit of profit, leading to avoidable health harms. Pharmaceutical companies have also used intellectual property protections and aggressive pricing in ways that maximize their profits while limiting access to essential medicines for those unable to pay the often-excessive prices, with obvious impacts on health equity.

The fact that diverse commercial actors are causing avoidable harm reflects their shared underlying motivation to maximize profits. Moreover, the strategies used to extend and defend those profits, as outlined below and detailed in subsequent chapters, are also shared across industries (1, 4, 5), sometimes referred to as the industry playbook (6).

Box 1. The diversity of commercial actors

The commercial world is made of a diversity of actors, which use a diversity of practices. Most research in public health, to date, has focused on a narrow set of actors, particularly global manufacturers of health-harming products. In reality, there is a broad range of actors, and it is important to understand that diversity to better address the CDoH.

Commercial actors can be for-profit, private entities. There are also state-owned businesses involved, for example, in the production of cigarettes or food products, or in the banking or mining sectors. Commercial actors have various sizes as well as a myriad of legal forms, such as franchises, joint ventures, limited liability companies, and corporations, just to name a few.

Commercial actors include manufacturers, retailers, and third parties associated with them, such as trade associations, law firms, public relations firms, consultancies, and other services. The commercial world also relies on researchers, think tanks, medical professional societies, patient organizations, and other groups funded by commercial actors to further their interests, overtly or covertly (7).

CDoH and health inequity

Commercial actors can drive inequity through a range of pathways, and inequity can be created regardless of the product or service sold. For example, commercial actors selling products which may not be inherently unhealthy may have labour and employment practices which drive inequity and health inequity. These include exposing workers to harm from the products they produce, such as “green tobacco sickness” among tobacco workers caused by handling tobacco leaves (8), as well as the harmful effects of the employment itself. The latter category includes precarious employment, informal employment, child labour, and slave and bonded labour, and insecurity and vulnerability in employment, which is associated with hazardous working conditions and higher income inequality (see labour practices below).

The establishment of “smoke-free” legislation, which means legislation that promotes smoke-free environments, was driven by an awareness that tobacco smoke harms not just the smoker but also workers in those environments, such as bar and restaurant staff who were often disadvantaged, as well as children and other members of the public. Employment-related gender inequities are also common. It has been noted that, in industrialized countries, lower-paid manual jobs are often left to women workers while machinery and work tools are often designed to male anthropometric standards.

Health inequities may also be created directly through exposures to commercial products and the marketing of those products. For example, the strong and consistent social gradients in harms from gambling, alcohol, smoking and other harmful and addictive products appear to be driven by the higher concentrations of outlets selling these products in poorer areas (9–11). In the case of alcohol, disadvantaged groups experience higher rates of alcohol-related harm compared with advantaged groups, despite reporting similar or lower levels of consumption on average (1). The explanations for this are complex and may include the experience of disadvantage itself and other upstream structural factors, such as economic factors (12).

Individual and socially derived vulnerabilities to NCDs – such as stress, racism and other forms of discrimination and exclusion – may exacerbate commercially driven inequalities. This means that people subject to these vulnerabilities may be doubly penalized by the marketing preferentially targeted at them by commercial actors; for example, the tobacco and fast food industries’ targeting of black communities (8, 13) (see also the alcohol industry’s targeting of LGBTQ+ communities in Chapter 7 of this report).

When it comes to accessing health care to deal with commercially driven harms, further inequities are created, driven by inequitable health-care markets. Health-care costs for NCDs can prevent people from accessing effective health care, and when it is available, it can drain household resources, driving families into poverty. Commercial barriers also exist to the prevention of disease, including access to affordable preventive health care as well as to affordable healthy diets in some settings (9, 10).

Finally, the pathways through which inequity harms health are subject to commercial influences. Take, for instance, the relationship between occupation and high blood pressure. One’s job could determine one’s income, which influences whether a person can buy healthy food, afford and receive adequate medical care, or experience stress over financial matters – all which might affect blood pressure (11). All steps in this causal pathway are commercially influenced.

Finally, commercial actors also exploit the concept of inequities to defend themselves against public health policies, such as increasing taxes on harmful products or regulating their marketing. They do this by claiming that such policies would harm the poorest the most, thus creating inequity. This type of inequity exploitation is used by the tobacco, arms, fossil fuel, gambling, UPF and many other industries (13, 14).

Commercial determinants as a systems problem

The complex links between the commercial sector and health, detailed above, indicate that CDoH is not a simple problem of single harmful products or industries. Instead, CDoH is a systems problem where industries work closely together, learn from each other, exploit political and social systems to defend themselves, and influence those systems in their favour (1, 15). Moreover, the harms described above have increased over time as a result of changes to global political and economic systems, specifically the shift to deregulated forms of capitalism and trade liberalization in which the promotion of free markets and economic exchange take precedence over people and their health (16, 17). Among other things, these changes led to the significant consolidation of many industry sectors, which are now dominated by a small number of large and uniquely powerful transnational corporations (18). They also enabled these corporations to externalize the costs of harms they cause and influence the regulatory contexts in which they operate with negative consequences for public health as explored further below (1, 19).

For this reason the recent Lancet Series on the Commercial Determinants of Health (1) adopts a wider focus on CDoH that goes beyond health-harming products and services. Instead, it recognizes that the links between the commercial sector and health involve complex political, economic, and social systems (20).

Defining the CDoH

The Lancet Series defines CDoH as, "The systems, practices and pathways through which commercial actors drive health and equity (1)." This definition acknowledges that there are also beneficial products and services, even though there are a number of industries whose primary products are harmful to health.

The Lancet definition encourages a focus on all commercial actors, from the smallest to the largest, and not only corporations (Box 1). It also aims to convey the complexity of CDoH, which goes beyond just harmful products to include the political, financial, economic, social, and other systems within which CDoHs are embedded, and which they also shape.

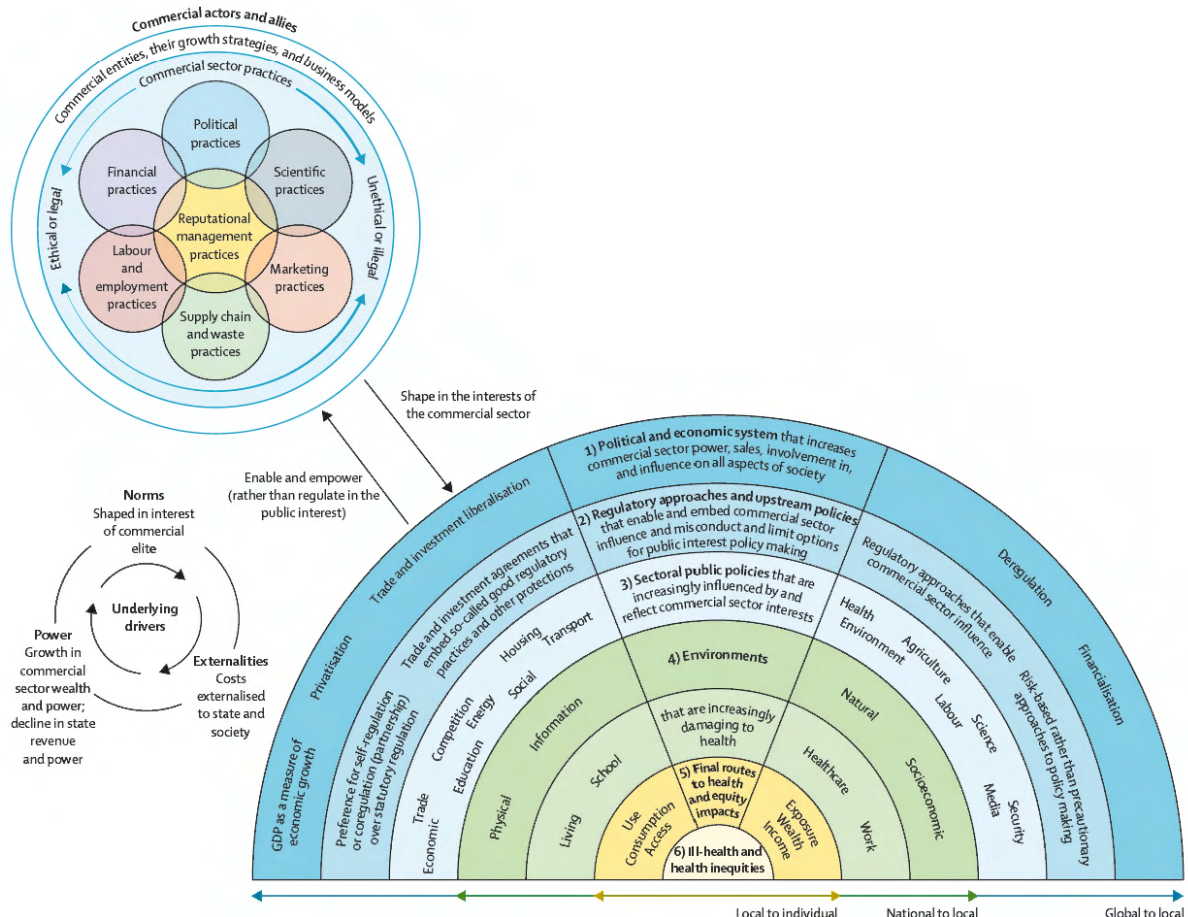
This idea is also at the core of the WHO definition, "Commercial determinants of health are the private sector activities that affect people's health, directly or indirectly, positively or negatively (21)." This definition aims to recognize that CDoH are part of the wider social and economic determinants of health, reflecting the fact that commercial actors and practices impact living, working and social conditions across the life course.

Conceptualizing the commercial determinants of health

The Lancet Series developed a conceptual model of CDoH (Fig. 2) which aims to help understand CDoH. The model details three elements:

1. the commercial sector and its practices (top left);
2. the determinants of health "rainbow" (bottom right), which draws on existing determinants of health models (22) to illustrate how commercial practices impact health through a series of levels, from the most upstream (level 1) to the most downstream (level 5); and
3. the underlying system drivers (black arrows in the centre).

Fig. 2. A model of the CDOH



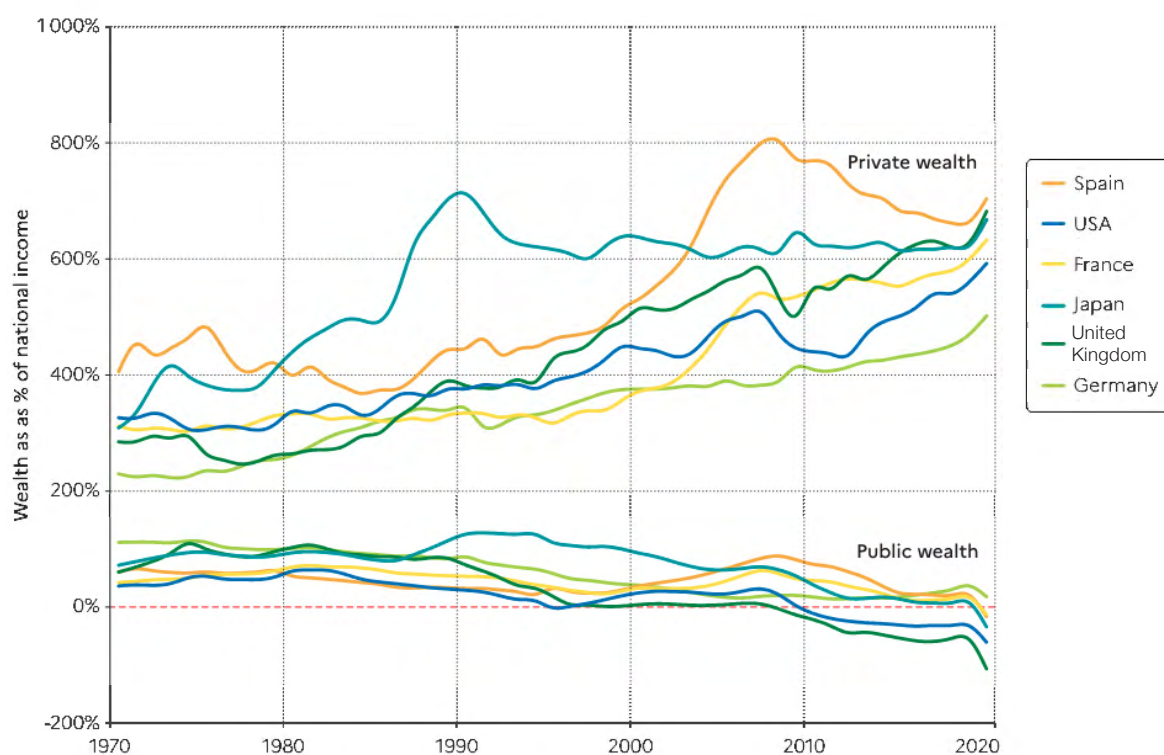
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An overview of the model focusing on the system and underlying drivers

The model highlights that commercial actors engage in diverse practices (top left) which seek to shape the whole system in their own interests (black central downward arrow), often in ways that ultimately lead to health harm (level 6). There is, for example, clear evidence that major corporations and the very wealthy played a substantial role in influencing our current global and regional political and economic systems (level 1) (16, 17, 23, 24). Deregulation, privatization, and trade and investment liberalization, among other things, are all part of those systems and have had impacts on health (1, 16, 17, 23, 24). Trade and investment liberalization, for example, helped globalize the tobacco, obesity and NCD epidemics (see Chapter 5) (25, 26). Deregulation led to a rolling back of regulation in many areas and made it harder to pass new legislation that would protect human and planetary health, while instead encouraging voluntary or multistakeholder partnership approaches now largely shown to be ineffective (27, 28). It also led to reduced taxation, leaving corporations increasingly able to externalize the costs of harm they cause (circular black arrows). Evidence shows, for example, that, since the late 1970s, effective tax rates on health-harming corporations fell while harm from those industries increased (19). This means that corporate profits and power increased while governments and individuals, having to meet the costs of that harm, became increasingly impoverished (circular black arrows). To this end it is notable that, over approximately the same period (i.e. since the late 1970s) in major European and other economies, private sector wealth has been increasing while public sector wealth stagnated or declined, to the extent that wealth in high-income countries, including those of the EU, now lies entirely in the private sector (Fig. 3) (29). This compounds the harm because it means governments have less resources with which to tackle the environmental and health harms created (29).

Meanwhile, governments, the EU, and some intergovernmental organizations are often enabling rather than regulating these harmful commercial practices (central black upwards arrow) and, consequently, over time, health and environmental harms have continued to increase (1).

Fig.3. The rise of private versus the decline of public wealth in rich countries, 1970–2020



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Understanding commercial practices and routes to health harm

We turn now to explore some of the specific commercial practices and routes in which they lead to harm, noting that many of these practices are explored in detail in other chapters. The model identifies seven practices that can impact health and equity in diverse ways and at different and often multiple levels in the model (1).

The impact of specific practices on human and planetary health and equity varies with the type of commercial actor. The most egregious evidence relates to large transnational corporations. In part this is because they have the resources to employ, for example, large numbers of lobbyists or the major accountancy firms that enable their tax avoidance practices (30) and lawyers to defend them when such practices become more unethical or illegal (31, 32); just one way in which small firms are often disadvantaged (1).

Impacts also vary with the industry sector. For commercial actors selling products or services that directly impact health, including those in HHIs, such as tobacco, alcohol, UPF, and gambling, and pharmaceutical or health-care sectors, marketing (including pricing) (Chapter 2) and scientific practices (Chapter 6) are particularly important in driving negative impacts. Marketing can increase health harms and inequity by driving consumption or inappropriate consumption (level 5), including in vulnerable population subgroups who are often specifically targeted (33, 34). This includes, for example, reshaping environments (level 4) so that, in some areas, particularly deprived areas, it can be hard to access healthy food (9,10,11). Conversely, pricing can be used to restrict access to health-care or pharmaceutical products, particularly among the most disadvantaged, as explored earlier in this chapter. Such corporations, and others whose products impact health, including chemical and fossil fuel companies, have been shown to engage in the same scientific practices which, among other things, have been used to deliberately hide the dangers of their products and the benefits of interventions to address those dangers from both users and governments (5, 35–37). This serves to increase use both directly (level 5) and indirectly, by limiting regulation (level 3) and creating what has been labelled “misinformation environments” (level 4) (1, 5).

Labour, supply chain and financial practices can lead to harm across all industry sectors largely through efforts to drive down costs and maximize profits. Direct health harms tend to occur through labour and supply chain practices. Problematic labour practices include avoidable accidents in the workplace (38) and the growth in modern slavery and precarious working contracts which, among other things (17, 39, 40), were associated with higher rates of COVID-19 (41). Over time, rates of unionization have fallen and average workers have seen pay stagnate and conditions deteriorate, while executive pay has increased exponentially, increasing inequities (17, 42–44). Problematic supply chain practices include illegal discharges of hazardous substances (45) and deforestation leading to climate change, biodiversity loss and infectious

diseases (46, 47). Such practices impact diverse environments (level 4) including work, socioeconomic and natural environments, shaping them in ways harmful to health. Indirect health harms occur through financial practices (30). A key issue here is commercial tax avoidance and evasion. Amazon reportedly paid no corporation tax in Europe in 2020, despite a sales income of €44 billion (£38 billion) (48), and tobacco companies British American Tobacco and Imperial Brands paid almost no corporation tax over a 10-year period in the United Kingdom where they are headquartered (49). It is now estimated that 40% of all multinational profits made abroad end up in tax havens, significantly reducing government resources (30). Tax Justice Network calculated that tax evasion through tax havens, both corporate and individual, was equivalent to losing salary of one nurse every second (30).

Political practices are relevant to all industry sectors and impact health and equity indirectly, in large part by driving down regulatory standards across many areas – labour, tax, environment, health and so on (level 3) – effectively enabling all other practices. For example, there is now overwhelming evidence that HHLs engage in the same political practices to prevent, weaken, and delay the implementation of government policies (including the WHO “best buys”) that are needed to reduce NCDs and other harms of their products (see Chapter 4). What is less well known is that they have also successfully shaped upstream policies (level 2) in their own interests. For example, diverse HHLs worked collectively to secure the implementation of a system of policy-making known in the EU as Better Regulation (50, 51). This system has a built-in a requirement for early consultation with affected actors and requires a form of business impact assessment; evidence shows that well-resourced commercial actors have been able to exploit this assessment to exert significant influence, thus weakening and delaying policies (52–54).

Reputation management practices, which include corporate social responsibility (CSR) (Chapter 7) and other efforts to shape business legitimacy and credibility (1), are perhaps the most overlooked and, therefore, poorly regulated type of practice. These often involve businesses funding philanthropic activities which governments may mistakenly see as benign and which, because of trends in commercial tax avoidance, they are often increasingly dependent on. Yet evidence indicates that CSR is better understood as a way of shaping policy outcomes that work against the public interest (28, 55, 56). While all industry sectors engage in reputation management because it buys them access and influence, thus underpinning and enabling all other commercial practices, it is particularly essential to HHLs who invest in it heavily (4).

Power and norms: how corporations shape thinking, deny responsibility and shift the blame to individuals

Through the diverse range of practices detailed above, commercial actors seek to shape norms – social expectations about how individuals, communities, and organizations, including governments and regulatory agencies, should behave. Corporations’ ability to influence norms in this way reflects their power and the resources available to them (see circular black arrows in Fig. 2). It is also enabled by an increasingly supportive mass media (1, 57).

Among other things, commercial actors consistently promote the idea that individuals, rather than businesses, are the problem. These ideas are based on framing individuals’ so-called “poor” or “irresponsible choices” as the principal driver of NCDs, thus promoting the idea that individuals should therefore be the focus of interventions to address NCDs (58–60). This is, of course, because individual-level interventions – which require changing behaviours, often including addictive behaviours – are less effective than population-level policy interventions (61, 62), and thus the least likely to reduce commercial sales and profits.

The scale of the problems belies the fact that these are not the problems of a few individuals. Of the world’s population, 53% have overweight or obesity, for example, yet PepsiCo’s chief executive opines, “if all consumers exercised, did what they had to do, the problem of obesity wouldn’t exist” (63).

The reality is instead that commercial actors expend considerable resources creating hyper-consumption environments (64, 65) or seeking to cut costs by avoiding the maintenance of environmental standards, while blaming the public for the harms that arise from such profit-maximizing practices. Defining individuals as the problem means that those least responsible for the choices available to them, including the unhealthy environments in which they live or work, are paradoxically blamed as the cause of NCDs and burdened with the greatest responsibility for addressing them.

Commercial actors complement their own framing by presenting their own products – whether information and educational materials (37) or new commercial products (e.g. “low fat” or “low sugar” or other “low risk” alternatives) – as solutions to the problems they have created. Not only does this obscure the pressing need for effective regulations (4), but industry-funded education materials (1) have been shown to be highly misleading (37, 66). Moreover, consumers do not have the capacity, meaning time or resources, to make the “right” choice, however much education is carried out (23). For example, tobacco industry-funded so-called “youth smoking prevention campaigns” were found to be ineffective at best and harmful at worst (67).

This industry-favourable approach to NCDs is further normalized by drawing on ideas and values that downplay the need for government interventions or that define government intervention as an infringement of personal freedoms and a slippery slope to complete rule by government (4). In contrast, commercial actors present themselves as protectors of individual freedom and as credible public health actors who can self-regulate and help to address NCDs.

The extent to which these ideas are perceived as the normal way of thinking about the drivers of NCDs and the required solutions should not be underestimated. Providing new ideas and counter-framings represents an important element of any effort to address NCDs and the commercial interests who profit from the status quo.



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Conclusion. The urgent need to address CDoH

Given the scale and cost of commercial harm and the systemic nature of the problem, including the fact that commercial wealth and power are growing while public wealth and power decline, threatening governments’ ability to address the harm and fund health care, there is an urgent need to recognize and address the CDoH (68).

This requires, at a minimum, that governments recognize that the primary interest of all major corporations is profit and, hence, regardless of the product they sell, their interests do not align with either public health or the broader public interest. Any policy that could impact their sales and profits is therefore a threat, and they should play no role in the development of that policy. Similarly, governments must also recognize the now overwhelming evidence (see also chapters 4, 6 and 7) that HHIs engage in the same political and scientific practices as tobacco companies (69) and that voluntary or multistakeholder partnership approaches do not work where conflicts of interest exist (27, 70). Instead, they must regulate other HHIs, their products and practices, as they do tobacco.

Beyond this, governments need to recognize and address the system problems that are simultaneously driving ill health and making it harder to develop and implement effective solutions to it. This will require, inter alia, that they start to regulate in the public interest rather than the corporate interest. Ways to achieve this are detailed in chapter 12 (68).

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Chapter 2.

Marketing strategies increase exposure to NCD risk factors and negatively affect NCD care



Key highlights

- Marketing strategies can have a direct impact on people's behaviours and noncommunicable disease (NCD) risks and care.
- Data-driven marketing techniques capitalize on individual vulnerabilities by targeting and personalizing digital marketing messages in ways that maximize profit.
- Marketing in most areas is largely unregulated.
- Myths and legal threats are used by industry to delay or stop the implementation of marketing restrictions.

Marketing affects both NCD prevention and care. When focusing on care, it is worth noting that the pharmaceutical and medical device industry have developed very specific marketing strategies to promote their products to both the medical community (see Box 2) and general public (see Box 3) due to their need to circumvent some unique regulations. This publication will not go into the details of these strategies, but simply provides short briefs about them (Box 3 and an example in Case study 3). This chapter focuses mainly on prevention and how promoting products to vulnerable populations increases exposure to NCD risk factors.

The marketing of products known to increase the risk of NCDs, such as alcohol, tobacco, e-cigarettes, and unhealthy foods and drinks, is a major commercial driver of poor health across the world. Through strategic and integrated marketing campaigns, industries create allure for these products, often glamourizing them

and associating them with desirable experiences and lifestyles. These marketing practices are deeply embedding these products into our everyday lives, exaggerating their benefits, and normalizing their consumption.

Marketing practices often target populations that already experience health inequities and higher rates of NCDs. For example, the tobacco industry has used First Nations imagery in tobacco advertisements, selectively targeted First Nations peoples in their marketing campaigns, and provided commercial sponsorship to First Nations foundations (1). Similarly, unhealthy food marketing has been found in greater quantities in more socioeconomically disadvantaged neighbourhoods or where high numbers of ethnic minority residents live (2). The tobacco, e-cigarette, alcohol, and food industries all target children with their



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marketing campaigns (3–5). In 1978, the tobacco industry stated that “the base of our business is the high school student” (6) – today, the colourful packaging and flavours of e-cigarettes, marketed through social media and influencers to young people online (7), suggests that little has changed. Gender-based marketing strategies are commonly used by alcohol companies to link alcohol to everyday gendered activities and identities to encourage alcohol consumption, perpetuating harmful gender norms and related stereotypes (8).

Digital marketing

With the global proliferation of the internet and social media, virtually no country is untouched by the digital marketing of health-harming products and brands. Multinational corporations are collaborating with technology giants to integrate health-harming products and brands seamlessly into our digital lives and culture. Data-driven techniques capitalize on individual vulnerabilities by targeting and personalizing marketing messages in ways that maximize profit. For example, adolescents are targeted by food companies because of their avid use of social media and increased spending power (9, 10), and alcohol companies exploited the COVID-19 pandemic by promoting the online purchase and delivery of their products alongside “fun isolation activities” (11, 12). Children are targeted through the use of so-called kidfluencers, where marketers engage children with a significant social media following and influence to endorse products and brands among younger audiences (13). The goal is to leverage the kidfluencer’s popularity to connect with their audience and drive sales. This raises ethical concerns regarding child exploitation, privacy, and the influence of commercial interests on children’s behaviour and preferences.

Industry use of digital marketing strategies has grown significantly in recent times. This is largely due to the ability to harness advanced technologies, such as algorithmic targeting and personalized messaging, facilitated by the analysis of extensive behavioural and demographic data. Digital marketing techniques are immersive, captivate audiences, and ensure maximum engagement. The dissemination of marketing content through trusted and authentic channels, including peer recommendations and influencer endorsements, further amplifies its impact. Marketing messages are seamlessly integrated into various digital platforms, such



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as social media, influencer content, advergames, and even news media. Furthermore, with the advent of emerging virtual spaces, such as the metaverse, marketers have found new avenues to connect with audiences in innovative and immersive ways. This covert approach to marketing allows brands to engage with consumers more organically, fostering deeper connections and relationships with little oversight and consumer protection. The complexity of the digital marketing ecosystem has raised concerns related to the difficulties of regulating harmful digital marketing. However, countries are starting to take action, showing that it is feasible.

Regulatory action

Regulating the marketing of harmful products and brands is a crucial response to safeguarding public health from commercial interests. Specifically, children and vulnerable populations need to be protected from exposure to the marketing of harmful products and brands. Many international organizations, including WHO, advocate for regulatory measures to protect populations, particularly children, young people and vulnerable groups, from the adverse health consequences of marketing practices by large corporations that manufacture or promote products that are harmful to health. With the notable exception of tobacco marketing laws that have been adopted in many countries, global efforts to regulate harmful marketing have, at best, been underwhelming. While legal measures regulating alcohol and unhealthy food marketing are in existence in several countries across the WHO European Region and across the world, these are often narrow in scope, focused on specific media or settings, certain population groups or on specific marketing techniques, and therefore confer insufficient protection.

A major barrier to the adoption and implementation of legal measures to protect the public from harmful marketing is the powerful opposition by commercial industries. This chapter describes two case studies outlining how governments have adopted laws to protect the public from the marketing of health-harming products, how industry has sought to undermine these efforts, and how public health groups have overcome industry's formidable opposition.

Myth busting industry arguments against marketing laws

Governments that attempt to introduce legal measures that restrict harmful marketing will face strong opposition from industry, including those marketing their products, such as food, alcohol, and tobacco, and the advertising and marketing industries as well as online platforms. The arguments used to oppose legal measures for marketing are similar across industry types, with the aim to avoid government regulation that will negatively impact sales of their products, and therefore their financial position. Common industry arguments and counter-points to these are listed below.

Myth 1. Self-regulation is sufficient. Voluntary codes of practice have often been found to be ineffective (14, 15). For example, the voluntary commitments of the food industry through the EU Pledge programme¹ have been shown to be ineffective in preventing the marketing of unhealthy food products to children (16). There is a clear conflict of interest (COI) when industries write the rules and enforce regulations for marketing practices that drive their profits and stakeholder returns.

Myth 2. People should take responsibility for their own and their children's behaviours. Individuals must make choices about what they and their children purchase and consume, but these decisions are greatly affected by the affordability, accessibility and acceptability of the healthier choices. The current marketing landscape undermines healthy population behaviours by misleading consumers, shaping choice environments, manipulating preferences, and constraining the ability to make genuinely free and informed choices about health and well-being.

Myth 3. Marketing restrictions will cause a loss of jobs and will negatively influence the economy. There is no evidence, internationally, showing that marketing restrictions have had a negative impact on jobs and/or the economy. In fact, the opposite is true. For example, examination of the Chilean Food Labelling and Advertising Law, which included restrictions on all unhealthy food marketing considered to be directed to children, revealed no discernible effect on labour market outcomes within the food and beverage industry – including aggregate employment and average real wages – during the 18-month period following the policy's enactment (17).

Myth 4. Marketing does not target children or other vulnerable groups. Even if marketing does not specifically target a particular group, marketing is insidious, and individuals share many of the same spaces, settings, and devices and consume the same media. Marketing shapes social norms as well as more immediate behaviours, regardless of whether it is targeted or not.

Legal threats

Governments are also often concerned that their legal mandate to regulate marketing will be challenged either domestically or under international investment law or trade law, such as through regional trade bodies, or through World Trade Organization (WTO) procedures. Four common legal arguments industry uses to threaten legal action to stall marketing laws include:

1. the law is discriminatory as it applies to certain products and not others;
2. the government does not have the mandate or jurisdiction to introduce the law;
3. the marketing restriction impinges on commercial rights to trade or use intellectual property; and
4. the legislative response is more trade-restrictive than necessary.

The forceful propagation of these legal threats by industry to avoid marketing regulation has stifled policy progress and/or eroded existing laws. However, governments do have the jurisdiction to introduce public health laws if the legal principles related to trade and investment are observed and accounted for (18–21). Working with in-country lawyers throughout the policy development process has been crucial.

Case study 1. Harnessing civil society to overcome industry influence in national food marketing policy

In 2021, the Government of the United Kingdom announced global landmark food marketing restrictions, including a ban on all marketing of foods and beverages high in fats, salt and/or sugar (HFSS) between the hours of 05:30 and 21:00 on television and a ban on paid-for HFSS food marketing online, as part of a multi-faceted obesity strategy (22).

This announcement was the culmination of approximately 20 years of effort from a range of stakeholders, including academics and medical associations. The role of NGOs and civil society to inform policy-makers, engage the media, and garner public support for tougher restrictions was pivotal to pushing back on industry influence and ultimately having the policy enacted into law (read more in Chapter 13). Key NGO and civil society groups include:

1. the Obesity Health Alliance (OHA) (23), established in 2015 as a coalition of more than 50 organizations advocating together for policies to address obesity and improve population health;
2. Bite Back 2030 (24), an innovative youth-led movement to influence government to put young people's health first; and
3. the Children's Food Campaign, run by Sustain (25), a consortium of NGOs and advocates. More details can be found in a report by the Center for Digital Democracy (26).

Throughout policy development, the industry maintained strong opposition, including undermining the science (27) and the rationale for the policy, calling it a tokenistic ban (28); lobbying policy-makers to repeal or delay implementation of the policy; and offering alternative, more limited proposals, claiming they would be more effective (28).

NGOs and civil society organisations (CSO) swiftly mobilized a collective, representing the public health community with coordinated effort and messaging (29) to advocate for enactment and implementation of the policy. Research collaboration with academics on topics, such as the ineffectiveness of existing (industry-led) television advertising restrictions, provided important data (30) to support development. Effective relationships with key government agencies, especially the Department of Health and Social Care, were leveraged and industry rhetoric and research were rapidly challenged (31). Throughout the process, these organizations created and maintained pressure on the Government to act on evidence and deliver on its commitments, including via policy position papers (32). Bite Back 2030 (24), in partnership with academic institutions, created youth-led advocacy campaigns; for example, their Fuel us, Don't Fool Us campaign revealed the huge reliance of food manufacturers on unhealthy food and beverages to make profit in the United Kingdom.

As a result of this coordinated action, the legislation to restrict HFSS food advertising was enacted as part of the United Kingdom's Health and Care Act in 2022, although its implementation has been delayed to October 2025.

Case study 2. Overcoming industry opposition – the French *Loi Évin* to restrict alcohol marketing

The French alcohol law named *Loi Évin* was enacted in 1991 to regulate the advertising and promotion of alcoholic beverages, particularly those targeting youth and vulnerable populations. Over time, the law has faced criticism and debate over its effectiveness and implementation and its balance between public health objectives and commercial interest. The law has faced intense opposition from the alcohol industry, which has used long-term lobbying strategies and carefully constructed arguments to weaken its design, implementation and effectiveness (33). In fighting back, proponents of the law have also had some wins.

The law mandates that all promotional messages for alcohol must be accompanied by a health warning and provides a list of where alcohol can be promoted if the marketing message is for the purpose of providing objective information. So-called permitted media include printed press for adults, radio (at certain times), billboards, posters, displays at points of sale, and digital media, except if young people are specifically targeted or the advert is surreptitious or hidden. The implication is that alcohol cannot be promoted through all other media and settings, such as on television or through the sponsorship of sports or other events.

Legislative reforms over time have expanded the list of media where alcohol marketing may be allowed, thereby eroding the scope and potential effectiveness of the law (34). For example, in 1994, alcohol marketing in public spaces was added to the permitted list and, in 2009, digital media was added if it does not target children. This has created a major loophole, and children remain exposed to digital marketing online (35). This is because digital platforms are often shared spaces between children and adults, age verifications are easily circumvented, and there is a lack of transparency and independent data to monitor what advertising specifically targets children online.

These reforms have been in response to persistent lobbying by the alcohol industry. The Association Nationale de Prévention en Alcoologie et Adictiologie (ANPAA) documents 15 tactics that the alcohol industry has undertaken in recent times to undermine the law, including undermining the science, spreading misinformation, the development of “prevention plans”, intimidation of advocacy groups, and lobbying of policy-makers (36). The exploitation of legal loopholes has also been widely documented, including the use of alibi marketing by alcohol companies in sports. This involves using core elements of a brand’s identity, such as colours, slogans, shapes, or symbols, to create positive associations with its brands or products, instead of directly featuring the brand name, logo, or specific products (37).

Public health and CSOs have sought to protect the law from erosion through strong advocacy and public litigation against infringements. For example, in 2017, the ANPAA challenged an advertisement on a website owned by a beer company, which referenced the *Game of Thrones* series, thereby contravening the *Loi Évin* (by way of associating alcohol with fantasy and adventure). The court upheld the challenge, affirming that the advertisement had nothing to do with providing factual information related to the production methods or the regions of origin of the beer, but instead promoted the consumption of an alcoholic beverage among youth (38).

Box 2. Pharmaceutical promotion to health professionals and health consumers negatively affects NCD care

A 2018 WHO report focusing on cancer medicine reported that, across all pharmaceutical company categories, expenditures related to selling and marketing represented between 25% and 31% of industry-reported costs, compared to 5% to 19% for research and development (39).

Most of this marketing effort is directed at doctors and other health professionals. They are exposed to widespread pharmaceutical promotional practices during their entire career, starting at medical school and through to continuing medical education (CME)-sponsored events, and through educational material from sales representatives and gifts, and the distribution of free samples, where it is not banned, to seed the market. In France, almost all medical students surveyed in 2019 had been confronted with pharmaceutical product promotion (40). COI policies remain poorly implemented at medical schools (41). A 2018 survey identified policies related to COI for only two of 38 German medical schools (42).

A well-known example of sponsored CME events is the OxyContin marketing campaign in the United States that led to the medically-induced opioid crisis, which started at the turn of the century. It initiated a trend credited with causing more than 600 000 deaths between 1999 and 2021 in the United States (43) and its effects are still felt today. As part of its marketing strategy, OxyContin manufacturer Purdue conducted more than 40 national pain-management and speaker-training conferences at resorts in the United States between 1996 and 2001; more than 5000 physicians, pharmacists, and nurses attended these all-expenses-paid symposia, where they were recruited and trained for Purdue's national speaker bureau (44).

While a systematic review found that exposure to information provided directly by pharmaceutical companies was associated with higher prescribing frequency, higher costs, or lower prescribing quality (45), a recurrent research finding is the cognitive dissonance observed among health professionals – believing that they are themselves immune to the effects of promotion, while being convinced their peers are influenced. This has been observed all over the world, among all health professionals, and this perception is consolidated during their training (46).

Box 3. Direct-to-consumer advertising of medical products

Direct-to-consumer advertising (DTCA) of prescription drugs is illegal in Europe; however, other forms of direct and indirect promotion to the public occur. These include industry-sponsored disease awareness campaigns, promotional material on the internet, and patient compliance and disease management programmes.

Disease awareness campaigns are a marketing strategy that has since long been denounced as such (47). An example is the recent worldwide shingles awareness campaign sponsored by GlaxoSmith-Kline (GSK) to promote its vaccine (48).

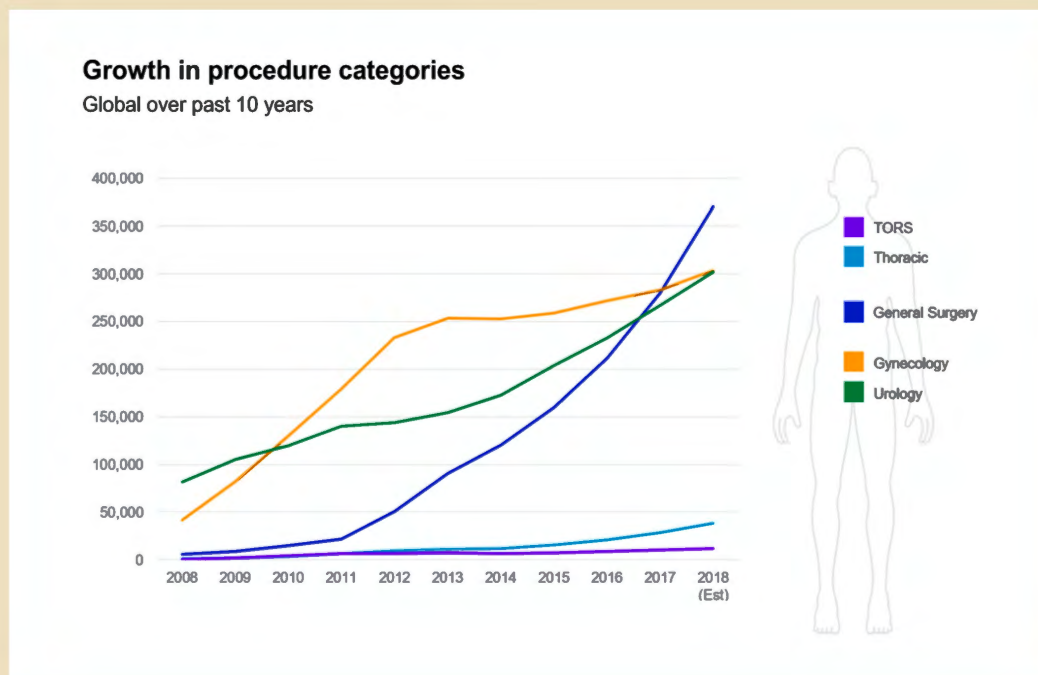
Unbranded advertising campaigns prompt consumers to “ask your doctor” for treatment. In many low- and middle-income countries, prescription-only status is poorly enforced, and people can generally buy any medicine at pharmacies without asking their doctors. In countries where prescription-only status is well enforced, such unbranded campaigns have been shown to result in more prescriptions (49).

The promotion of non-evidence-based screening tests is not regulated and is a growing concern, particularly as direct-to-consumer laboratory tests become increasingly available, notably through the internet (digital marketing). Companies heavily promote packages of screening tests that individuals can purchase regardless of their age and risk factors. Private clinics market “full check-ups” to health-conscious consumers, typically involving blood tests and full-body imaging. Most of these screening tests and procedures are conducted without any valid medical indication, and their sensitivity/specificity is unclear. Furthermore, their capacity to reduce the incidence or mortality of NCDs is absolutely not demonstrated. These tests are not part of any established screening pathway nor are they subject to a quality assurance scheme; therefore, if an abnormal result is detected, it can lead to all sorts of diagnostic procedures and overtreatment. Many of the unnecessary diagnostic procedures and treatments resulting from such “wild screening” are not only costly but can also cause mental and/or physical harm to individuals who were originally in good health (50).

Case Study 3. Promotion of surgery robots and its consequences in the United Kingdom

Another example of how industry promotion and marketing strategies can negatively affect NCD care and deepen inequalities is from the medical device industry. In the last two decades, the Da Vinci Robotic Surgical System has been one of the major new technologies within cancer care. The device was approved by the United States Food and Drug Administration (FDA) in 2000 and enables surgeons to undertake minimally invasive surgery while sitting at a console to operate remote-controlled arms. The number of robotic systems, offering different console options, image enhancement and size, is also growing rapidly with numerous manufacturers now in the market offering more technical or lower cost options (51). Expected advantages of this technique included improved ergonomics for the surgeon, better visualization of the surgical field, and an enhanced range of motion within the surgical field, which is expected to translate into improvements in patient outcomes, particularly when compared to open and laparoscopic techniques (52). However, the improved functional and oncological outcomes have failed to materialize for a range of cancer types (53–55). Despite the lack of clear evidence, it has undergone rapid adoption across the United States and Europe, even penetrating many middle- and low-income countries (56–57) (Fig. 4). It could now be considered the cornerstone of surgical treatment for prostate cancer in these countries and other cancers, such as colorectal and head and neck cancers, with increasing utilization across tumour types, despite the lack of level-one evidence and routine surgical procedures (52, 58, 59).

Fig. 4. – Grown in robotic surgery within particular anatomical disease areas.



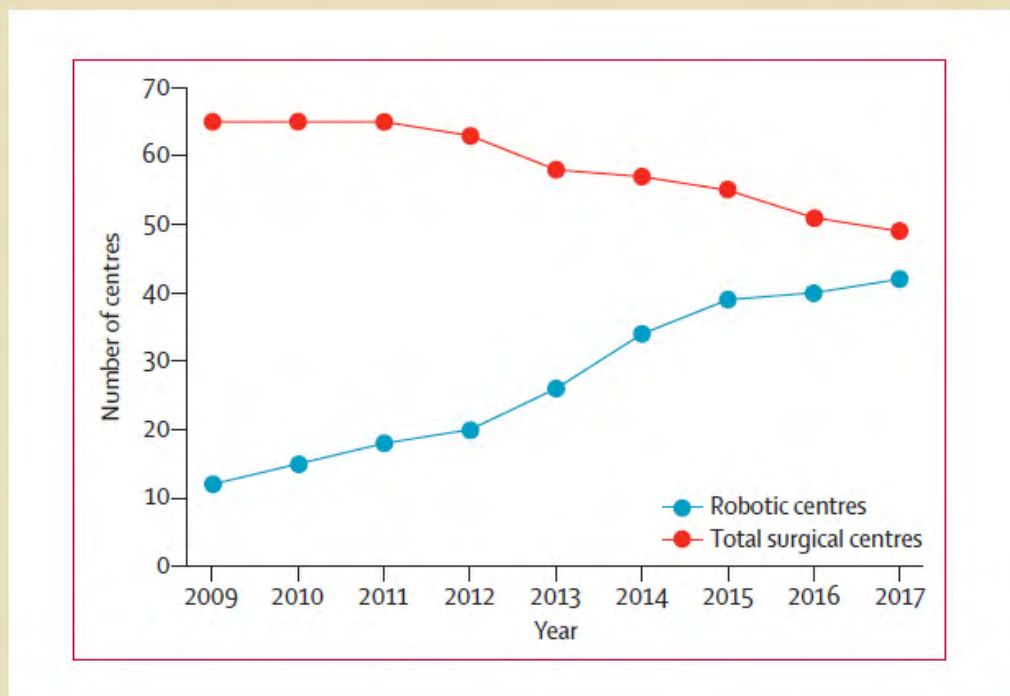
Source: reproduced with permission of Elsevier B.V. (60) published under CC BY 4.0 DEED, Attribution 4.0 International (<https://creativecommons.org/licenses/by/4.0/>)

This rapid adoption is in part because robotic surgery and its marketing has become one of the most significant technological markers of reputation stimulating patient mobility for health-care services (61).

continued

In the English National Health Service (NHS), where health care is free at the point of use, the piecemeal adoption of robotic surgery for prostate cancer and colorectal cancer has resulted in the significant bypassing of local centres by men wishing to access these treatments at alternative centres where it was routinely available (62, 63). Over a six- to eight-year period, the number of robotic surgery sites increased from 25% to 90% for prostate cancer surgery (64) (Fig. 5). This occurred prior to commissioning/health technology guidance on its adoption. Essentially the market had supported its rapid adoption. The substantial levels of patient mobility, driven by the differential availability of robotic surgery, has meant that hospitals have needed to compete with other hospitals to retain their local patients and prevent a loss of income (64). This resulting competition contributed to the closure of one in four radical prostatectomy centres in the NHS and widespread adoption of robot-assisted radical prostatectomy. Similar processes are occurring across other tumour types at present (62).

Fig. 5. Changes in the number of robotic centres and total number of centres in the NHS in United Kingdom (England) (2009–2017)



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Policy considerations and implications

The above case studies illustrate both the scope and force of industry opposition to restrictions on harmful marketing, which includes the marketing of products that are not harmful as such but can become harmful when marketed in certain ways. They also illustrate the power of public health advocates within CSOs to overcome such challenges and achieve legislative change for the benefit of public health.

- Strong and resilient collaborative actions within the public health community, including academics and lawyers, have enabled several governments to restrict the marketing of food, alcohol, and tobacco, as well as medical products despite industry pushback.
- Restrictive policies should be future-proofed where possible to reflect the rapidly shifting and innovative digital marketing ecosystem, and made sufficiently robust to minimize the existence of loopholes that could be exploited by industry to continue to promote their products in harmful ways, even after the implementation of restrictions.
- Regular monitoring, evaluation, and review must be built into the policy cycle, so any weaknesses in protection can be identified and resolved promptly. As a result, the maximum public health benefit can be realized, including meaningful reductions in health inequalities and NCD incidence across the Region and beyond.

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Chapter 3.

The negative influence of industry structure and market power on policies



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Key highlights

- Market concentration, which places the control of entire sectors into the hands of a limited number of powerful commercial actors, is very high in most HHLs and the pharmaceutical sector.
- Given their economic importance (as providers of employment and tax revenues), firms in concentrated sectors are often of key strategic importance to governments, which confer such firms with significant political power relative to state actors.
- High levels of access to policymakers can lead to increased government hesitancy to implement policies and regulations that could threaten the profit-making abilities of these dominant firms.

Market concentration places the control of entire sectors into the hands of a limited number of powerful commercial actors. The majority of HHI are oligopolistic in nature and, in some cases, oligopsonistic. In the pharmaceutical sector, market concentration is very high as well, with some suggesting the sector is a conglomerate of monopolies (1) (see definitions below). This has important ramifications for efforts to curb the consumption of the products and medications they produce, market and sell, while concentrated markets often also confer dominant firms with considerable political power (2,3).

Box. 4. Key definitions

Monopoly: a market in which a single large firm has the exclusive possession or control of the supply of or trade in a commodity or service, making it a market without competition

Oligopoly: a market in which there are only a few large firms (sellers) that dominate the market, thus limiting competition

Oligopsony: a market in which a few large buyers dominate demand

When it comes to market strategy, high levels of market concentration provide leading firms with:

- a) the ability to control the production, marketing, distribution, and pricing of products along supply chains; and
- b) the power to generate profits at the expense of other market stakeholders, including consumers and suppliers (2).

Such market concentration, and by extension supply chain control, in HHIs is typically achieved through mergers and acquisitions (M&As) or strategic partnerships with relevant supply chain actors. The most relevant forms of M&As in the context of this chapter are, first of all, horizontal integration, also known as consolidating acquisitions, aimed at increasing market share by eliminating competition. A second type is vertical integration, which is aimed at supply chain control through acquisitions of, or gaining control over, suppliers, distributors or buyers, and confers firms with a high level of structural advantage over rivals and new market entrants. A final relevant type of M&As are so-called product extension mergers, which are about the expansion of a product or service offerings. That is, rather than focusing on merging with a company in the same industry with similar offerings, firms target businesses with different products and services than their own. By acquiring or merging, a company creates opportunities for cross-promotions and sales and navigates or circumvents regulation. In the pharmaceutical sector, market concentration stems primarily from legislative protections (most notably patents), market exclusivity, data protection, and other policy measures designed to give pharmaceutical companies the chance to recoup investment in a new drug and keep would-be competitors out of the market (4).

Apart from supply chain control, having high levels of market concentration also typically means that firms are very large and profitable, which in turn means they have more resources that they will be able to dedicate to branding and promotional practices. Highly concentrated sectors often also consist of firms with high levels of transnationality, meaning business extends or operates across national boundaries, which allows firms to expand into new markets more easily (3).

Furthermore, given their economic importance as providers of employment and tax revenues, firms in concentrated sectors are often of key strategic importance to governments, which confer dominant firms with significant structural and relational power relative to state actors. That is, such firms typically have high levels of access to policy-makers and this, as well as their structural power, can lead to increased government hesitancy to implement policies and regulations that could threaten the profit-making abilities of these dominant firms as well as the wider stability and health of national economies (2). In addition, there is ample evidence that the greater resources commanded by large and, in particular, transnational firms are known to increase their ability to exert political influence (3).

This chapter includes three case studies. Case study 4 looks at the implications of increased market concentration in the meat sector. There is ample evidence of the influence of meat trade and consumption on diet-related NCDs, such as colorectal cancer, diabetes and coronary heart disease (5–8). Recent research has shown that, in the European context, the impact of red and processed meat trade on diet-related NCDs in the northern and eastern parts of Europe is particularly severe. That is, the incidence of diet-related NCDs in these countries has increased most rapidly due to trade in and, as a result, consumption of red and processed meat (5). There is another way that consumption and trade in meat and other animal foods is having an impact on the spread of NCDs: they are responsible for 14.5% of all greenhouse gas emissions (6) and, as is well known, there is a clear link between climate change and NCDs, including stroke, heart disease and asthma (9). Case study 5 looks at M&As and business partnerships between soft drink companies and firms in the alcohol sector. Research has shown that both the consumption of soft drinks as well as alcohol consumption are related to NCDs (10, 11). Alcohol is responsible for an estimated 3.3 million deaths globally every year (5.9% of global mortality) and accounts for approximately 5% of the global burden of disease, while alcohol consumption is also responsible for a range of socioeconomic as well as health harms (12,13).

The pharmaceutical industry's influence is evident in the pricing and availability of NCD medicines. Commercial interests often drive the focus towards more profitable markets, sometimes at the expense of equitable access. Case study 6 focuses on mechanisms of the pharmaceutical industry to keep monopolistic positions and delay the development of generic competitors. Box 5 illustrates the issue of high prices for innovative medicine.



Case study 4. Meat production in Europe

As a recent report shows, market concentration in the meat sector has increased significantly over the years globally (14). Today, ten very large global meat companies play a defining role in determining how meat and feed are produced, transported and traded. These ten meat producers and processors have their headquarters in just five countries/regional blocks – Brazil, China, EU, Japan and the United States – but through their globalized supply chains, they dominate markets around the world and have a presence in all the main meat-producing regions.

These large companies also have a very strong presence throughout Europe. Companies such as JBS S.A. (Brazil), WH Group (China), Crown (Denmark), Tyson (the United States), Cargill (the United States) generate their European profits by selling fresh and frozen meat produced in Europe or meat products imported from other countries, such as Brazil and Thailand. They have used M&As to swallow up small and large firms to significantly increase their market power in Europe and to gain control over the entire meat supply chain (14). These firms are typically involved in, or even control, everything from meat farming and production to processing and trading and often also own distribution centres, so they can distribute the products directly across Europe. Some relevant recent M&As include United States meat giant Tyson's acquisition of all European operations of BRF (Brazil), the world's eighth largest meat company (15), and JBS buying up one of the biggest United Kingdom-based pork meat processors to expand its European market share (14). JBS is also considering buying German meat company the Tönnies Group, which is one of Europe's largest meat producers and the German market leader for pork production (16).

The market power these firms have gained as a result of these developments has, according to research, hindered a reduction in meat consumption as it enables them to exert influence throughout the supply chain; for example, by imposing low producer prices and forcing farmers to sell below their cost of production (17). This has other consequences too: farmers must raise large numbers of animals in order to keep satisfying the demand of the big meat companies dominating the market and, to survive in such an economic climate, they often rely heavily on public subsidies for support (14). For instance, EU cattle farmers rely on direct subsidies for at least 50% of their income (14).

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Market power often also translates into political power. A recent illustration of this in relation to the meat sector is its successful lobbying effort (read more in Chapter 4) related to the EU's Farm to Fork strategy, which was launched in 2020 (18). Part of the EU's Common Agricultural Policy (CAP) 2023–2027 and at the heart of the European Green Deal, the aim of the strategy is to make the EU's food system fairer, healthier and more sustainable. It has a strong emphasis on NCDs, as illustrated by this passage from one of the key documents published by the EU detailing the strategy:

Moving to a more plant-based diet with less red and processed meat and with more fruits and vegetables will reduce not only risks of life-threatening diseases, but also the environmental impact of the food system. It is estimated that in the EU in 2017 over 950 000 deaths (one out of five) and over 16 million lost healthy life years were attributable to unhealthy diets, mainly cardiovascular diseases and cancers. The EU's 'beating cancer' plan includes the promotion of healthy diets as part of the actions for cancer prevention (18).

However, recent analyses show that more than two thirds of the strategy will likely remain unimplemented before a new European Commission takes office in November 2024, with most legislative proposals still under discussion by lawmakers and some of the most ambitious initiatives either having been put on ice indefinitely or scrapped entirely (19). A key reason for this derailing is that the legislation has fallen victim to an intensive political campaign by industrial pressure groups and evidence suggests that multinational meat giants, together with companies, such as petrochemical or pharmaceutical companies, have played a pivotal role in these efforts (20). The political campaign by the meat industry has consisted of intensive lobbying against key components of the strategy (21, 22) as well as abusing science (read more in Chapter 6) and skewing media coverage in relation to Farm to Fork (22). For instance, meat lobby groups, including the Liaison Centre for the Meat Processing Industry in the European Union (Clitravi) and the European Livestock Voice, have commissioned studies that attack the Farm to Fork strategy (22).

These efforts have been successful because proposals put forward as part of the Farm to Fork strategy, such as explicit references to health risks associated with intensive farming, requirements to increase transparency by labelling products, and the ability of EU Member States to impose higher taxes on unsustainable products, have all been delayed or watered down (22). Another proposal – to ban the financing of the promotion of red meat – was not just delayed but blocked (23). In fact, in recent years, the EU has invested millions of euros into campaigns to promote beef consumption, among which a €4.5 million initiative called "Proud of EU beef" supports two beef lobby groups: Provacuno in Spain and APAQ-W in Belgium (24). Big meat companies have also lobbied against initiatives to promote and fund research for the development of alternative protein sources, and with success: reports show that, because of their political power meat companies have been able to block the development of greener and healthier alternatives (17, 25). A recent analysis of lobbying, subsidies and regulations showed that money spent on lobbying by meat producers in the EU dwarfed lobby efforts for alternatives and that of all research and innovation spending, 97% went to meat producers rather than to plant-based meat or cultivated meat groups, and almost all these funds were aimed at improving meat production (17).



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Case study 5. Nonalcoholic beverage industry product extension into the alcohol sector

A relatively recent development is HHI forming partnerships with firms in other sectors, which are also often health-harming, or which engage in product extension mergers and acquisitions by targeting businesses with a product or service offering different than their own.

A clear example is the nonalcoholic beverage industry forming partnerships with and/or buying up companies in the alcohol sector, such as the Coca-Cola Company's expansion into alcohol products. Six years ago, the Coca-Cola Company started to steadily build up a portfolio of alcoholic beverages. The first step was taken in 2018 in Japan, when the company launched Lemon-Dou, its first ready-to-drink alcohol beverage (26). Two years later, in 2020, the company paired with Molson Coors to make Topo Chico Hard Seltzer. And in 2022, Coca-Cola entered into agreements to produce Schweppes Pre-Mixed Cocktails, Fresca Mixed Cocktails, Simply Spiked Lemonade and, in 2023, a canned Jack Daniels and Coke (27). Chico Hard Seltzer is now available in more than 20 markets, including several European countries (28); and Jack Daniels and Coke is available in Mexico, the United States, and a selected number of countries in Europe, including Netherlands (Kingdom of the), Spain and the United Kingdom, with other markets likely to follow in the coming years. In the United Kingdom, Coca-Cola also launched Jack Daniel's & Coca-Cola Zero Sugar and there are plans to roll out this variant to more markets, including other European countries, from 2024 as well (29).

In 2022, PepsiCo followed Coca Cola's example by also moving into the alcoholic beverage market, although it has to date focused solely on the United States market. The company first signed a deal with the Boston Beer Company and launched Hard Mountain Dew (5% alcohol by volume) in 2022 and, in 2023, it entered a business arrangement with brewing company FIFCO USA to produce a series of iced-tea-flavoured alcoholic beverages called Lipton Hard Iced Tea (30).

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Initially, Coca-Cola and PepsiCo only entered distribution partnerships with alcohol companies, which meant that they licensed their brands to manufacturers who own the alcohol products and formulas and use Coca-Cola's and PepsiCo's logistics expertise and relationships with retailers to distribute the final products. One reason for this is that, in many countries, regulations prevent them from directly purchasing alcohol companies. For instance, in the United States, a liquor manufacturer is not allowed to also be a liquor distributor. In Europe, such rules do not exist and therefore Coca-Cola was recently able – through its production, bottling and distribution company Coca Cola HBC – to directly purchase the alcohol company Finlandia Vodka. Finlandia is a particularly strong vodka brand in the central and eastern European region where it sells 2.7 million nine-litre cases per year (31).

This development has raised public health concerns. Public health experts are particularly worried about the ready-to-drink alcohol drinks Coca-Cola and PepsiCo are involved in (27). Sales of these hard seltzers and ready-to-drink canned cocktails have exploded since the two soft drink giants entered this market. These products tap into consumers' connection to brands that they are very familiar with for many years. Moreover, as these types of drinks tend to be inexpensive, packaged in single-serve containers, and sold in places such as petrol stations, supermarkets and corner shops, they appeal to young people. This has the potential for tragic consequences and could reverse the long-term decline in alcohol consumption by young people (32). It is also suggested that the push into hard sodas appears to have targeted the female drinker, whose alcohol intake has been catching up to that of men in recent years (27). "A low-calorie, flavoured alcohol beverage has been their tried-and-true approach to attracting a female market (27)."

Case study 6. Keeping monopolistic position as long as possible: how pharmaceutical companies fight behind-the-scenes wars over generic drugs

The pharmaceutical sector has also gone through a process of increased market concentration. For instance, in the United States in the period between 1995 and 2015, 60 pharmaceutical companies merged into 10. As a result, pharmaceutical companies have become much more selective about which drugs they make, which, in turn, means that entire areas of medicine research have been effectively abandoned (33). What is more, the market and political power of big pharmaceutical companies has been strengthened even further because these companies enjoy actual monopolies due to the way the sector is regulated. That is, medicines are made under patent, giving the producing pharmaceutical companies full control over the drugs for which they own intellectual property rights (IPR). As IPR rules have become much tighter, stricter and more global over the last four decades - influenced by the political pressure from and power of pharmaceutical companies - pharmaceutical companies have become among the most profitable and transnational companies in the world (34). From 2000 to 2018, the profitability of large pharmaceutical companies was significantly greater than that of other large, public companies (35).

The pharmaceutical industry employs all kind of tactics to delay or prevent generic competitors from entering the market, allowing brand-name drug makers to maintain their monopolistic position and, as such, keep prices high and maximize profits. Below are some examples of how these campaigns unfold.

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1 Refusing collaboration with generic companies and blocking access to samples

Some brand-name manufacturers intentionally obstruct cooperation with generic companies, notably by preventing generic competitors from fulfilling regulatory requirements. Furthermore, for some type of medicines, generic drug manufacturers need access to samples of the brand-name drug to demonstrate equivalence to the United States FDA and European Medicines Agency (EMA). Some brand-name drug makers refuse to provide samples to generic companies, hindering their ability to prove bioequivalence. Without access to samples, the FDA and EMA cannot approve the generic version, thereby allowing the brand-name drug to maintain its monopoly (36).

2 Smear campaigns

A smear campaign is a deliberate effort to spread false or misleading information about the safety, efficacy or quality of a generic medication. Such campaigns are usually initiated by pharmaceutical companies or affiliated stakeholders to maintain market dominance or higher prices for brand-name drugs. Tactics used in these campaigns may include disseminating unfounded claims about adverse effects, questioning the bioequivalence of generics, or casting doubt on regulatory approvals, as well illustrated by the story of the Janssen-Cilag laboratory first preventing and then restricting the development of generic versions of Durogesic (an opioid analgesic) in France. As stated by the French competition authority which fined the laboratory for €25 million, “These are grave practices” (37). Another example resulting in a fine of €40.6 million by the same French competition authority is the strategy of denigration against generics of Plavix (a cardiovascular disease medication) implemented by Sanofi-Aventis (38). The goal of such practices is to undermine a doctor’s confidence in a generic drug, thereby discouraging its use and potentially preserving market share for more expensive brand-name alternatives. Smear campaigns impede health-care cost savings and erode trust in the pharmaceutical industry and regulatory agencies.

3 Fighting patent wars

Another way pharmaceutical companies delay generic drugs from entering the market is by filing additional patents. A recent report shows that pharmaceutical companies filed for a sizeable number of attempted patents – 1500 – on the 12 best-selling drugs in the United States, most of which were granted, aimed at further strengthening their monopolistic status well beyond the 20 years of protection they already typically enjoy under current IPR rules (39). One such company, AbbVie, applied for over 250 patents for their arthritis drug Humira in the United States. Rival drugmakers launching generic versions of the medicine found themselves blocked in court. So, while the medicine was launched in 2003, the first competitors could only enter the United States market in 2023, while Humira biosimilars became available in Europe in 2018. This has led to the observation that lawyers and lobbyists have become the key figures of the pharmaceutical industry instead of researchers and medical experts (33).



Box 5. High prices versus fair prices for innovative medicines

National public health insurance and private health insurance are the main clients of the pharmaceutical industry. In a monopolistic situation, such as is the case for novel drugs, orphan drugs, and often oncology drugs, prices are simply what the market can bear (40). Extremely high prices have become the norm and a growing threat to health-care budgets. “The most expensive drug in the world” (41), Libmeldy – a gene therapy treatment, for a rare disease, costing €2.5 million – has recently become available in Belgium, Ireland, and Netherlands (Kingdom of the). Pharmaceutical expenditures are increasingly driven by high-cost drugs used by small numbers of patients. In Belgium, five oncology drugs made up 12% of the entire pharmaceutical expenditure in 2022 (42).

The justification offered by the pharmaceutical industry – high prices because of high research and development costs – has repeatedly been proven wrong. For example, a recent study found that three years is the median time required to offset development costs for oncology drugs (43). Another common argument for high prices is that the medicine should be rewarded according to its value; for instance, the price of a curative gene therapy should reflect all health expenses that would have occurred during the life of the patient if they had not been cured. A French pharmacologist argues that this equates to rewarding fire fighters according to the value of the destruction they prevented by extinguishing a fire (44).

The Drugs for Neglected Diseases initiative (DNDi) has shown that another, not-for-profit drug development model is possible. DNDi has, for instance, developed a simple-to-use, affordable cure for hepatitis C and neglected diseases, such as leishmania and sleeping sickness (45)

Summary

Leading firms in concentrated sectors and markets typically control cross-border production, marketing and distribution processes and hold significant political power relative to states. The case studies discussed in this chapter show that market concentration is high in most HHIs, as well as in the pharmaceutical industry, and that this has significant implications for policy efforts to constrain the consumption of harmful products and for the medications these firms produce.

Policy considerations

- The public health community should take market structures and by extension the market power of firms into consideration when developing ways to tackle NCDs and pharmaceutical policies
- To do so, it is vital that policy-makers, CSOs and researchers pay more attention to understanding, identifying, tracking, and addressing the market power of firms in key sectors.
- One key question from a public health perspective is which form(s) of market structure (a) is/are least likely to increase the use of health-harming products and (b) has/have the most positive impact on the types of medicines being developed/produced, as well as on the price consumers pay for such drugs.

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Chapter 4.

Industry lobbying and its impact on NCD policies



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Key highlights

- Commercial actors engage in a range of activities to shape the policy and regulatory regimes relating to their businesses.
- This includes long-term, proactive relationship-building strategies with policy-makers to shape the regulatory environment and short-term reactive tactics, such as legal challenges, to block or delay unfavoured policy proposals.
- These commercial actors seek to frame the terms of policy debates in ways amenable to their interests and to present positive images of their businesses, products and services through CSR strategies.
- This chapter highlights these approaches through case studies of the tobacco, electronic cigarette, food/beverage and pharmaceutical industries.

Introduction

Lobbying – the formal and informal engagement between industry actors and policymakers, regulators and other governance actors for the purpose of shaping policy outcomes – is a widely employed but perhaps misleading catch-all term for the myriad ways in which commercial actors seek to influence policy and policy-making processes. As a concept, it is predominantly used to describe a direct and often explicitly transactional form of political influencing. It suggests these processes are issue-specific, proximate, and targeted at achieving particular overtly expressed short-term outcomes. This form of lobbying is often reactive and, in the case of HHLs, designed to prevent policy proposals or government initiatives. While this type of lobbying practice is an important component of HHLs' political strategies, their efforts to influence policy extend well beyond this, and are more varied, hidden, nuanced and sophisticated than many public health actors and policymakers often perceive. The full gamut of their approaches over both the short and long term is more accurately captured by the concept of corporate political activities (CPA), described as "practices to secure preferential treatment and/or prevent, shape, circumvent or undermine public policies in ways that further corporate interests" (1). These "non-market strategies" are designed to complement and support companies' "market strategies" to promote products and drive sales, by seeking to establish favourable regulatory environments (2). The following sections introduce key aspects of CPA in which HHLs engage to shape policies and policy-making processes in their interests.

Long-term influencing strategies

A vital component of CPA involves long-term, proactive forms of relationship-building through which industry actors seek to present themselves as legitimate policy stakeholders and key partners to governments in addressing health harms associated with their products (3, 4). This occurs through participation at various stages, and in different forums, throughout the policy process – by attending meetings, responding to consultations, and participating in expert advisory groups – through the promotion of voluntary self- and co-regulatory policy responses (5, 6).

A key example of this is how commercial actors, whose products are damaging to health or the environment, worked collectively to promote the "Better Regulation" agenda in the EU and similar initiatives elsewhere (7, 8). Internal industry documents show tobacco companies used this to make it more difficult for governments to pass public health policies (7), and subsequent evidence shows they have gone on to use "Better Regulation" in that way (9–11).

At certain times, regulatory and policy-making bodies may perceive their interests – and those of the populations they represent – to be synonymous with those of the industry or to be beholden to businesses to such an extent that they are unable to take independent decisions in the public interest; a situation described as regulatory capture (1, 12). This may lead to not just industry-favourable domestic policies, but to national governments promoting the interests of HHLs in bilateral engagements with other states and in multilateral forums, such as the WTO (13).

Policy framing

HHLs seek to shape perceptions of their products, their health effects and the scale of the issues associated with their use or consumption. This involves minimizing or downplaying the scale of harm; exaggerating their positive value, in the case of medicines or health products; claiming that effective policy responses or regulation would either be unworkable or would have negative, unintended side-effects; and instead promoting ineffective but industry-favourable alternatives (1, 14). Such alternatives often include industry-funded youth education programmes on harmful products, such as alcohol, for which there is limited evidence of effectiveness (15). In addition, they seek to legitimize their participation in policy-making by projecting the perception or image of themselves as individual companies and wider industries having responsibility and expertise. In this way, they present themselves as part of the solution to tackling health harms as opposed to key vectors of harm. These strategies have been evident in the practices of the global alcohol industry (5, 16). For example, in Poland, industry actors succeeded in framing alcohol tax debates in primarily economic, as opposed to health, terms to minimize their impact and marginalize health actors and interests from the decision-making process (17).



Reputation management

Such efforts are supported by wider so-called reputation management or CSR initiatives, which serve to promote the reputation of commercial actors, distract from the harms they cause, shift the focus to other issues not associated with their products, and enable policy influence (1, 14, 18). For example, in Greece, after Philip Morris International (Philip Morris International) donated ventilators for the COVID-19 response, its chief executive officer (CEO) was invited to join a Chamber of Commerce roundtable discussion on the COVID-19 vaccine alongside the Greek Prime Minister, in contravention of Article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC) (see Table 1 in (9)). CSR is thus best understood as a tax-deductible public relations exercise that serves to shape policy outcomes against the public interest (19–21).

Subverting science

Closely aligned to this is HHI's so-called epistemic strategy (22), designed to influence the informational environment surrounding policy debates and shape the body of policy-relevant evidence available to and used by key decision-makers (1, 14,

23). This involves industry actors producing, funding and widely promoting often methodologically weak and conflicted research that supports industry-favoured policy framings and positions, and promoting this to the media, government and other relevant policy actors, while contesting public health evidence in an attempt to shape policy outcomes (4, 5, 16, 23, 25).

Undermining policy responses

Even where governments succeed in implementing more effective policies to tackle the harms resulting from HHIs, commercial actors seek to stymie or delay their implementation, water down their effects, and ultimately reverse them. For example, the long, well-documented history of tobacco industry lobbying, evident through internal tobacco industry documents (25), led to the agreement of the FCTC in 2005 and the inclusion of Article 5.3, which aimed to prevent the undue influence of the tobacco industry over policy (9). However, enforcement remains partial and incomplete and tobacco industry engagement remains common in some areas, including in many European countries (26, 27). Tobacco industry actors have consistently sought to undermine and circumvent Article 5.3 (28), most recently through their investments in e-cigarettes and other ENDS and heated tobacco products (HTPs), such as Philip Morris's IQOS. The use of product innovation has been referred to as the tobacco industry's technological strategy – a strategy also employed by other HHIs – to so-called healthwash a discredited industry and re-engage with regulators, scholars and policy-makers in their guise as the nicotine technology industry (22). Other examples of industry attempts to reverse health policies include the use of legal challenges to policies under international TIAs and EU single market laws (see chapters 5 and 10).

Different industries, different responses

While our knowledge of the tobacco industry is more extensive than for other sectors, comparative analyses have identified significant similarities in CPA across the tobacco, alcohol, food/beverage and other HHIs (1, 29–32). Most notably, evidence-based taxonomies of tobacco industry CPA (13) apply to other HHIs, including alcohol and food companies (1, 33–35). Moreover, there is evidence that there has been

significant strategic learning and cross-fertilizations between these industries, facilitated in part by historical co-ownership between companies in the tobacco, alcohol, and food sectors (29, 36). On other occasions, companies in various HHIs have collaborated to achieve shared policy objectives (9).

Despite evidence of commonalities in CPA, interlinkages, and, in some instances, collaboration across HHIs, the policy approaches deemed politically feasible for different products, and the political status afforded to the associated industries, varies significantly between tobacco and other areas (9, 32). For example, while tobacco products in many countries are required to be sold in generic packaging with large graphic health warning labels in many settings, labelling regimes for alcohol remain politically controversial and examples of their introduction are limited (see Chapter 10 on the EU single market, for example). Similarly, no equivalent of the FCTC and Article 5.3 exists in other policy areas. Consequently, policy actors at all levels treat other HHIs very differently from the tobacco industry, and often welcome them as key stakeholders and policy partners in ways that are not easy to justify (32). The EU, meanwhile, has passed robust tobacco control laws but its response to alcohol is comparatively limited as evidenced by the failure to update its much weaker alcohol strategy (see Chapter 10).

The disparity in approaches across HHIs has led to calls to develop framework conventions for other harmful products and their associated industries, either via sectoral accords or a general framework convention on public health, including an equivalent of an Article 5.3 for other HHIs (36). To date, however, little progress has been made towards this despite the obvious need for such an approach. The following sections set out two examples of CPA from the tobacco and SSB industries, examining CPA at the national level and, in the case of SSBs, the interaction between Member State and EU levels.

Case Study 7. Food/beverage industry opposition to SSB taxes

Taxes on SSBs have been consistently opposed by major food and beverage industry actors (37, 38), including at the EU level (39). Following Mexico's introduction of a tax on SSBs in 2014, interest in introducing similar policies in Europe has grown rapidly, with SSB taxes in force in over a third of countries in the WHO European Region as of June 2022 (37). As in other regions, this rising policy interest was met with sustained opposition from commercial actors and allied organizations. Notably, such opposition has focused not only on preventing or delaying the adoption or implementation of new SSB taxes, but also weakening or reversing existing SSB taxes. Norway's long-standing excise tax on sweetened soft drinks, for instance, was repealed in 2021 (40).

Commercial sector opposition to SSB tax policies has primarily originated from beverage companies as well as business associations representing the sector and third-party organizations with ties to commercial interests. In the European context, for instance, this includes major producers such as Coca-Cola, representative organizations such as FoodDrinkEurope, and the libertarian think tank, the Institute for Economic Affairs (38).

Direct engagement with policy processes and decision-makers harnesses the industry's ability to translate their significant resources into access. In addition to participating in formal, open opportunities for engagement, such as government consultations, commercial actors have solicited meetings with policymakers directly or through professional lobbying firms. Notably, non-health government departments are important lobbying targets. Fora which bring government and industry together provide further venues for informal discussion. The latter encompass not only health-focused multistakeholder platforms, but also events, such as the World Economic Forum, where Coca-Cola has previously discussed SSB taxation with the Irish Taoiseach [Prime Minister] (41).

Lobbying against SSB taxes tends to combine claims that the policy is not evidence-based, effective, or necessary, with warnings of negative impacts on employment, the economy or vulnerable populations (37). Moreover, commercial actors have warned about the potential non-compliance of SSB taxes with national or supranational law, with some going as far as threatening or taking legal action (37, 38). In the context of EU single market law (read more in Chapter 10), SSB taxation has been construed as illegal state aid for untaxed products. Although a European Commission assessment requested by the Government of Ireland concluded that well-designed SSB taxes do not constitute illegal state aid, threats or challenges can exert a significant delaying or chilling effect (37).

Underpinning the above strategies and arguments are information management strategies, such as funding scientific studies on the health effects of added sugar or SSBs, in parallel to discrediting independent studies, which support SSB taxation (37). Similarly, reports commissioned from commercial research firms have been commonly utilized by those lobbying against SSB taxes, lending credibility to common arguments that SSB taxes are unnecessary and ineffective, and exaggerating the potential costs and employment impacts of the policy (37). For example, ahead of the introduction of the Irish SSB tax, Food Drink Ireland commissioned an evaluation of the sector's voluntary reformulation efforts, which concluded that SSB taxation was unnecessary (38).

Case study 8. Regulating electronic cigarettes and heated tobacco products (HTPs) in Georgia

Following the successful implementation of comprehensive smoke-free policies and bans on tobacco advertising and promotion, including e-cigarettes and HTPs in 2018, and tax increase in January 2018 and November 2019 (42), smoking prevalence in Georgia dropped by 3% among the general population and by 9% among smokers, with a 15% reduction in cigarette consumption by 2021 (43–45). However, the tobacco industry and their allies have consistently sought to oppose and undermine adoption and implementation of tobacco control legislation to protect their commercial interests. The tobacco industry has been more successful in interfering and delaying the implementation of provisions, particularly regarding the e-cigarettes and HTPs.

Philip Morris International (Philip Morris International) dominates the Georgian tobacco market with a 40.8% share (46) and has increased its influence on health policy since the authorization of IQOS by FDA as a modified risk tobacco product (47). Aggressive marketing (read more in Chapter 2) of IQOS by Philip Morris International was supported by the Business Association of Georgia, whose members include Philip Morris International and Japan Tobacco International (JTI) (48–50). The Business Association was also involved in directly lobbying the Parliament to reduce the tax on HTPs and e-cigarettes and to legalize their promotion and advertisement, while opposing measures to strengthen tobacco control legislation via their main supporter media channels (51–54).

Philip Morris International and its allies regularly communicate with members of Parliament, the Government, and other state structures. For instance, the Business Ombudsman's Office of Georgia (BOO) officially applied to the Parliament on behalf of the tobacco industry to delay entry into force of the plain tobacco packaging regulation in 2022 (55). In addition, the BOO addressed the Parliament twice in mid-2023 and issued industry-favourable recommendations on the plain-packaging regulations, while seeking to exclude IQOS from this regulation (56,57).

Philip Morris International also sought to promote IQOS through the involvement of medical professionals, including former high health officials, collaborating with a new front group, the Institute of Social Researches (ISR), to promote IQOS (58). The ISR worked directly with family doctors, dentists, and other medical specialists to organize seminars and training events on "tobacco harm reduction" between 2021 and 2023, with Philip Morris International support (59–62). The FCTC Implementation and Monitoring Center in Georgia (FCTC IMCG) identified several IQOS promotional activities by the ISR as running counter to the convention and national legislation (62,63). The United Kingdom-based organization, Knowledge Action Change, whose events and key executives have been identified as having significant tobacco industry connections (64), and the Georgian organization, Health Research Union, also organized an international conference on "Tobacco Harm Reduction" in Tbilisi in May 2022 (65–70). Through these and other related efforts, the tobacco industry is lobbying for the use of novel tobacco products as harm reduction and smoking cessation devices, aiming to integrate them into tobacco control policies as shown in the report and article funded by the Philip Morris International Foundation for a Smoke-free World (69,70). Simultaneously, the tobacco industry is illegally marketing these products (71).

Following BOO recommendations in 2022 and 2023 certain members of Parliament, including members of the Health-care and Social Issue's Committee, successfully pushed to delay the implementation of tobacco plain packaging regulations until 31 July 2024 and to remove IQOS from plain packaging regulations (72–74). This was despite the widespread disapproval of the general public and major stakeholders, such as Tobacco Control Alliance of Georgia, Georgian National Centre for Disease Control and Public Health, WHO, other UN agencies.

One of the key issues in Georgia in the field of tobacco control remains the non-implementation of FCTC Article 5.3, with undisclosed interactions between decision-makers and the tobacco industry, including in relation to HTPs (75).

These issues overshadow and threaten the significant success achieved in recent years through the joint efforts of the government and civil society sector in tobacco control in Georgia. To address this, it is crucial to implement appropriate measures, including full implementation of the FCTC and its guidelines and investing more in this field.

Case study 9. An example of pharma lobbying instrumentalizing patient associations and families

In 2013, the Belgian Capacity Remuneration Mechanism advised against covering the costs for patients of Soliris®, a new treatment from the United States company Alexion for the very rare, atypical hemolytic-uremic syndrome. The Mechanism's reasons were its uncertain added value and its high price – €400 000 per year, per patient. The Canadian Health Technology Assessment agency, at the time, provided similar advice for similar reasons (76). The health ministry in Belgium was open to reimburse the drug but did not agree to reimburse the drug at the price proposed, but Alexion refused to lower its price.

At the time of this negotiation, a large and emotional media campaign ensued in Belgium, featuring a 7-year-old child with atypical hemolytic-uremic syndrome and his parents, pleading for the reimbursement of the drug and fuelling debates on the price of life. The media pressure led to an agreement being reached with Alexion on the reimbursement of Soliris® (77–79).

The media campaign had been orchestrated by Alexion, using the personal and emotional story for their benefit, while the family had not been aware of Alexion's involvement in the campaign: they were contacted by a parent association, itself manipulated by a private lobbying firm paid by Alexion. The aim of the campaign was to force the government to reimburse the drug, while taking away its power to negotiate for fair prices on behalf of patients. The reimbursed price, revealed two years later, was indeed extremely high and the agreement signed mentioned that the price "cannot be modified at any time" (78).

Summary

It is impossible to understand either the prevalence and inequitable distribution of NCDs in Europe, or the policy responses to these, without considering the role of CPA by HHLs. These practices extend beyond what we often think of when we use terms such as political lobbying. Commercial actors pursue highly sophisticated, nuanced and often integrated influencing strategies, which seek to shape perceptions of health harms and divert policy-makers between those responses that best guarantee their commercial interests, but which are often the least effective in protecting public health. They present themselves as key partners in the policy process and look to involve themselves in policy-making and implementation through voluntary and self-regulatory regimes. There is also a high degree of similarity across industries in terms of the strategies employed. Despite this, there are very different policy responses considered for tobacco, and different policy statuses afforded to the tobacco industry, versus other HHLs which are not justified by the best available evidence. Alcohol, ultra-processed foods, SSBs and gambling, for example, are not regulated in the same way as tobacco – for example, to have warning labels – and these industries remain engaged with policy-makers and government agencies to a far greater degree than is possible for tobacco within the WHO European Region. If we are to tackle the rise of NCDs in Europe, more effective policy responses are needed in these areas. There is also an opportunity to transfer the policies successfully used to decrease smoking rates to these products, but this will require governments to more effectively minimize the influence of these industries over policy-making in ways analogous to the approach set out in FCTC Article 5.3.

Policy considerations

- Industry actors enjoy significant access to policy-makers and the opportunity to shape policy in their interests and against that of public health in various contexts.
- Governments, civil society actors and researchers should exercise great caution when engaging with HHLs and develop policies for managing such engagements and avoiding perceptions of COI.
- International policy frameworks, such as FCTC Article 5.3, have been invaluable in addressing such issues in regard to the global tobacco industry, but similar initiatives are lacking for other sectors, such as alcohol. A framework convention on public health would offer one way forward to address this.
- Different forms of engagement and associated governance regimes will be relevant for industries not identified as health-harming, such as the pharmaceutical sector.

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Chapter 5.

The impact of international trade and investment agreements (TIAs) on policy



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Key highlights

- International TIAs have significant implications for health, including the availability of medicines and health-harming commodities, such as tobacco, alcohol and processed foods.
- Such agreements can restrict the regulatory space available for national governments to adopt health-protective measures or policies to combat ill health in their populations.
- Regulatory cooperation chapters allow commercial actors to influence the content of policy prior to adoption, while investor-state dispute settlement (ISDS) mechanisms allow them to challenge those already in effect.
- Together these may have a so-called chilling effect on policy-making, deterring governments from enacting effective, but potentially controversial, measures to protect public health.
- This chapter examines these issues through case studies of tobacco control, the United Kingdom's exit from the EU, and pharmaceutical policy.

Introduction

International TIAs are designed to facilitate the trade of goods, services and agricultural products across borders, and establish particular legal frameworks and governance mechanisms to oversee this (1). In so doing, they have important implications for population health and NCD control. On the one hand, these agreements can lead to efficiency gains and have positive effects on economic growth, national wealth, and improved access to, and affordability of, health-beneficial products and services. To the extent that TIAs increase national wealth and are subject to effective distributional policies (as evident to greater or lesser degrees in European welfare states), they may contribute to a decline in population mortality and morbidity. International trade and investment can also support health in other ways; for example, by improving access to medicines and medical devices and technologies essential for preventing and treating NCDs.

However, trade can also have negative effects on population health through increased marketing, access to and affordability of health-harming products, such as tobacco, alcohol and ultra-processed food and beverages, driven by the marketing, pricing and promotional activities of transnational producer industries. Trade agreements have also had significant implications for the availability of and access to medicines in specific contexts, including the availability and distribution of anti-retroviral drugs to treat HIV/AIDS and vaccines during the COVID-19 pandemic. In addition, trade flows, and the agreements governing these, are major contributory factors for poor diet and associated health outcomes (2). The content of these agreements reflects, in turn, the ability of powerful commercial actors, with privileged access to trade negotiations, to present their particular interests as being in alignment with governments' objective to promote economic prosperity via market liberalization (3, 4).

In addition, TIAs pose significant potential barriers to the enactment and implementation of effective policies to tackle NCDs, including those designed to reduce consumption and restrict the promotional strategies of the industries which produce and market them (5, 6). ISDS mechanisms in trade agreements, and related procedures, such as the EU's Investor Court System, create the ability for commercial actors to challenge the legality of policies which potentially infringe on their rights as investors as enshrined in such agreements (7). These processes have been extensively criticized by health actors and democracy campaigners on the grounds that they are highly technical, procedurally opaque and designed to favour trade liberalization over other social outcomes, including public health (7). Cases brought under ISDS clauses in TIAs have resulted in the award of significant compensation – often extending into tens of millions of dollars – to governments found to have transgressed them (8).

Even where courts have ruled in governments' favour, the costs, both economically and in terms of human resources diverted from other policy objectives, are significant, including for high-income countries (8, 9).

Regulatory cooperation chapters in TIAs are designed to pre-emptively identify any domestic laws or regulations which may run counter to such agreements with the effect of harmonizing regulatory approaches through the establishment of oversight committees and procedures. These create a mechanism through which commercial actors can oppose, delay and dilute health-protective laws which run counter to their interests prior to their adoption (7). Following the maxim that prevention is better than cure, in commercial actor political lobbying as much as in medicine, these procedures create perhaps an even more powerful mechanism for commercial actors to pursue their policy objectives than ISDS challenges. Of similar importance, these mechanisms create additional points of access for commercial actors to engage policy-makers, influence their thinking, build relationships, and position the commercial sector as a key partner and expert in policy-making (read more in Chapter 4). Taken together, these aspects of TIAs create additional so-called veto points (7, 10) through which health policies and laws must successfully navigate in order to come into effect, and where their progress may be stymied, or their content diluted. Their very existence can lead policy-makers to avoid controversial but effective health policy measures leading to so-called regulatory chill (11).

The case studies which follow offer examples of the specific ways in which TIAs have impacted on NCDs and NCD policies before offering final reflections on the implications of these for population health and health governance in the future. By their nature, these case studies can capture only certain aspects of the myriad ways in which trade impacts on public health, NCDs and the policy responses to these, and so offers only a partial account of this complex topic.

Case study 10. Tobacco packaging, ISDS and regulatory chill

This area of tobacco control is one in which ISDS mechanisms have been used most obviously in ways designed to obstruct the adoption of evidence-based policies to address key NCD risk factors. Smoking remains the biggest avoidable cause of mortality and morbidity globally, while tobacco control measures designed to denormalize smoking, and shrink demand for tobacco products, have had significant success in reducing smoking rates in many contexts. This is despite a decades-long and highly adaptive strategy by the tobacco industry to prevent the recognition of smoking-related harms and the adoption of policy measures to reduce smoking (12). Initially, their tactics, like those of other HHI, focused on engagement and alliance-building with governments and regulators, via political lobbying, financial contributions and the proposal of co-regulatory measures, as well as attempts to shape the information environment and research evidence through the co-option and corruption of tobacco science and the production of industry-funded and favourable research outputs (13). As their tactics were increasingly revealed via the publication of internal industry documents, opportunities to shape science and policy in this way diminished. This culminated in the agreement of the WHO FCTC Article 5.3, which requires signatories to take active measures to protect against the undue influence of the global tobacco industry over policy (14). Tobacco companies had to adapt their approach and find new channels of influence. They found one such avenue in the potential for legal challenges under international trade and investment law as part of their shift to more confrontational forms of policy prevention (9, 15).

Two legal challenges were brought by Swiss-based transnational tobacco corporation, Philip Morris International (Philip Morris International). The first legal challenge was against the Uruguayan government's plans to introduce tobacco labelling restrictions. Specifically, the government wanted to increase the size of graphic warning labels on tobacco products and to ban the use of both misleading descriptors, such as "light and mild", and multiple variants of cigarettes brands. The second legal challenge was brought by Philip Morris International's Hong-Kong subsidiary against Australia's proposals to require tobacco products to be sold in plain packaging (i.e. unbranded) (9, 15).

In the Uruguay case, Philip Morris International claimed that the graphic warning images would repulse and disgust consumers, undermining goodwill and trust toward established brands. In the Australia case, they argued that plain packaging was disproportionate and unnecessary to guarantee public health; that it was protectionist, discriminating against overseas producers, and that it undermined their legitimate expectations as investors about the business environment in which they would operate – despite, it should be noted, Australia's long history of tobacco control innovation (15). In both cases, they argued that the measures deprived the company of its intellectual property rights by unfairly limiting the use of established trademarks (9). Both cases were accompanied by concurrent challenges in relation to domestic law and constitutional protections and, in the Australia case, by a dispute initiated at the WTO by its Member States whose legal fees were alleged to have been paid by the tobacco industry (16, 17). All these cases were unsuccessful but resulted in significant costs to the litigants and, in the case of Uruguay, both a delay and a watering down of the measures proposed. While the details of ISDS cases lack transparency, and their resolutions are often the subject of non-disclosure agreements, it was widely reported at the time of the case that the Australian government's legal bills were around US\$ 50 million.

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Australia, as the first country in the world to introduce so-called plain packaging, became a key policy battleground. For the tobacco industry, it was vital to block its introduction to avoid setting a precedent for the policy's introduction and the development of a real-world evidence base of its effectiveness, and to prevent so-called spillover to other, larger, strategically more important markets, such as the EU, and growth markets in low- and middle-income settings (LMICs). In addition, the cases brought against Australia had a significant so-called chilling effect on the development of similar policies in other contexts (9). The experience of Australia suggests that countries, which are policy innovators, face particular political challenges and can benefit therefore from the support of other governments, multilateral agencies, such as the WHO, which can give evidence at the WTO, and international public health and NGO networks to support their efforts to withstand significant industry pressures (read more in Chapter 13). This will be especially the case for LMICs which may lack the political and economic resources of a country, such as Australia, to contest legal challenges on multiple fronts. Experience from Europe demonstrates the important role played by Australian public health and tobacco control actors, intergovernmental connections, and NGO networks in facilitating the transfer of plain packaging to the Ireland and the United Kingdom. (18).

Case study 11. Brexit, trade and health

Following its withdrawal from the EU customs union and common commercial policy, the United Kingdom began the process of implementing an independent trade regime. It concluded a Trade and Co-operation Agreement with the EU in December 2020 and successfully negotiated the so-called rollover of 36 EU trade agreements covering trade relationships with 67 countries (19). Subsequently, it finalized trade agreements with Australia (2022) and New Zealand (2023) while negotiating accession to the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) in July 2023. At the time of writing, the negotiations with the United States and for an updated agreement with Canada have stalled, while those with India are progressing slowly. Taken together, these agreements have significant potential implications for NCD risk factors and policy responses, notably diet and nutrition. The post-Brexit trade regime will wield significant influence over diet quality through the new trade agreements signed by the United Kingdom. Recognizing this, the United Kingdom and Australian governments agreed to a "side letter" on health clarifying the terms of the interpretation of the commitments of their trade agreement and reaffirming their commitment to public health, including the need for effective tobacco, alcohol and nutrition policies (20).

While free trade agreements have the potential to reduce the prices of certain foods, the implications for nutrition and NCDs hinge on which specific items decrease in price. For instance, should less healthy options become more affordable, this is likely to have adverse effects on NCDs. Furthermore, new trading arrangements may increase inflation, and thus the cost of foods, as happened in the case of Brexit. Research found that almost a third of food price inflation since 2019 has been due to Brexit, exacerbating financial burdens for households (21). When unable to afford or access nutritious foods, individuals and families facing financial strain may be compelled to compromise on the quality and variety of their diets as a means of survival. This compromise can have significant consequences for overall diet quality, a primary risk factor for NCDs. For example, they may resort to cheaper, less healthy options, increasing their vulnerability to conditions such as obesity, cardiovascular diseases and diabetes. Similarly, recent studies have suggested that Brexit could reduce fruit and vegetable consumption, equivalent to -15 kcal/week from fruit and -34 g/week from vegetables, but that this could be mitigated through eliminating tariffs on fruits and vegetables (22).

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A further concern arises from the increased industry influence facilitated by these new agreements. For instance, the United Kingdom's recent accession to the CPTPP, primarily shaped by the United States with substantial industry influence, has been criticized for promoting weakened regulations pertaining to food standards and safety (23). Specifically, text in the agreement effectively rules out the use of the precautionary principle, which often features in public health regulations, and policy measures, such as product bans. Instead, Article 7.9 states that decisions are mandated to be based solely on "documented and objective scientific evidence" (24). This requirement may pose challenges for public health regulation where scientific consensus is lacking or when emerging research indicates potential risks – a scenario commonly encountered in the realm of food standards (25).

The inclusion of ISDS and regulatory cooperation mechanisms within the agreement is also likely to make it more difficult for the United Kingdom government, and governments of all CPTPP signatories, to enact regulatory policies to decrease the consumption of unhealthy food. If the United Kingdom government wanted to implement an anti-obesity measure, for example, such as calorie labelling requirements, it would need to adhere to a provision in the CPTPP that allows foreign commercial actors to be allowed to contest any such regulation (23).

Following Brexit, the United Kingdom is also pursuing trade through novel legal frameworks, such as the memoranda of understanding (MOU) signed between the United Kingdom and individual states of the United States, which afford the United States greater latitude in advancing its commercial interests with minimal oversight. These MOUs are agreed upon relatively quickly and below the radar of public knowledge and typical scrutiny measures (26).

Together, these developments also hold implications for the EU and its Member States. As the United Kingdom establishes new trade agreements and regulatory frameworks post-Brexit, it may influence trade dynamics and regulatory standards within the EU. Consequently, the EU will need to closely monitor these developments and consider their potential ramifications on its own trade policies and public health regulations.

Case study 12. Trade and pharmaceutical policy

While products and practices of commercial actors contribute to the burden of NCDs and their inequitable distribution among different populations, their actions can also shape who has access to affordable, effective and quality treatment for NCDs. For example, global intellectual property regimes, such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) of the WTO, for which the pharmaceutical industry lobbied, has had significant impact on the availability and pricing of medicines, especially in LMIC setting (27). Industry-influencing activities target national or EU-level pharmaceutical and health systems policy and lobbying for the inclusion of these sectors within TIAs. The scope and complexity of modern TIAs means there is an increasing number of mechanisms through which commercial actors can influence pharmaceutical policy. While provisions around intellectual property rights can influence access to medicines, other mechanisms have important implications for health systems and the delivery of universal health coverage achieved through ensuring equitable access to safe, high-quality, affordable and effective services and medicines (28).

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A review of large regional trade and investment agreements between 2016 and 2018 identified ten types of provisions that could potentially impact domestic pharmaceutical policy and regulation (28). These provisions cover a broad range of areas, from the reduction or elimination of tariffs on pharmaceuticals or their ingredients, intellectual property protection and ISDS mechanisms, to procedures relating to pharmaceutical pricing and reimbursement programmes, the regulation of safety and quality testing, government procurement, regulatory practices, and marketing. Such provisions have the potential to impact the accessibility, affordability, efficacy, and/or safety of medicines as well as their clinical use and local production via multiple pathways (28). For example, three of the four trade agreements reviewed contained provisions that were identified as having the potential to impact national pharmaceutical pricing and reimbursement programmes in several ways, including stipulating procedural rules for how applications are assessed and how interested parties are consulted and involved in decision-making processes. Such rules, and the associated guiding principles, can be designed in ways favourable to industry interests and in conflict with public health priorities (28).

Importantly, the pharmaceutical industry acts to influence the inclusion and content of such provisions in TIAs in ways that favour their commercial interests over those of patients, the public and national health systems. Evidence of these practices emerged during the early stages of negotiations between the United Kingdom and United States in relation to a potential post-Brexit trade agreement. Following the 2016 Brexit referendum, preliminary meetings were held between the United States and United Kingdom as the latter prepared to formally leave the EU and establish its future relationship with the EU block. Both the United Kingdom and United States held stakeholder engagement exercises and began drafting negotiation objectives for a future trade agreement between the United Kingdom and United States. As part of the consultation processes in the United States, the industry's main trade group in the United States, the Pharmaceutical Research and Manufacturers of America (PhRMA), submitted a response in which it called for "the negotiation of a comprehensive and ambitious trade agreement between the US and the UK" (29) and promoted the United States-Mexico-Canada Agreement as a "very strong base from which to negotiate a trade agreement with the UK," demonstrating the tendency for trade agreements to set the foundations for subsequent negotiations and the ways that industry draws on these precedents to pursue their objectives. The trade body also targeted the functioning of the National Institute for Health and Clinical Excellence and its systems for appraising the cost effectiveness of medicines and other health technologies in the submission (health technology assessments). The trade body and other United States stakeholders framed the National Institutes's activities as creating undue "non-tariff barriers to trade", arguing that these types of systems should, therefore, be eliminated. PhRMA also called for "meaningful opportunities for input from manufacturers and other stakeholders ... both in the development and the specific implementation of all relevant laws, regulations, and procedures" (29). The trade body additionally outlined their support for prolonging the period during which brand name medicines are protected from competition from the manufacture of generic and biosimilar products.

While the completion of a formal United Kingdom-United States trade agreement has since fallen down the political agendas of both countries, these preferences of the United States pharmaceutical industry, like those of the United States food industry, may resurface in the previously discussed MOUs currently being negotiated. Ultimately, these insights demonstrate the ways in which TIAs represent powerful mechanisms through which commercial actors can advance their interests with consequences for health systems and the treatment of NCDs.

Summary

The preceding case studies demonstrate the important implications that TIAs have for the causes of, and policy responses to, NCDs. Yet TIAs also have important ideological and systemic effects. The current focus on economic liberalization via such agreements reinforces political and economic systems that prioritize economic objectives and commercial actors' interests over population health and well-being. This is often justified by the logic of so-called no-other-option. However, there are different so-called varieties of capitalism (30); alternative economic models are possible, which consider the health and wider societal impacts of commercial policy beyond crude measures of gross domestic product (GDP) growth. Relatedly, we need a more holistic understanding of trade policy within the wider nexus of public policy, with trade policy actors cognizant of its relevance for and impact on other areas including, but not limited to, health. This requires the meaningful input of health and other policy actors and advocates into the development and execution of trade policy. Recent measures adopted by the EU to develop health safeguards in its TIAs offer one potential route forward. Finally, there are important lessons which can be learned about the framing, governance and content of trade policy agreements and strategies for resisting industry challenges to health-protective policies, both in the pre-legislative phase and in subsequent legal challenges. This will help embolden governments to adopt innovative policies and offset potential chilling effects arising from industry tactics (31, 32).

Policy considerations

- National governments should design health policies in ways that minimize their potential for challenge under international trade and investment law without undermining their effectiveness.
- Public health should be seen by governments and the European Commission as a core trade policy issue, with health actors and health impacts central to the development of trade policy and the content of trade negotiations.
- National governments and the European Commission should consider the elimination of ISDS mechanisms, or the inclusion of robust public health exemptions to these, in the conclusion of future trade agreements, while seeking to limit the ability of commercial actors to use exiting measures to stymie health policy.
- Trade agreements must also be designed in ways that ensure the widespread availability of pharmaceuticals globally while maintaining incentives for research and development.

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Chapter 6.

Casting doubt on evidence: manipulating research evidence related to NCD causes, prevention and management



Key highlights

- Corporate influence on scientific research is extensive and multifaceted, with many similarities across industry sectors, such as tobacco, alcohol, pharmaceuticals, gambling and fossil fuels.
- The manipulation of knowledge and research evidence is a system-level problem. Common strategies used by industry to influence the product of science are:
 - influencing the conduct and publication of science to skew the evidence base in industry's favour;
 - influencing the interpretation of science to undermine science that is seen as unfavourable to industry and create a distorted picture of the evidence base;
 - influencing the reach of science to create an echo chamber for industry's scientific messaging;
 - creating industry-friendly, policy-making environments which shape the use of science in policy decision-making in industry's favour; and
 - manufacturing trust in industry and its scientific messaging.

Introduction

Previous chapters showed that harmful industries adopt a wide range of strategies to protect their commercial interests. One way they do this is to use scientific and pseudoscientific practices to cast doubt on public health evidence. The Lancet Commission on the CDoH described these as “practices involving the production and use of science to alter products or otherwise secure favourable outcomes (or both) for the industry” (1).

Science and pseudoscience can be used like this in several ways. Industries can influence the production of science – particularly science which meets its own needs, and which undermines public health policy and practice as well as public health; for example, science can conceal evidence on the harms caused by commercial products or practices. They can do this by funding particular types of industry-friendly research, leaving other lines of inquiry, which are unfavourable to industry, unfunded and unexplored.

Industries can also promote and use science to defend their commercial and legal interests. This has been described as a cycle of bias where misleading research, based on narrow, irrelevant or misdirected research questions, is commissioned by industry – sometimes through legitimate science funders and researchers, and sometimes when their involvement is concealed – and the findings of this research then further distort and muddy the evidence base (2).

The manipulation of research evidence should therefore be seen as a so-called system-level problem – even if one specific piece of research may itself be reliable, it, and the researchers who create it, may contribute to producing misinformation and ignorance, thereby misleading and misinforming policy-makers. These practices compromise the integrity of scientific research and pose risks to patient safety and public health.



These practices compromise the integrity of scientific research and pose risks to patient safety and public health.

This chapter describes how the NCD evidence base becomes distorted through these and other industry practices. It draws on the Science for Profit Model (SPM), an evidence-based typology of how and why corporations attempt to influence science (3). The SPM identifies five ways in which corporations, across diverse industries, influence the system of science. Attempts to influence science from corporate sectors, including tobacco, pharmaceuticals, fossil fuels and gambling, are

remarkably similar and are conducted for the same reasons – ultimately to weaken regulation, prevent litigation against industry, and maximize the use of industry products and practices.

1 Influence the conduct and publication of science to skew the evidence base in industry's favour

Commercial actors can influence every step of the scientific process, from the ways in which research topics are selected and framed, to the design, conduct and reporting of research (3).

For example, when it comes to influencing the research agenda, according to internal industry documents from 1959 to 1971, the sugar industry funded research into enzymes that break up dental plaque and a vaccine against dental caries in order to divert attention from interventions aimed at reducing sugar intake (4). Similarly, when evidence began to show the health hazards of smoking, United States tobacco companies created a research council that funded research on other potential causes of cancer and heart disease, such as infection, hormones, stress, personality and psychological factors, and environmental factors, to distract from the role of tobacco smoking (5, 6).

Evidence from several fields also shows that industry-sponsored studies have results and conclusions that are more often favourable to the sponsor's product compared to non-industry sponsored studies. Favourable results might be achieved by industry “through a variety of biasing choices in the design, conduct and reporting of their studies” (7).

For example, trials sponsored by the pharmaceutical industry are more likely to use placebo controls or inferior doses of active comparators compared to non-industry sponsored studies (7–9); this might increase the chances of achieving favourable results for industry.

The final step that industry sponsors can influence is the publication of research results. Constraints on the publication rights of investigators have been found in industry-initiated studies; for example, the sponsor owns the data or needs to review or approve the final manuscript (10). This can lead to unfavourable results being suppressed, thus skewing the evidence base in favour of industry.

2 Influence the interpretation of science to undermine science that is seen as unfavourable to industry and create a distorted picture of the evidence base

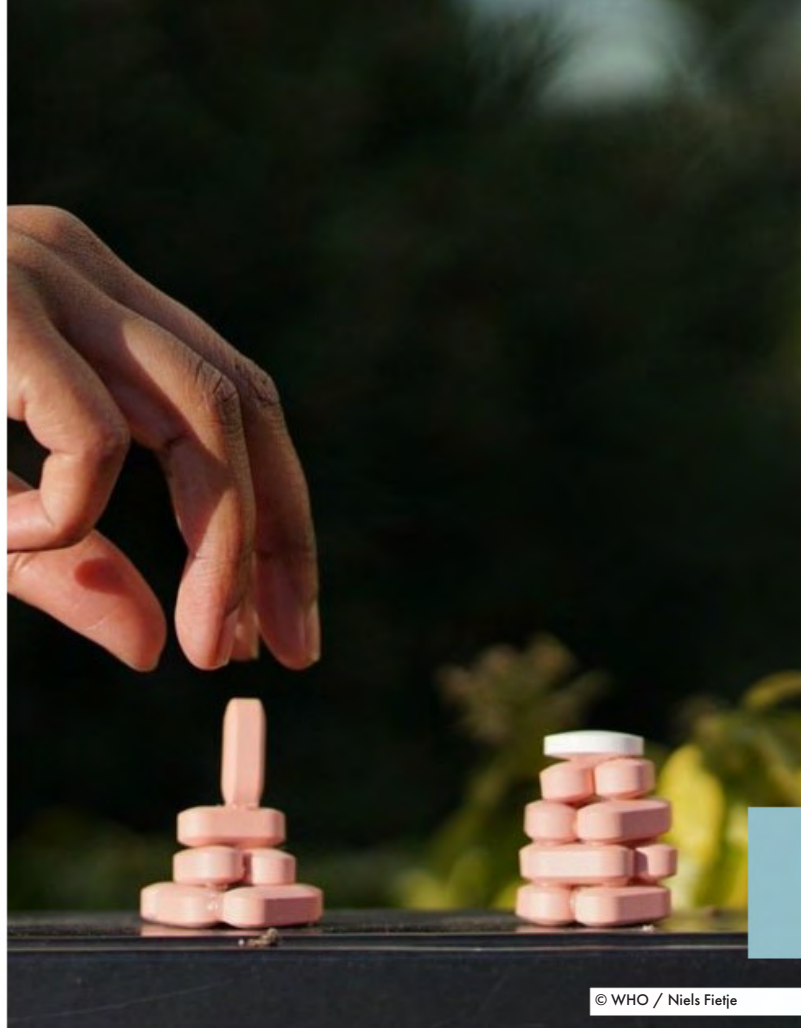
The manipulation of research evidence also involves the promotion of misleading scientific concepts and criteria in ways intended to undermine science and policy-making. This manipulation sometimes involves using legitimate scientific concepts, and statistical or epidemiological language, but applying them in ways that scientists would not recognize or accept. For example, the tobacco industry dismissed the evidence that smoking causes cancer and chronic heart disease as merely statistical (11) and deployed epidemiological language to argue that it could not be proven that smoking causes cancer, arguing that it can also be caused by a host of other factors, such as pollution, drinking green tea, being bald, stress and many other factors (12). These arguments, which are intended to obscure the independent causal contribution of a product to harms, are a form of pseudo-epidemiology, and can also be seen in the alcohol industry, opioid industry, food industry and other industry arguments (13). Similarly, when harmful industries argue that a causal relationship is complex – by implication, too complex to be dealt with by regulation – they are also employing this sort of pseudo-science as a smokescreen (14, 15). In the same way, the fossil fuel industry disputes its role in climate change by arguing that global heating can also be caused by solar flares, volcanoes, and natural variations between places and over time (16).

Distorting and denying the evidence in this way often depends on attacking scientific methods and scientists, as well as misrepresenting or cherry-picking single pieces of evidence. Attacking epidemiological research simply because it is so-called observational research is particularly common, despite the facts about what is known about smoking and lung cancer comes from cumulative evidence from observational studies.

Demanding perfect evidence like this (e.g. evidence from randomized controlled trials before policy-makers can act) is also a cross-industry tactic. Public health issues don't require perfect evidence. Instead, effective and ethical public health policy and practice, based on the precautionary principle, depends on preventing harm to the public using the best available evidence, while collecting further evidence over time, as needed.

The introduction noted that misinformation and distorting science should be seen as a so-called system-level problem. This is because, even if a specific piece of research is reliable, it may contribute to a wider system of misinformation if the research questions are shaped by industry funders – even if researchers see themselves as independent and not open to influence. For this reason, transparency about research funding alone, while important, is insufficient. Preventing the distortion of science in the first place is key.

The Brussels Declaration (see Case study 5) is an example of this type of strategy, as it shapes how scientific evidence and scientists are seen by policy-makers.



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Case study 13. The Brussels Declaration: Influencing and distorting the interpretation of science

The Brussels Declaration: Ethics & Principles for Science & Society Policy-Making (17) sets out a number of principles to guide the role of science and the involvement of scientists in policy-making. It was developed from consultations with more than 300 stakeholders from 2012 onwards, including public health scientists, science journalists, senior science advisors, government officials and ministers, and industry representatives, with substantial tobacco industry and alcohol industry representation.

Given the title, it is perhaps surprising that extensively questioning science itself is at the core of the Declaration:

This bottom-up initiative began as a genuine attempt by the scientific community to question the robustness of science-led policy-making worldwide... Most policy decisions are informed by evidence provided by experts. All too often, who those experts are, how they are chosen and how reliable their advice really is, is open to question (17).

The Declaration goes on to question what it calls “scientific and political ‘elites’”. While highly critical of scientists, it also promotes tobacco and other industry narratives and positions, minimizing the importance of the need for safeguards or the management of vested interests and COI.

The background and apparent purpose of the Declaration has been analysed in a research paper by McCambridge et al. (18) who note the similarity of the content of the Declaration to arguments made elsewhere by the tobacco industry. These include distorting sound science and good epidemiology, such as the tobacco industry proposal that only a relative risk of >2.0 (meaning that a particular exposure, such as to tobacco smoke, at least doubles the risk of harm) should be considered meaningful. This rule of thumb about relative risks, McCambridge et al. note, “conveniently eliminated most of the evidence on the harms of passive smoking”. This proposal was in turn promoted by epidemiologists and epidemiological associations who were unaware of the tobacco industry links. It is also clear that many of the scientists and others involved in the meetings leading up to the Brussels Declaration were unaware of the tobacco industry's involvement.

The Brussels Declaration also had substantial pharmaceutical and alcohol industry involvement, consistent with other instances where the alcohol industry sought to influence science and scientific principles. One example is the Portman Group, the United Kingdom alcohol industry social responsibility body and regulator for alcohol labelling, packaging and promotion, who paid researchers to write anonymous critiques of a WHO-sponsored evidence review (18). McCambridge et al. also note the similarity to the 1997 Dublin Principles, sponsored by the International Center for Alcohol Policies (ICAP) (19), another alcohol industry CSR organization. The Dublin Principles were developed with significant input from the alcohol industry and alcohol industry-funded organizations and aimed to promote cooperation between the beverage alcohol industry, public health actors, and governments. Among other things, they promote industry-friendly framings of alcohol harms and solutions to those harms, such as self-regulation, industry-provided educational initiatives, individual responsibility and responsible drinking (20).

McCambridge et al. concluded:

The Brussels Declaration seemed to be a vehicle for promoting corporate vested interests with respect to science and policy. Overall, this episode shows that harmful industry attempts to influence science go well beyond influencing specific studies or scientists, but also involve influencing policy-makers' perceptions of science and scientists themselves.



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3. Influencing the reach of science to create an echo chamber for industry's scientific messaging

As mentioned above, commercial actors influence every step of the scientific process, from evidence production to its dissemination and use. This reflects what Bero has described as a cycle of bias (2), noting, "If the evidence base that informs these decisions is flawed or distorted, the entire foundation for systematic reviews, guidelines, health policy, clinical advice, and consumer information crumbles".

To disseminate biased research, industry also misuses standard scientific approaches and outlets – such as industry-funded conferences, journals, journal supplements and other events – and then uses this research to position itself to policy-makers and the public as a legitimate and trusted source of evidence. Academic researchers are also recruited to act as supportive so-called voices, to promote and defend the research. Conversely, industry may use legal – and, at times, illegal – means, such as claiming that data cannot be released because of commercial sensitivities, to prevent its evidence from being discovered or accessed. In the case of pharmaceutical products, this means that evidence about harmful or ineffective treatments is missing, so that reviews of the evidence are themselves inadvertently biased.

4. Create industry-friendly policy-making environments which shape the use of science in policy decision-making in industry's favour

The preceding strategies work together to increase the likelihood that science favourable to industry will be used in policy and practice. Extending this even further, commercial actors have attempted – sometimes successfully and sometimes not – to create policy-making environments which shape the ways in which science is used in policy decision-making in their favour (3).

For instance, in the 1990s, the tobacco company Philip Morris International (Philip Morris International) attempted, ultimately unsuccessfully, to embed industry-friendly standards in EU regulatory decision-making, which would create an impossibly high bar that evidence would have to meet before policy-makers could officially consider it. These standards were originally promoted by the tobacco industry itself as part of a campaign to redefine so-called good epidemiology, so that the industry could dismiss evidence it deemed unfavourable by hijacking the criteria for determining scientific proof. Ultimately, the motive was to reduce policy-makers' ability to use a precautionary approach to regulatory decision-making and prevent regulatory action on passive smoking (20).

Also in the 1990s, British American Tobacco, the United States-based multinational tobacco company, along with chemical, fossil fuel and pharmaceutical industry actors, worked – this time, successfully – to secure and utilize policy-making reforms in the EU which became known as “Better Regulation”. One key feature of these reforms was the mandatory use of business impact assessments (IAs), which create a reliance on industry data and prioritize evidence on economic impacts over evidence on other impacts, such as to human and environmental health (22). These have subsequently been used by industries, including the tobacco industry to push against the EU’s 2001 Tobacco Products Directive as well as the pesticides industry to argue against stronger regulation of endocrine disrupting chemicals (23, 24). Another feature of Better Regulation is mandatory stakeholder consultation, which embeds the right for industry to have its voice heard early in scientific debates. This process has been described as “an opportunity for highly resourced corporations to slow, weaken, or prevent public health policies” (25).

5. Manufacture trust in industry and its scientific messaging

Many of the strategies used by commercial actors to cast doubt on the evidence depend on the industry itself building trust among policy-makers, the public, and health and non-health professionals who the industry needs to influence. To do this, the industry must portray itself as a trustworthy source of evidence and advice. Of course, when it comes to evidence about health, there is no reason to believe that the tobacco, alcohol, gambling or other industries have any particular health expertise; their expertise lies in producing and marketing their products, and they have no special claim to expertise in public health, epidemiology or other health-related sciences.

Despite this, they are active in academic and scientific settings to help them gain credibility. They do this by creating links with individuals, particularly clinicians, and with respected institutions. For example, the SSB industry funded individual researchers to help promote its misleading messages about the causes of obesity with the aim of shifting the blame for obesity away from diet – and, by implication, their products – and onto lack of exercise (26).

Funding industry-friendly research like this is one way to build trust and help create a supportive evidence base, which is why Food Politics researcher Marion Nestle has said that food and drink companies should not be funding scientists “because research sponsored by food companies almost invariably comes out with results favorable to the sponsor’s interests, even when independently funded research finds otherwise” (27).

Concealing such influence is also key to building trust, and such industries are skilled at hiding their messaging behind front groups (“astroturfing”), community groups, and charities (“charity-washing”) (3).

Case study 14. Industry-funded youth education programmes in the United Kingdom and the distortion of evidence

Harmful industries, such as the tobacco industry, have a long history of influencing youth education about their products. The promotion and funding of youth education is favourable to harmful commercial sectors in many ways. For example, an analysis of tobacco industry internal documents shows that the tobacco industry saw funding and the promotion of youth education programmes as amenable to their commercial interests because it allowed them to: shift blame onto children and parents; deflect from and substitute for more effective but commercially threatening policy measures (particularly restrictions on advertising); burnish their corporate image; gain access to policy-makers; and form partnerships with credible and trusted organizations (28).

Many other commercial actors adopt the same strategy, often as part of their CSR initiatives. For example, in the United Kingdom, both the alcohol and gambling industries are major funders of youth education programmes about their respective products. Despite the COI that this causes, charities who receive funds from the alcohol or gambling industries continue to provide a number of programmes to schools across the United Kingdom. Analyses of the content of these programmes have shown that they reproduce industry-favourable ideas and framings about personal reasonability, shifting the burden of blame for harm onto children and young people while normalizing gambling and alcohol use and deflecting from the role of the industry's practices and products, and a failure to effectively regulate these, as major drivers of harm (29, 30). In the case of the alcohol industry-funded programmes, some of the materials provided to schools contain misinformation that distorts the evidence on the risk of cancer associated with alcohol use and the risks during pregnancy.

A further analysis of gambling industry-funded programmes and the practices adopted by those who develop and deliver them shows that agnogenic – meaning doubt-creating – practices, well documented among harmful industries, are used to promote and legitimize these programmes while misrepresenting and distorting the evidence base. These practices help to create doubt about the harm caused by commercial actors and their products, and doubt or ignorance about the evidence base for measures to prevent these harms. In conflict with the international literature, these programmes are presented by the gambling industry and those in receipt of its funding as an effective way of keeping children safe from gambling harms (31). They present the industry-funded programmes as “evidence-based” and “evaluation-led”, but the evaluations that have been conducted to date, and that are in the public domain, have important limitations and have not been designed to establish effectiveness.

Industry influence on youth education reveals the contradictions in the evidential practices of commercial actors. That is, despite presenting themselves as authoritative voices on how to keep the public safe from their products and inform them about the risks and continual claims to be committed to so called “evidence-based” policy-making, they fund and promote youth education programmes for which there is limited or no evidence of effectiveness (32). Furthermore, it is well established in the public health literature that education in the absence of other policy measures, such as restrictions on advertising, accessibility, availability and pricing strategies, is ineffective at preventing harm. Concerningly, such programmes continue to be delivered to youth throughout Europe and in the absence of robust and independent evaluation for unintended consequences, such as exacerbating inequalities or the promotion of harmful products.

Ireland has taken a lead in addressing this issue. In response to the efforts of community action groups and others who helped to raise the issue of alcohol industry influence on schools in Ireland, the health and education departments issued formal guidance advising schools not to use materials funded by the alcohol industry and that “these guidelines apply in regard to resources funded by other industry sectors where there is a potential conflict of interest” (33, 34).

The pharmaceutical industry also uses strategies to influence scientific research, which correspond to the different stages of the cycle of bias described above (Box 6).

Box 6. The pharmaceutical industry as a commercial determinant of health and its influence on science

The pharmaceutical industry uses strategies to influence scientific research, which correspond to the different stages of the cycle of bias described above. Michaels' seminal book "Doubt is their product" identifies six widely used approaches (35):

1. testing a drug against a treatment that either does not work or does not work very well (trials with placebo comparisons are ideal for this);
2. testing a drug against too low a dose of the comparison drug because it will make your drug appear more effective;
3. testing a drug against too high a dose of the comparison drug because this will make your drug appear less toxic;
4. publishing the results of a single multicentre trial many times because this will suggest that multiple studies reached the same conclusions;
5. publishing only that part of a trial that favours your drug, and burying the rest of it; and
6. funding many clinical trials, but only publishing those that make your product look good.

Many other strategies are also described, including avoiding the use of a comparison group entirely, and testing the drug on highly selective and often relatively healthier populations because these are less likely to suggest the existence of side-effects. These practices undermine the integrity of medical research and can affect clinical guidelines and patient care (36).

The health-care industry more generally employs many of the strategies of harmful commodity industries, and their approach to casting doubt on evidence includes creating uncertainty about the harms of products, misleading marketing, manipulating and distorting evidence, as well as health-care-specific activities, such as disease-mongering – that is, expanding the boundaries of treatable or apparently treatable disorders in order to increase sales of commercial products, such as pharmaceuticals (33). The opioid epidemic is one recent example of this, where Purdue Pharma aggressively marketed and promoted the liberal use of Oxy-Contin to physicians, particularly for use in the large and lucrative nonmalignant pain market (37).

The company responded to evidence about the harms of their product in the same way that other companies do: blaming the user; saying that the problem of opioid addiction was actually due to a lack of personal responsibility among users (an argument used by all harmful industries); saying that some people just have addictive personalities (an argument used by the tobacco and gambling industries); and using complexity arguments, in claiming that the problem was very complex, and that opioid addiction is actually due to a wide range of societal and other factors, so the company can't be blamed for the opioid epidemic (38). Using the same complex arguments to dispute the evidence is a widely documented strategy among harmful industries (39).

Summary

The pharmaceutical industry's influence on scientific research is extensive and multifaceted, with many similarities to other industries described in this report. These practices compromise the integrity of scientific research and pose risks to patient safety and public health. Greater transparency and independence in clinical research are crucial to addressing these issues. The mandatory publication of all trial results, and more rigorous oversight by regulatory bodies, can help ensure that decision-makers and the public have accurate and reliable evidence to inform their decisions.

Policy considerations

Industries often seek to influence the processes, methods, findings, and perceptions of science and scientific research in ways that ultimately harm the public. Perhaps the most important way of preventing these harms is to protect science itself from such influences.

Transparency in lobbying and funding, and strictly enforced COI declarations, are an important part of this, while acknowledging that this is a partial, downstream measure and can even have negative effects (Box 7).

Raising the awareness of the public, academics and policy-makers about what COIs in science are, and why it is important to prevent them, will also be key.

Box 7. Declaring COIs does not prevent COI

Solutions to counteract industry influence on science often focus on protecting individual parts of the science system, such as the integrity of individual researchers. Ultimately, however, this does not work because, as we have seen, industry funding of science produces effects beyond simply corrupting single pieces of evidence or individual researchers. The entire pipeline of knowledge production and dissemination can be configured by industry to meet its own needs at the expense of public health.

For example, if research questions are shaped by industry, even if the research itself is robust, the resulting science can still benefit the research funder if it distracts attention from industry harms, frames industry and industry products as part of the solution to complex problems, and/or promotes interventions that minimize damage to sales.

Therefore, while it is important for researchers to be transparent about the origins of their research funding, it is insufficient because it does not eliminate bias; ultimately, the mechanisms through which industry is able to influence science to meet its needs remain in place and intact.

Disclosure can actually have unexpected or unintended effects on researchers, including strategic exaggeration, which is, when individuals disclose COIs, they then inflate bias in their advice to counteract any discounting the reader might do; and moral licencing, which means that people feel licensed to inflate their bias after engaging in the moral behaviour of disclosing a COI (40). These are subconscious processes: researchers can be affected by funding even if they believe themselves not to be.

What is the takeaway message? Good research practice from individual researchers cannot wholly protect against commercial influence on science. Preventing industry influence on science must be the goal and this will require robust and sophisticated systems of governance that are informed by engagement with substantial bodies of evidence on COI and the CDoH.

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Chapter 7.

Corporate social responsibility and its negative impacts



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Key highlights

- Corporate social responsibility (CSR) activities are often presented by commercial actors as inherently beneficial to society and helping to address public health issues and meet social needs. These practices need to be examined critically from a CDoH perspective.
- Some commercial actors adopt CSR programmes that are designed to promote their preferred approaches to public health issues, burnish their corporate image while deflecting from their role as drivers of harm, and substitute for public health policies that threaten their business interests.
- There is a need to raise public and policy awareness of commercial CSR activities, their purposes, and how they can harm health and misinform the public. CSR campaigns, including industry-funded educational materials aimed at children and young people, are a particular concern.
- Novel approaches to public health counter-marketing campaigns, building on the “truth campaigns”, which aimed to expose the tobacco industry’s efforts to mislead the public, could be developed to counter the CSR activities of HHI, such as alcohol, gambling, vaping and others.



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Definitions of CSR

CSR is based on the principle that corporations should not simply pursue profit, but also have social and other responsibilities to wider society. CSR is, therefore, related to the concept of philanthropy and refers to the wide range of specific practices that corporations engage in that appear to have a social purpose. Such practices include funding charities, community groups, and research and educational programmes, or providing resources, expertise and other related practices, and are outlined below. However, in the case of industries whose products and practices are health-harming or environmentally destructive, their engagement in CSR is not simply philanthropic or altruistic but plays several important strategic roles. These include defending the industry against criticism; deflecting attention from the harm caused by their practices and products; presenting the industry as part of the solution and not the problem; and, ultimately, preventing policy-makers from regulating their practices.

There are three main types of definitions of CSR:

- i. business definitions, which emphasize the obligation of companies to give back to society;
- ii. transformative definitions, which emphasize the power of CSR to influence public perceptions and choices; and
- iii. public health definitions, which point to the negative health consequences of CSR, and which describe the importance of countering them (1).

In focusing on the commercial determinants of NCDs, it is particularly important to consider the strategic purposes served by CSR and to reflect on associated public health consequences.

A comparative analysis of the CSR campaigns of the soda and tobacco industries provides important insights into their commercial purposes (2). The study found that such campaigns arose because of increasing pressure on these industries and policy-makers were becoming more aware of the harmful nature of these products. As a result, these industries were faced with a mounting threat of stronger regulations. In response, the industries sought ways to improve their corporate and product images to prevent legal and regulatory action that might harm future revenue in direct or indirect ways. These included supporting charities, supporting so-called prevention programmes, and funding scientific research.

Sometimes such commercial actors explicitly acknowledge that the purpose of their CSR programmes is to help avoid regulation unfavourable to their business interests. The programmes also have a range of other

effects, including helping to build brand loyalty among children and young people, spreading misinformation about the negative health effects of products, and normalizing product use. For example, major tobacco companies developed so-called youth smoking prevention programmes. However, their funding and promotion of their favoured programmes enabled the industry to build partnerships with trusted actors, displace independent public health actors, downplay and obscure the harms caused by smoking, shift blame onto youth, and burnish their sponsoring actor's corporate image. The same role is played by alcohol industry messaging campaigns on how to "Drink responsibly" and, in the United Kingdom, the alcohol industry charity Drinkaware's "Drink Free Days" campaign (3, 4). Similarly, a major SSB company launched Project Refresh to fund individual youth's proposals on how make "the world more exciting and fun" (2). The gambling, alcohol, firearms and fossil fuel industries deploy similar child and youth-oriented programmes as part of their CSR practices (5).

Commercial actors also seek to influence the research and medical communities through their CSR. For example, a major tobacco firm funded the provision of medical education courses on smoking cessation, delivered through a well-established medical information company. These were similarly found to promote the company's commercial objectives, including promoting the use of smokeless tobacco and e-cigarettes (6). Gambling industry-funded educational and other "Gamble responsibly" campaigns have also been shown to promote gambling industry narratives and framings (7). Fossil fuel industry examples are also well-known (See Case study 16).

An analysis of tobacco industry internal documents summarized the purposes of industry-funded youth smoking prevention programmes:

...to serve the industry's political needs by preventing effective tobacco control legislation, marginalizing public health advocates, preserving the industry's access to youth, creating allies within policy-making and regulatory bodies, diffusing opposition from parents and educators, bolstering industry credibility, and preserving the industry's influence with policymakers (8).

This quote serves as a valuable general summary of the purpose of HHI CSR. The role of CSR in manipulating and undermining policy is well-documented across different industries. One of its purposes is policy substitution, where CSR, including voluntary self-regulation, is used to prevent or delay the implementation of effective public health policies, such as the regulation of marketing. For example, when opposing the WHO FCTC restrictions on marketing, the tobacco industry saw youth access schemes as a way to "make a significant gesture that would divert attention from the FCTC, moderate the WHO's moves toward the FCTC, and bring the tobacco companies together against the FCTC" (9, 10).

Case study 15. Charities and pinkwashing

Reputation management through engagement with charities is very common when an industry seeks to gain a so-called health halo by being associated with reputable and trusted organizations. One of the most well-documented examples of this form of CSR is pinkwashing, where commercial actors associate themselves with breast cancer charities, while some of these commercial sectors, specifically the alcohol industry, promote products associated with an increased risk of breast cancer and/or actively undermine public understanding of the modifiable risk factors for breast cancer. The term was initially defined by the United States-based activist organization Breast Cancer Action as “a company or organization that claims to care about breast cancer by promoting a pink ribbon product, but at the same time produces, manufactures and/or sells products containing chemicals that are linked to the disease” (11).

The alcohol industry is a source of many related examples. Alcohol consumption is a risk factor for breast cancer, and alcohol industry-funded charities, including those based in the United Kingdom, have spread misinformation about the role of alcohol as a risk factor, often denying it or seeking to confuse the public with misleading explanations (12). At the same time, the alcohol industry has often sought to align itself with breast cancer campaigns. Alcohol and gambling and other industry charities are themselves a form of industry CSR and reputation management, claiming to educate the public about alcohol harms, while at the same time promoting misinformation about breast and colorectal cancer, cardiovascular disease, foetal alcohol syndrome and other issues and health conditions. In Ireland and the United Kingdom, for example, Drinkaware and Drinkaware Ireland have been shown to selectively omit and/or misrepresent the risks of breast cancer. A recent British Medical Journal investigation described how industry-friendly misinformation about breast cancer appears in materials for school children produced by the charity Talk About Trust (formerly the Alcohol Education Trust), which has indirect alcohol industry funding (13).

The term pinkwashing has more recently been extended beyond breast cancer and is also now applied to the commercial practice of superficially appearing to promote the civil liberties of LGBTQ+ communities for marketing and public relations purposes (14). This includes United Kingdom alcohol and gambling industry charities funding academic research on LGBTQ+ people’s alcohol use and gambling (15, 16). Informing the public about industry exploitation of pinkwashing campaigns increases public perceptions of the way such practices are misleading in nature, and can increase public support for alcohol policies (17). In the same way, informing the public about the nature and purpose of tobacco, gambling and alcohol industry-funded charities, among others, may be an important step towards denormalizing harmful industry CSR. This would involve questioning the legitimacy of these CSR activities as public health interventions or as inherently beneficial to society, and building greater understanding of the ways such practices undermine public health goals while advancing commercial interests.

Case study 16. CSR and artwashing

The arts have been another common target of industry CSR. Notably, Purdue Pharma, owned by the Sackler family, sponsored the arts, including museums and galleries, as part of its corporate philanthropy programmes, while at the same time promoting its drug OxyContin, the design and marketing of which has driven the opioid epidemic. The Louvre in Paris, the V&A museum, and the Tate Modern and Serpentine Galleries in London all have had wings, rooms or galleries named after the Sacklers, as have many museums and galleries in the United States. As awareness increased of the company's practices for downplaying the risks of addiction and misleadingly and inappropriately promoting the use of the drug, many museums and galleries dropped the Sackler name. The benefits to the drug company of this form of CSR include distraction from the harms of the product and raising the reputation of the company, thus making it more difficult to criticize their aims or activities.

The dissonance between the good works in the foreground and the harms in the background are highlighted in a quote from the former chair of psychiatry at Duke University School of Medicine:

I don't know how many rooms in different parts of the world I've given talks in that were named after the Sacklers ... their name has been pushed forward as the epitome of good works...but when it comes down to it, they've earned this fortune at the expense of millions of people who were addicted... (18).

This type of so-called CSR artwashing continues, for example, by the gambling industry, where The Courtauld Gallery in London controversially named one of its exhibition galleries after the billionaire founder and CEO of online gambling company Bet365, following a donation of an undisclosed amount to the gallery (19). The tobacco industry is still active in this space, too, with the British Museum still taking sponsorship from JTI, the international tobacco and vaping company (20). The Tobacco Tactics website documents a wide range of similar tobacco industry arts activities and sponsorships over many decades, noting the different purposes that they serve – including boosting legitimacy with the public, bypassing advertising regulations, and helping to buy influence with policy-makers. Among its more recent examples is the case of the vaping and heated tobacco brand IQOS (owned by Phillip Morris International) which commissioned British artist Alex Chinneck to create exhibits for the IQOS World exhibition during Milan Design Week in 2019 (21).

CSR and engagement in science

Industry funding of science, and the risks this holds, is discussed in Chapter 6 of this report. Funding and supporting scientific research are also an element of CSR programmes. Establishing industry-funded scientific organizations, which manipulate the evidence, as well as appearing to do good, is a win-win for industries.

A further effect of CSR practice, particularly those that involve industries partnering with communities and researchers, includes fostering division, thereby weakening opposition to the industries themselves.

When industries build alliances and support from scientists, NGOs and communities, it reduces the number of potential allies that other activists and NGOs striving to mobilise and thwart industry interests can work with, in a sense, reducing civic resources for the activist community (22).

While this relates to the context of the food industry, and the practices of companies such as Nestle, it also applies to other industries. The tobacco industry, for example, realized that sowing division was an important aspect of CSR, and Philip Morris USA's Project Sunrise, which aimed to promote the social acceptability of smoking and of the company, sought to create divisions within the tobacco control movement (23).

CSR during crisis

HHI also have a long history of exploiting crisis situations (24). An analysis of CSR practices during the COVID-19 pandemic showed the four ways in which corporations that were producing health-harming and potentially health-harming products, including tobacco, alcohol, fossil fuels, and ultra-processed food and drink, took advantage of the pandemic, based on examples from more than 90 countries (25). Companies used the crisis to portray themselves and their products in a positive light, and to use it as an opportunity to build relationships with governments, increase the scope for lobbying, and incorporate messaging on their contribution to the pandemic response into their marketing (read more in Chapter 11).

Policy considerations

There is much to be done in managing CSR and its negative impacts, particularly the wider impacts on norms and policy and in the longer term. Some potential ways forward are suggested in the report “Signalling Virtue, Promoting Harm – Unhealthy commodity industries and COVID-19” by the NCD Alliance and SPEC-TRUM Consortium (25).

- Develop norms and practices to constrain commercial interference in public health policies. For example, FCTC Article 5.3 aims to constrain commercial interference. In particular, the actions of alcohol and ultra-processed food industries demonstrate the need to urgently advance international efforts to establish principles of engagement and manage COIs.
- The report points to the pressing need to develop mechanisms to support CSOs in managing their interactions with commercial actors (read more in Chapter 12 and 13). The recently developed “Governance Toolkit for Commercial Determinants of Health”, by the Association of Directors of Public Health in the United Kingdom is an example of how countries are coming forward with models for dealing with interactions with commercial actors and how to manage the risks (26).
- Raise awareness among the public and policy-makers of the purpose, nature, and harms of industry CSR practices which, as the report cited above shows, can help build public support for effective policies to regulate commercial actors.

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Chapter 8.

Employment and health: the role of commercial economic narratives and shifting labour markets



Key highlights

- Commercial actors influence health through employment and working conditions, both within their own firms and through their purchasing practices. These factors can either promote or undermine public health and significantly impact the prevalence and distribution of NCDs and associated inequalities in Europe.
- Political and economic systems shape how commercial actors affect health in the context of employment and working conditions. The interplay between economic policies, labour market conditions, regulatory frameworks, and corporate practices determines the extent of health impacts, highlighting the need for an active role of the government to protect public health.
- Commercial actors often attempt to sway policy-makers away from regulation by emphasizing their role in job creation and generating economic growth. Such arguments are often overstated and, in some cases, have proven to be false. Policy-makers need to be aware of these tactics, consider broader social costs, and prioritize public health in their decisions.



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Introduction

In the context of employment and labour markets, commercial actors hold a pivotal role in shaping health outcomes, exerting a dual influence that can either enhance or undermine public health. Commercial actors can promote public health by providing individuals with both financial security and psychological well-being through stable and meaningful employment. Further, as large employers, they can stimulate economic growth, strengthen fiscal space for financing public goods, and reduce poverty and spending on social protection measures. Conversely, if companies impose long working hours, stressful work environments, poor prospects for career development, and substandard health and safety practices, they risk exacerbating the prevalence of NCDs among their workforces. Commercial actors also often leverage their role as employment providers to exert pressure on policy-makers, potentially limiting regulatory oversight, with negative implications for NCDs.

Employment conditions, working conditions and NCDs

Given that individuals spend a substantial portion of their lives at work, the employment and working conditions they are exposed to can significantly impact their health. Workers across all sectors face the risk of NCDs, with those in manual work or essential services particularly affected. NCDs have been linked to both employment conditions and exposure to material workplace hazards (1). Employment conditions related to job insecurity and limited contract status, for example, have been associated with NCDs in the European context – particularly mental ill health (2). On the other hand, exposures related to material workplace hazards, such as physical and chemical hazards, have been linked to cancer, respiratory illness and musculoskeletal disorders (3). The significance of this latter point is heightened when understood in the context of the increasing commercialization of occupational health services (4). Further, the use of algorithms, artificial intelligence and digital technology to monitor workers' performance is increasingly impacting health (5) by introducing stressors and privacy concerns with potentially important implications for NCDs.

Employment and working conditions are often seen as intertwined determinants of health, as workers with precarious employment conditions, characterized by employment insecurity, inadequate incomes, and a lack of rights and protections (6) have been found to experience higher exposures to poor working conditions (7). Women and other population groups in disadvantaged or marginalized positions, such as young people and migrants, are also more likely to be engaged in non-standard employment (2, 8). Finally, NCDs are strongly socially patterned across Europe, with those in manual and less skilled occupational classes having the highest risk and burden of NCDs (9).

Another way commercial actors can influence NCDs in the context of employment and working conditions is through purchase practices. Purchase practices involve the decisions and policies a company follows when buying goods and services, which can significantly influence health and social objectives. For example, if a company sources materials from suppliers with poor labour standards, this can undermine worker health and safety. On the other hand, purchase practices that support local economies and increase local tax revenues can potentially enhance community health and fund local NCD prevention interventions.

Influence of commercial actors on public health and NCDs through economic narratives

A final way commercial actors impact health in the context of employment and labour markets is by leveraging their role as employment providers in discussions with governments. Many policy-makers are already influenced by traditional economic paradigms that historically overlook public and social goods, such as health and equity, social cohesion, literacy and the environment. As such, they may exhibit resistance to public health imperatives aimed at regulating industry practices, including policies aimed at curbing NCDs through labelling, marketing, and excise taxes (10). Consequently, establishing and implementing robust government regulation of industries producing health-harming products remains challenging (11).

This challenge is exacerbated when commercial actors leverage their role as employment providers or invoke economic arguments in discussions with governments, often framing their economic contributions as vital to national or local economies (12). By emphasizing their role in job creation and retention, commercial actors can exert considerable influence over public policy, including health regulations (13). In doing so, they advocate for unrestricted market competition, defend consumers' right to choose, ask for more evidence and IAs, and urge governments to refrain from direct regulation, proposing instead voluntary standards of consumer protection (10). This persuasive power can lead to a scenario where governments may hesitate to impose strict health regulations on businesses for fear of jeopardizing employment, fiscal space via tax revenues, or economic growth. This economic narrative has become a potent tool in commercial actors' arsenal to sway policy decisions in their favour, sometimes at the cost of public health.

For example, alcohol stands as a leading cause of preventable deaths in France (14). In response to its detrimental effects, the country implemented

the pioneering *Loi Évin* law in 1991, aimed at regulating alcohol marketing (read more in Chapter 2). A cornerstone of this legislation is the prohibition of alcohol advertising in media targeting young audiences. Additionally, permitted advertisements must strictly provide factual information, forbidding any association of alcohol with notions of pleasure, success, or glamour. Finally, all alcohol promotions are mandated to include the warning message “alcohol abuse is dangerous for health”.

Despite these measures, the effectiveness of the *Loi Évin* law has been compromised over time in favour of commercial interests (15). For instance, in 2009, the advertising of alcohol online became allowed, despite widespread use of the internet among youth. Furthermore, by 2016, alcohol products with a “certification of quality and origin and linked to a production region or to cultural, gastronomic or regional heritage”, such as wine produced in France, vodka in Russia, or whisky in Scotland, were excluded from the *Loi Évin* law. Research examining the strategies employed by the alcohol industry to undermine the *Loi Évin* law found that a central argument used by the alcohol industry emphasized the significant negative economic impact





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of marketing restrictions (15). Producers attributed financial and job losses, as well as declines in export revenue and tourism, to the legislation. Given the economic significance of alcohol, particularly wine, to the French economy, these arguments found resonance with officials in national and governmental bodies.

To counter the economic narrative, it is crucial to acknowledge that, while these industries wield considerable economic influence, their arguments regarding economic impacts often lack robust evidence and, on several occasions, the opposite of their concerns have been proven true (16). For instance, despite commercial actors' warnings of negative economic consequences, when advertising restrictions were put in place across Transport for London (TfL) the local government body responsible for most of the transport network in London, the sales of health-harming food and drinks decreased, and TfL's revenue actually increased (17). Moreover, commercial actors' economic arguments tend to overlook the significant economic and social costs associated with the consumption of health-harming products, including health-care and social protection expenses, productivity losses and environmental degradation. Considering this, it is imperative for public health advocates to recognize these tactics and emphasize the overall benefits of regulation on these health-harming products. By demonstrating that regulation is a sound investment for public health and societal well-being, advocates can push for more ambitious government policies that prioritize both social and economic objectives.

In the case studies that follow, we offer examples of the specific ways in which employment can impact NCDs and NCD-related policies. Following this, we offer some final reflections on the implications of employment and economic objectives for NCDs and future NCD policy.

Case study 17. Precarious gig-work and mental health in Sweden

Sweden, like the other Nordic countries, is traditionally viewed as having high rates of secure and stable employment and well-protected workers (18, 19). Recently, however, precarious employment has grown, especially within the country's commercial sector (20). This has occurred alongside a relaxation of labour market regulations and a downsizing of welfare state protections (18, 19).

Precarious employment, characterized by employment insecurity, inadequate incomes, and a lack of rights and protections (21), is linked to adverse mental health among workers (6, 22–24). Contributing factors to this are feelings of powerlessness, uncertainty, and poor psychosocial working conditions (22). In the platform economy, goods and services are mediated through online platforms in which companies can connect workers with customers. Those who work through platform companies often perform short-term, temporary tasks, known as gigs, and are generally referred to as gig-workers. The platform economy is growing in Europe and Sweden, and since gig-workers' employment is often characterized by precariousness (25), such as unpredictable schedules, low rewards and high employment insecurity, these workers experience several mental health risks through their work (19).

In Sweden's platform economy, an increasing number of companies are circumventing labour market regulations or operating in its grey zones by renouncing their employer-employee responsibilities (26–28). This has led to a rising concern about ambiguous or bogus employer-employee relationships (29) and a situation where more workers have to become self-employed to work (19).

There are two kinds of key commercial actors operating in this space. First, there are platform companies themselves, such as Uber, Wolt, Tiptapp or Taskrunner that have high control over the workers – increasingly through algorithmic management – by determining factors such as their working hours, scheduling, the number and frequency of work tasks, cost of services, and pay (30–31). These companies claim to not have employer responsibility, arguing that they merely mediate contact between workers and customers (27).

The second type of commercial actor is becoming more common in the country's platform economy and is a so-called self-employment company that acts as employer for self-employed workers only while tasks are carried out. These companies are responsible for deducting taxes, paying social security contributions, and paying out a salary (26), but are not responsible for the working conditions and the working environment (27), adding an additional layer of complexity for the employer-employee relationship. Importantly for the workers, social contributions are not guaranteed as such contributions often require employee status (26).

Both types of commercial actors profit financially while workers are left with lower wages and greater uncertainty concerning their employment relationship. This can have knock-on effects for mental health due to increased exposure to factors that are known to cause poor mental health (22).

Two court cases regarding the employment status of gig-workers illustrate their ambiguous employment status and the lack of consensus on how to determine it. Arbetsmiljöverket, the Swedish governmental work environment authority, has pursued two legal challenges to platform work in Sweden, arguing that two companies, Taskrunner and Tiptapp, should be viewed as employers due to their autonomy over workers (32). However, in both cases, the courts ruled in favour of the companies on the basis that the companies have little or no control over the working environment of the workplace. As such, commercial actors' renouncing of employer responsibility, while maintaining a certain degree of control over workers, appears legitimized and, thus, gig-employment in Sweden continues to carry a number of mental health risks for workers in the sector.

Case study 18. Health effects of labour market shocks

Recent research by Ann Case and Nobel-laureate economist Angus Deaton has garnered widespread attention to the declining health of workers in deindustrialized areas, sparking the so-called deaths of despair debate (33). The authors argue that health crises driven by deindustrialization reflect the broader failings of contemporary capitalism and are a global phenomenon. The mortality crisis in eastern Europe, characterized by significant economic upheaval, serves as a stark example of how political and economic systems shape the context in which commercial actors affect health and NCDs.

In eastern Europe, securing stability and welfare for workers was crucial to socialist societies. However, neoliberal reforms in the 1990s brought numerous changes to the labour market as commercial actors, often foreign-based, took over previously state-run companies. This shift significantly impacted the workforce. Those who remained employed often found themselves working in less desirable, more casual, and non-unionized positions. For many women, this transition led to their exit from the labour market because newly privatized companies closed their nurseries and kindergartens (34). Changes to maternity leave policies also made women less competitive in the labour market (34).

For men, research provides ample evidence that a surge in unemployment and labour market turnover was closely linked to excess mortality. Scheiring and colleagues, for instance, analysed data in a substantial cohort across Hungary and the Russian Federation (35). Their findings highlighted that industrial employment declines were strongly correlated with increased male mortality during the tumultuous transition period. Although both nations faced harsh deindustrialization, Hungary's social policies appeared to mitigate some of the health impacts tied to its more significant industrial employment losses, suggesting the potential for policy interventions to cushion such shocks.

Central to the discussion on the health implications of these labour market shocks is the role of alcohol consumption. Hazardous drinking was identified as a key factor exacerbating health issues during this period, with research indicating that, in post-socialist countries known for high alcohol consumption, such as Belarus, Poland, and the Russian Federation, there was a significant link between increased alcohol consumption and various health problems, including increases in suicide rates and NCDs, such as cardiovascular and liver diseases (36).

Most scholars agree that psychosocial stress significantly contributed to binge drinking and ill health during the post-socialist transformation (37–44). Overall, studies in this area underscore the complex interplay between economic shocks, commercial actors, stress and health, highlighting the need for effective state intervention.

State policies can play a crucial role in addressing the negative health impacts of labour market upheavals. Interventions can range from direct state involvement in industries to the implementation of comprehensive social and industrial policies aimed at softening rapid economic transitions. These strategies are vital for mitigating the adverse health consequences of labour market shocks and ensuring a more stable transition for societies undergoing significant economic restructuring. By learning from the transitions of the 1990s, there is an opportunity to develop more resilient frameworks for safeguarding public health amid profound economic changes.



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Summary

In the context of employment and labour markets, commercial actors can act either to promote or undermine public health. They influence NCDs through employment and working conditions, both within their own firms and through their purchasing practices. In Europe, these conditions are associated with inequalities in NCDs, with those in manual and less skilled occupational classes having the highest risk and burden of NCDs. Additionally, commercial actors impact health and NCDs by attempting to sway policy-makers away from regulation, emphasizing their role in job creation and generating economic growth.

The case studies presented in this chapter illustrate these pathways and highlight how broader factors, such as political, legal and economic systems, shape the context within which commercial actors operate. They demonstrate how the interplay between economic policies, labour market conditions, regulatory frameworks and corporate practices determines the extent of health impacts.

Policy considerations

- Adapt labour market regulations to protect workers in all sectors, including emerging gig and platform economies, to safeguard and promote mental health and overall well-being by ensuring fair employment and working conditions, including job security, adequate income and safe working environments.
- Mitigate the health impacts of employment and labour transitions through effective policy measures, such as social protection policies, to promote health and alleviate negative consequences.
- Regulate industries that affect health by enacting and enforcing policies that promote and safeguard public health, ensuring that the broader social and health costs of nonregulation are accounted for and that economic growth does not come at the expense of population health.

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Chapter 9.

Financial practices and the extraction of wealth: increasing inequity and undermining NCD prevention and control



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Key highlights

- Financial practices conducted by corporations to extract wealth (extractive financial practices), rather than create wealth, are common throughout the global political economy. Such practices are generally designed to maximize corporate profits and/or shareholder returns.
- Extractive financial practices can adversely influence health and equity through various pathways. For instance, extractive financial practices invariably drive and reinforce economic inequities, not least because the main beneficiaries tend to be disproportionately represented by wealthy individuals and groups based in high-income countries.
- Two illustrative examples of extractive financial practices are tax avoidance and large-scale share buy-back programmes. Tax avoidance can directly undermine the fiscal capacity of some governments to make health-promoting investments. Share buyback programmes effectively represent a proportion of profits that could have otherwise been invested in health-promoting opportunities; for example, research and development to promote equitable access to essential products and services.

The primary purpose of most corporations globally is to maximize profits for their shareholders. Accordingly, almost all corporate practices are designed to support this aim. Through a public health lens, this chapter focuses on a subset of financial corporate practices primarily designed to maximize profits for corporate shareholders through extracting wealth (or else reasonable claims to such wealth) rather than through generating wealth, such as via the production of new goods or services. Notably, such practices, hereafter referred to as extractive financial practices, are common and widespread throughout the global political economy (1–3). We therefore recommend understanding the case studies introduced in this chapter not as exceptional examples, but as potential entry points for exploring the wider political-economic system.

Extractive financial practices can be broadly categorized into two interrelated groups. The first group consists of practices through which corporations effectively extract wealth from external actors and social groups for the purpose of maximizing corporate profits. Corporate tax avoidance, a practice introduced in Case study 19, is a pertinent example. Corporate tax avoidance occurs when corporations – almost invariably transnational corporations – take advantage of their complex corporate structures and various regulatory loopholes to deliberately lower taxable profits, that is base erosion, and/or to shift profits to lower-tax jurisdictions, that is profit shifting, at the expense of government tax revenues.

The second group of extractive financial practices captures those that primarily benefit shareholders, but not necessarily the corporate entity itself, in the name of maximizing shareholder value. Large-scale share buy-back programmes, a practice introduced in Case study 20, are an illustrative example. When a corporation buys back its own shares, it effectively transfers a proportion of its profits to its shareholders. In this respect, share buybacks are similar to dividends. Yet the financial gains made by shareholders via share buybacks are generally taxed at lower rates than dividends, and share buybacks are often the preferred way for large corporations to transfer so-called windfall or excess profits to their shareholders. In many jurisdictions, share buybacks have only become legalized in recent decades (3). Although categorizing extractive financial practices into the two above groups can be useful, the boundaries between these groups are often blurred, which is well illustrated in Case study 21.

Key pathways through which extractive financial practices can adversely influence health and equity

The extractive financial practices discussed in this chapter can increase inequity and undermine NCD prevention and control through various pathways. For instance, corporate tax avoidance can widen economic inequities because the benefits stemming from this practice have mostly flowed to large corporations based in high-income countries (4). In some cases, corporate tax avoidance can partially undermine the fiscal capacity of governments, particularly those in lower-income countries that rely relatively heavily on corporate tax revenues, to finance, inter alia, the development and management of health-enabling services and infrastructure (4–6). At least in theory, corporations that benefit from tax avoidance can also allocate larger amounts of financial resources to practices that have the potential to undermine public health, such as lobbying and litigation to challenge public health regulations, compared to what otherwise might have been possible (7).

As with corporate tax avoidance, extractive financial practices designed to maximize shareholder value can also exacerbate economic inequities, not least because corporate shareholders tend to be over-represented by high net-worth individuals and households based in high-income countries (2, 7). Extractive financial practices designed to maximize shareholder value are also often associated with cost-cutting practices, including reductions in employment and research and development, which can potentially undermine public health. In industries such as pharmaceuticals and healthcare, for example, large share buyback programmes effectively represent a proportion of profits that could have otherwise been invested in health-promoting opportunities, such as research and development to promote equitable access to quality products and services essential to health and well-being (8–10). This includes, but is not limited to, products and services central to NCD prevention and control.

Case study 19. British American Tobacco and tax avoidance

British American Tobacco (BAT) is one of the world's largest tobacco corporations. As with other large tobacco corporations, BAT has routinely engaged in a range of practices to avoid and minimize its income tax obligations (6, 12). Between 2010 and 2019, BAT reportedly avoided paying approximately £760 million in income tax in the United Kingdom alone (12). It has also been estimated that eight low- and middle-income countries – Brazil, Bangladesh, Indonesia, Kenya, Guyana, Trinidad and Tobago, Uganda and Zambia – stand to lose around US\$ 700 million from BAT's tax avoidance practices over the 10-year period between 2020 and 2030 (6).

Tax avoidance practices, which invariably involve the leveraging of complex corporate structures and favourable regulations, can be broadly categorized into two groups. The first of these groups encompasses practices to minimize income tax obligations through deliberately lowering taxable profits, known as base erosion, such as by increasing reported interest payments. As an illustrative example, between 2007 and 2014, BAT's subsidiary in Souza Cruz, Brazil borrowed money from one of BAT's subsidiaries in Netherlands (Kingdom of the) (6). During this period, Souza Cruz paid US\$ 255 million in interest on these loans, which allowed BAT to avoid approximately US\$ 6 million a year in Brazilian taxes due to the tax treaty on loan interest between Brazil and Netherlands (Kingdom of the) (6). The second group of tax avoidance practices involve shifting profits from relatively high-tax jurisdictions to relatively low-tax jurisdictions, known as profit shifting. As an example, between 2010 and 2019, BAT was noted to have shifted around €1 billion in dividends per year through Belgium, where tax paid on such profits was less than 1% (12). In 2015 and 2016, BAT was also reported to have sent US\$ 26.5 million in dividends from Kenya to the Netherlands (Kingdom of the), rather than directly to the United Kingdom (13). Given that the tax treaty between Kenya and Netherlands (Kingdom of the) set withholding tax on dividends at zero during this period, Kenya subsequently lost approximately US\$ 2.7 million in potential tax revenue (6).

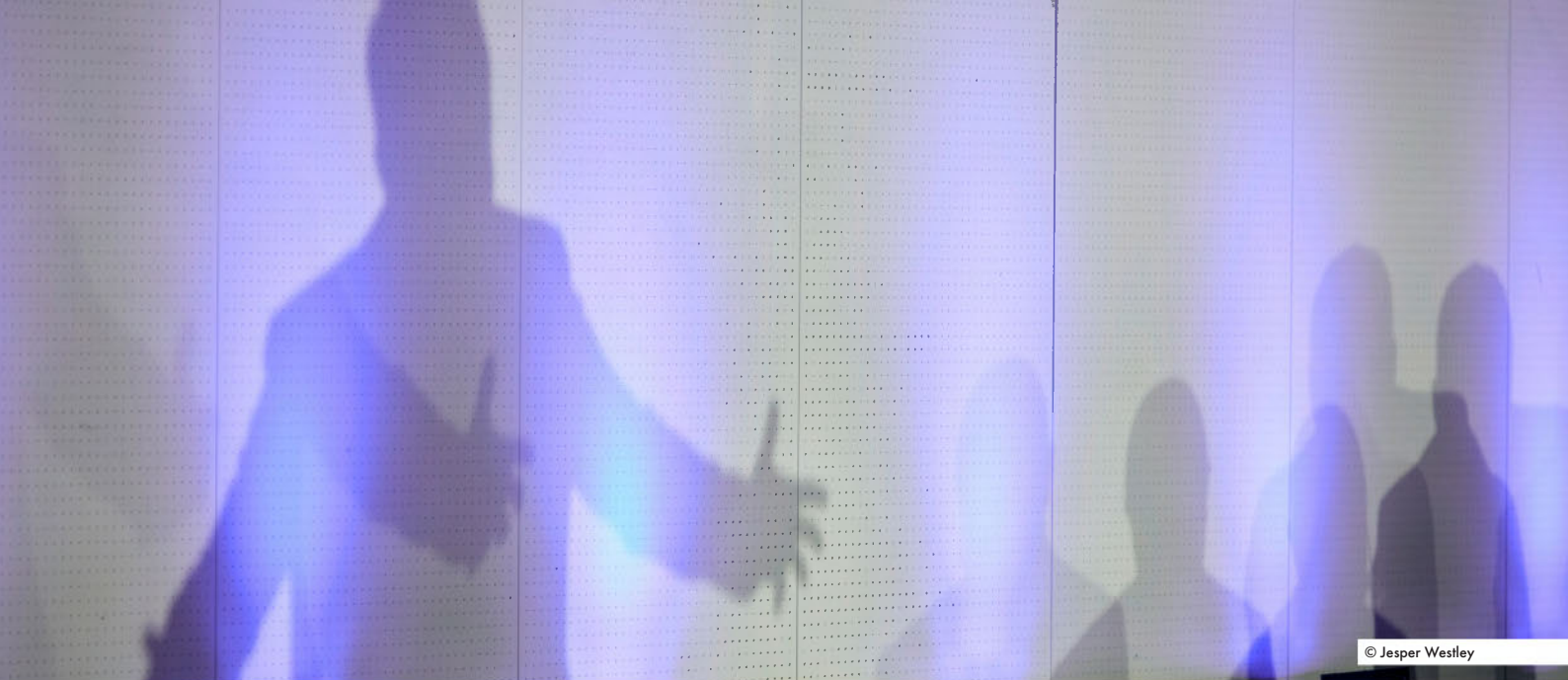
Various authorities and courts have challenged the tax avoidance practices of BAT in recent years, albeit in a relatively piecemeal manner. Brazil's Tax Authority, for instance, has filed a claim of €350 million based on allegations that the company illegally avoided tax between 2004 and 2012 (14). Also, in 2023, a Dutch court ordered BAT to pay a fine of €107 million for avoiding taxes between 2013 and 2016 (15). Such efforts notwithstanding, the tax avoidance practices of all transnational corporations like BAT, as well as the tax frameworks that permit such practices, warrant greater scrutiny from public health scholars, tax agencies, and courts alike.

Case study 20. COVID-19 vaccine manufacturers, share buybacks, and maximizing shareholder value

Since the early period of the COVID-19 pandemic, Pfizer, BioNTech, and Moderna have generated substantial profits from their COVID-19 vaccines developed with substantial amounts of public funding and support (8, 16). These corporations have subsequently transferred a considerable proportion of their profits to their shareholders, including through large-scale buyback programmes (3). Share buybacks – when a corporation buys back its own shares – are a financial practice increasingly used by many large corporations to transfer profits to their shareholders (10). In essence, share buybacks inflate the share price of the corporation in question, thereby increasing the capital gains that can be made by investors when selling their shares. Share buybacks can also serve to inflate executive bonuses where those bonuses are fixed to performance metrics, such as share price and earnings per share (10).

In 2022, a year when more than 100 countries were calling for changes to global intellectual property rules to improve COVID-19 vaccine equity (17), Pfizer, BioNTech, and Moderna announced large share buyback programmes to distribute some of their so-called windfall profits to their shareholders (3). In the first quarter of 2022, Pfizer bought back US\$ 2 billion of its own shares, while also making a further US\$ 2.2 billion in dividend payments (18). During the same year, both BioNTech and Moderna initiated their very first share buyback programmes. After BioNTech's chief financial officer announced the company's desire for its "shareholders to participate in [its] strong 2021 performance through a [share buyback] program[me]" (19), the company went on to buy back US\$ 1.5 billion of its own shares between March 2022 and March 2023 (20). Throughout 2022, Moderna bought back US\$ 3.3 billion of its own shares (21).

Calls have been made by some political leaders to tax share buybacks to disincentivize the practice (22–24). Nevertheless, it is helpful to understand large share buyback programmes as a symptom of a broader issue, in which corporate decision-makers in diverse industries across the global economy seek to prioritize the maximization of shareholder value above other considerations (10, 25). In this respect, there is arguably a strong case to implement taxes on windfall profits made during crises, such as the COVID-19 pandemic, to prevent such crises from being leveraged to maximize shareholder value (26). It could also be argued that, if the regulatory environment in which companies operate were changed so that share buybacks and/or large dividend payouts became conditional on particular social goals being met, then some of the current inequities associated with these practices would likely be reduced. With respect to the pharmaceutical industry, for example, governments could introduce regulatory requirements to allocate a specified minimum proportion of funds to particular types of research, such as into neglected tropical diseases, in order to distribute funds to shareholders.



Case study 21. Private equity investment in health care

In recent years, the European and global health-care industries have become key targets for the private equity industry (27). While the scale and nature of private equity investment in health care varies considerably across European countries, it is reportedly large and/or increasing in many (28). In Germany, for example, it has been estimated that nearly 20% of the country's 3800 ambulatory health-care centres were managed by private equity funds in 2020 (28). In Sweden, approximately one third of private primary care centres, which make up about 40% of all 1200 primary care centres in the country, are reportedly managed by international private equity funds (29).

Concerns have been raised about the ways in which private equity investments often lead to increases in health-care costs, as well as decreases in health-care quality (30, 31). In this respect, it is helpful to recognize that many private equity funds seek to maximize their returns on investment, including in, but not limited to, health care, within a relatively short time frame (commonly around 5 years) (1). Additionally, private equity funds very often acquire a controlling interest in their portfolio companies, which enables them to directly manage their portfolio companies to maximize shareholder value via practices such as increasing prices, cutting jobs, and by reducing investments in maintaining or improving product or service quality (1, 32). Many private equity funds also routinely use debt-related financial practices that can amplify the health and social consequences associated with their short-term approach. For instance, private equity funds generally use large amounts of debt to finance their takeovers because it provides them with a number of advantages, including that interest payments are generally tax-deductible (1, 33). Some private equity funds also opt to load their portfolio companies with additional debt, solely to finance dividend payments to themselves, in the form of dividend recapitalizations (34).

A number of policy solutions can help to address the potential harms associated with private equity investment in health care. These include measures such as disincentivizing private equity funds from loading their portfolio companies with excessive levels of debt, and strengthening competition regulation to block the consolidation of industries by private equity funds (1, 35). Robust health-care regulations of private health-care services, including with respect to the affordability and quality of care, are also important. Arguably, though, public ownership represents the most comprehensive approach to overcome the reality that the goal of maximizing short-term returns on health-care investments is very often fundamentally at odds with the prioritization of health equity and human rights (36, 37).

Policy considerations

- For governments seeking a comprehensive approach to improving health and equity, policies that systematically address extractive financial practices warrant serious consideration.
- Policies that seek to challenge the rules and incentives that orient corporate governance towards maximizing shareholder value could, among other things, facilitate a greater flow of resources towards health-promoting research and development in some industries, while also helping to curb economic equities more broadly (case studies 20 and 21).
- Robust tax frameworks could help to reduce inequity and the concentration of wealth by large transnational corporations, including those active in HHIs (Case study 19). In this respect, the proposed United Nations Tax Convention, which would reportedly establish a process for many governments to challenge unfair global tax rules, arguably represents a promising development (11).

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Chapter 10.

The Economic Union and the European Union's single market laws: how health-harming industries undermine policies to reduce NCDs



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Key highlights

- The EU single market places obligations on Member States, which impact their ability to adopt laws at the national level.
- Single market provisions allow private actors, including HHI, to influence the content of proposed laws and challenge these in national and European courts.
- However, single market law has provided the legal basis for the adoption of health-protective measures at the EU level that exceeded those at the national level.
- This chapter examines the contradictory dynamic of health policy-making within the single market through case studies of the alcohol and tobacco industries.



Introduction

The EU's internal market represents the most advanced form of supranational economic integration globally. It includes not just EU Member States, but also members of the European Free Trade Association to create a market of approximately 450 million consumers. Based on its core four freedoms – the movement of goods, services, people and capital – the EU's governing treaties and associated secondary and case law, known as the *acquis communautaire*, place significant legal obligations on Member States and provides strong enforcement mechanisms. The primacy of EU law over national law, and the requirement for the latter to conform with the former, places certain constraints on the ability of national, and indeed subnational governments at the regional and even municipal levels, to pass laws on a range of issues related to public health, including NCD prevention.

The principle of direct effect means that natural and legal persons, such as corporations, can seek direct legal redress for breaches of EU law via national courts (1). This includes the ability for HHIs to bring legal challenges against national public health policies, which they assess as running counter to EU law. Domestic courts may refer cases to the Court of Justice of the EU (CJEU) for adjudications on a specific point of EU law, and the CJEU may also hear cases of appeal from national courts.

The compatibility of national laws with EU laws are not determined only via legal challenges after the fact. The European Commission (EC) seeks to avoid such anomalies from emerging through a pre-legislative referral process set out in the Technical Standards and Regulations Directive (98/34/EC) (TSRD) and the Technical Regulations Information System (TRIS) (Directive 2015/1535/EU), which replaced the former (2, 3). This requires Member States to notify the EC of any legislative proposals with potential implication for EU law and the functioning of the single market, and provides an initial three-month pause in the legislative process to allow for the EC, Member States and, since 2015, private actors – members of the public and commercial actors – to make comments or share detailed opinions about the compatibility of the proposals with single market law. In principle, this is a useful process to minimize the risk of costly and acrimonious legal challenges. However, the process creates an opportunity for those with vested interests, including HHIs, to influence policy-making (read more in Chapter 4). Taken together, pre-legislative scrutiny and legal challenges function as potential so-called veto points (4) at which HHIs can oppose the enactment of national laws and other policy measures aimed at preventing and tackling NCDs that run counter to their commercial interests (5).

At the same time, EU law offers significant potential for the adoption of health-protective measures at the EU level. The evolution of health policies at the EU level has, at certain times at least, outstripped that at the national level, leading to the adoption of more comprehensive measures (1, 6). While the EU's foundational treaties contain specific provisions on health, these are weaker than those relating to the protection of the

integrity of the internal market. This reflects the need for robust harmonization and enforcement mechanisms to facilitate the function of such an ambitious and unprecedented political and economic integration project. Consequently, the most important public health measures adopted at the EU level, including those designed to address NCDs, have been adopted under the auspices of single market provisions in the treaties. For health policy advocates, it may be more effective and more resource-efficient to seek collective action at the EU level than in separate national campaigns, particularly where national government and national political culture may be less amenable to such measures than in other Member States and the EC. For similar reasons, commercial actors seek to oppose the adoptions of unfavoured measures, including through legal challenges to EU laws. More recently, the EU's Better Regulation agenda has been identified as creating additional barriers to the adoption of health-protective policies in the EU, and to have been exploited by commercial actors seeking to block or delay such measures, creating the potential for so-called regulatory chill (7).

This chapter seeks to demonstrate how the EU single market is used by commercial actors to contest the passage of public health measures through the examination of national and EU alcohol and tobacco policies. The first case study focuses on the adoption of tobacco control measures in the EU and the interconnection with policy developments at the national level. The final two cases are closely related and demonstrate the potential use of EU single market law by industry actors to challenge the adoption of alcohol control policies, and the complex interplay between policy development at the EU and Member State levels. Many of the strategies to prevent, delay and water down effective NCD policies identified here are analogous to those discussed in Chapter 5 in the context of trade agreements and the two can be read in conjunction. Restrictions of space means that this chapter focuses on particular aspects of EU single market law, and inevitably cannot consider all the implications these hold for health and health policy-making.

Case Study 22. Tobacco control in the EU

The EC has been active in the area of tobacco control since the 1990s, steering through a series of directives related to labelling and product regulation, advertising and sponsorship, and taxation (6). The EU's limited competence in health has meant that the most significant non-fiscal measures related to tobacco control have been adopted under the auspices of improving the functioning of the internal market, via Article 100a of the Treaty Establishing the European Community (TEC); subsequently Article 95 TEC and now Article 114 of the Treaty on the Functioning of the European Union (TFEU) (6). These included the annulled 1998 Tobacco Advertising Directive (98/43/EC) (TAD1) and the subsequent replacement directive (2003/33/EC) (TAD2) along with the 2001 (2001/37/EC) (TPD1) and 2014 tobacco products directives (2014/40/EU) (TPD2). All of these were the subject of significant industry lobbying, which succeeded in delaying and watering down their content (6). TPD2, for example, was one of the most controversial and highly lobbied pieces of legislation in the history of the EU and the passage of the directive lasted almost the entire duration of the 2009–2014 session of the European Parliament (8). Leaked documents from tobacco company Philip Morris International show that it orchestrated a ubiquitous and persistent lobbying campaign designed to “block, amend and delay” the passage of the directive, targeting key policy actors at all stages of the policy-making process (9) (read more in Chapter 4).

Legal challenges to early EU tobacco control measures

Following their adoption, these directives were subject to legal challenge by the tobacco industry and sympathetic Member States (6). TAD1 – which sought to ban the marketing of tobacco products in print, on television, in cinemas and at the point of sale – was challenged by the German government and four tobacco companies on the grounds that it was, in fact, public health legislation and thus exceeded the legal basis of Article 100a (10). The European Court of Justice (ECJ) annulled the directive on the basis that a number of measures within the directive – for example, the ban on cinema advertising – did not have the effect of facilitating cross-border trade and thus fell outside the scope of the internal market (11). The amended TAD2 focused explicitly on forms of advertising with obvious cross-border effects, such as television and magazine advertising, but was again challenged by the German government (10). While the ECJ held that Article 100a could not act as the legal basis for public health measures, single market legislation can have the secondary effect of harmonizing health policies (10).

Tobacco Products Directive 1

TPD1 sought to consolidate and update existing tobacco control measures and product specifications, such as tar yields and labelling requirements, and introduced new regulation on smokeless tobacco – for example, on snus, that is oral tobacco – while proposing new rules on ingredient disclosure and a ban on misleading product descriptors, such as “light” and “mild” (12). The tobacco industry's legal challenge argued that the proposed legislation did not serve the objectives of the single market, contested the application of proposed measures to export products, and argued that the ban on descriptors and increased labelling requirements infringed their trademark and intellectual property rights. In 2002, the ECJ ruled the directive valid, but disapplied this to cigarettes manufactured for export, since these fell beyond the remit of the internal market.

continued



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Tobacco Products Directive 2

TPD2 introduced a ban on flavourings and increases in the size of health warning labels and put in place a regulatory framework for electronic cigarettes, known as e-cigarettes. While a commitment to introduce so-called plain packaging across the EU had been dropped following industry lobbying, the directive included an explicit recognition that Member States were able to do so at the national level. Subsequently, various Member State governments announced plans to adopt plain packaging (13). Philip Morris International and British American Tobacco, supported by Japan Tobacco International and Imperial Tobacco, launched a legal challenge to the directive in the United Kingdom courts, arguing that, in delegating such wide-reaching regulatory powers to the EC, the EU had acted beyond its legal competence and infringed consumers' fundamental rights to product information (13).

A separate, contemporaneous action was brought in London's High Court by e-cigarette manufacturer Totally Wicked, questioning the legality of Article 20 of the directive relating specifically to the regulation of e-cigarettes. Following the referral of the case by the High Court for a preliminary ruling, the CJEU held that all aspects of the TPD were within the EU's competence and proportionate for achieving the stated aims of the directive, and, as a result, TPD2 came into effect on 20 May 2016.

In July 2014, the Government of Poland announced also that it would challenge the legality of the ban on menthol and other flavoured cigarettes and was supported in its action by the Government of Romania (14). Tobacco company Swedish Match, meanwhile, challenged the ban on snus outside of Sweden and Norway (14). Both cases were rejected by the CJEU. While legal challenges to EU-level public health measures have proven largely unsuccessful, in some instances the CJEU has found in favour of the industry, demonstrating the potential of such legal challenges to block, or at least delay, measures they oppose (1).

Case Study 23. Alcohol pricing policy in Scotland

While the EU has adopted a number of important pieces of tobacco control legislation, there is an absence of similar measures relating to alcohol. Instead, activities at the EU level have taken the form of coordination versus harmonization via the 2006 EU Alcohol Strategy and involve partnership with industry actors in ways which would be precluded for the tobacco industry (5, 15, 16).

Furthermore, measures implemented by Member States have been challenged by the alcohol industry for alleged breaches of single market rules, including the Government of Scotland's 2008 proposals to introduce a minimum unit price³ (MUP) for alcohol to address significant alcohol-related harms and health inequalities while the United Kingdom was an EU Member State (17, 18). Plans to introduce a MUP were vehemently opposed by vocal sections of the alcohol industry, which launched an extensive policy-influencing and public relations campaign designed to remove the measures on alcohol pricing from the Government's bill (19).

Industry strategies to shape the law

During the legislative process, the United Kingdom's status as an EU Member State afforded industry actors the opportunity to influence the content of the proposed measures under the TSRD consultation process in force at the time of the MUP legislation's passage (1). While there was some uncertainty about whether such a referral was necessary, the industry's clearly articulated intention to launch legal challenges to the MUP led the Government of Scotland to err on the side of caution (3). Some Member States, particularly those with domestic alcohol producers, raised issues about the MUP, including the Government of Poland, which reproduced statements by the Polish brewers' association as their submission (20). The Government of Scotland and health NGOs mounted an effective counter-lobbying effort to support the policy in Brussels and national capitals seeking to allay concerns (2). While the TSRD process created political barriers, which the Government of Scotland had to overcome, their policy emerged from this process largely intact.

Legal challenges

Following the adoption of the MUP legislation, the alcohol industry sought to prevent or at least stymie its implementation through legal challenges on the basis that it contravened national competition policy and EU internal market law. The Scotch Whisky Association (SWA) announced on 19 July 2012 it had begun proceedings against the Government of Scotland and was joined in its action by Spirits Europe and the European wine trade association, CEEV.

As a potential precedent for the MUP case, previous attempts to enact minimum pricing policies for tobacco in Austria, France and Ireland had been ruled to run counter to single market laws on the basis that they were "equivalent to quantitative restrictions" and that the same objectives could be delivered via less trade-restructuring measures, such as taxation (15, 16). Pricing is a key mechanism through which new, imported products can compete with established, local brands and, to the extent that it limits this, minimum pricing would be anti-competitive and would interfere with the ability of manufacturers to set the retail price of their products.

continued

³ MUP aims to create a floor price per standard drink. It is a measure of alcohol below which alcoholic drinks cannot be sold.

In a similar vein, the SWA claimed the policy infringed Article 34 of the TFEU prohibiting quantitative restrictions on the movement of goods between Member States and all measures having equivalent effect, and that no exemption could be justified under Article 36 of the same treaty on the grounds they are essential for “the protection of health and life of humans” (2, 3). The Scottish court of appeal referred up to the CJEU to provide a preliminary ruling on compatibility of the minimum pricing measures with EU law. The CJEU found that, while a MUP may run counter to Article 34, and the intended objectives may be achieved through other less trade-distorting means, it reiterated the responsibility of domestic courts to determine the necessity of a MUP to protect human health given other available measures. In December 2016, the SWA appealed the decision of the Scottish courts to the United Kingdom Supreme Court, which found in favour of the Government of Scotland in November 2017, finally exhausting the legal avenues open to the SWA. The MUP came into effect in May 2018, with a delay of six years between legislation and implementation of a measure designed to curb rising levels of alcohol harm.

Case Study 24. Alcohol labelling in Ireland

Ireland has been attracting international attention following its ground-breaking moves to introduce comprehensive health information labelling of alcohol products. The labels include warnings about alcohol and cancer, liver disease and drinking in pregnancy, as well as information on the energy and alcohol content of the product plus a link to a public health website. The legislation, originally proposed in 2013 and passed by the Oireachtas (Irish Parliament) in 2018, was signed into law by the Minister of Health in 2023. A further three-year lead-in period had been demanded by the industry, meaning labels would finally be introduced in May 2026. The significant delays in the adoption and implementation of these measures were the result of a well-organized campaign from within the global alcohol industry. In addition to relentless pressure placed on Irish legislators, in an attempt to oppose and shape the legislation, industry actors have sought to exploit international trade and EU internal market laws to oppose its introduction.

Alcohol labelling in the EU

Uniquely among consumable products, alcohol has a derogation from the 2011 EU labelling Food Information to Consumers Regulation (21) that would otherwise require alcoholic beverages to carry basic information on ingredients and energy values as are required on non-alcoholic drinks, including mineral waters. The alcohol industry claimed that they would introduce an EU-wide self-regulatory labelling regime and their proposal was finally put forward to the EC in 2018 (22). While some product categories, such as beer producers, did introduce voluntary labelling, others, such as spirit producers, did not. Thus, no standardized, sector-wide label was ever produced, and the EC has now accepted the need for mandatory ingredient and nutritional labelling (23). Similarly, the Europe Beating Cancer Plan recommends the addition of cancer warning labels to alcohol products (24). However, there has been little progress on either front to date (25).

Policy innovation at the Member State level

In the absence of comprehensive and effective action at the EU level, the Government of Ireland sought to legislate for mandatory alcohol labelling along with a series of other public health and alcohol control measures, such as a MUP and advertising restrictions. Following substantial advocacy by civil society groups, secondary legislation stipulating the exact label requirements, for elements such as font size and colour, was published in 2022 and notified to the EU through the TRIS procedure (26). In the absence of objections from the EC, the Minister for Health signed the regulations into law in May 2023.

Industry opposition

The alcohol industry claimed that Ireland's unilateral decision on mandatory alcohol labels sets a bad precedent for the EU's single market, with particular consequences for small producers facing the costs of a new labelling regime (27). During the TRIS process, comments were issued by six Member States and detailed opinions by nine Member States, many of which had significant wine producers reflecting industry concerns. Alcohol industry responses were well coordinated, putting forward similar arguments. Mirroring arguments made on the MUP above, Spirits Europe claimed the regulations would "exert a significant negative impact on the proper functioning of the EU's single market, disrupting the free movement and trade flows of alcoholic beverages between Ireland and other EU Member States" (26).

In addition, The Brewers of Europe claimed that Ireland's regulation would "pre-empt activity in areas where the EC has already announced its intention to bring forward legislation and are inconsistent with existing EU harmonised legislation on the provision of food information to consumers" (26).

These arguments demonstrate how industry actors engage in so-called venue shopping where they attempt to play off different policy contexts against one another and shift decision-making to the level at which they are best able to secure their interests (13). The ongoing lack of EU-level proposals on ingredient and nutritional labelling, despite the EC's previous commitment to bring these forward by the end of 2022, suggests that industry calculations – that they would be better able to water down and delay measures at the EU level – were well-founded (25, 28). There was evidence also of concerted effort by industry to denigrate the well-established scientific findings that alcohol causes cancer and liver disease, through bodies such as Drinks Ireland, citing reports they had commissioned from authors and organizations, such as the Gradient Corporation (26).

Blocking implementation

Despite the labelling regulations having cleared all hurdles to its adoption, the alcohol industry continues to try to disrupt the implementation of the measure through practices aimed at the WTO Technical Barriers to Trade Committee at which Member States have put forward similar arguments to those raised at the EU level. The EU and WHO have defended Ireland's position and the number of countries raising issues with the measures has dropped from 12 to 6. There are examples of other country efforts to introduce alcohol labelling being significantly delayed or derailed, often using international trading law (29). However, increasingly, the provision of statutory health information labelling is happening in different contexts with visible pregnancy warnings now mandatory on alcohol products in Australia and New Zealand (30), and countries such as Norway planning to introduce cancer warnings (31). Ireland's success in this area can help to accelerate this process across Europe and globally.

Summary

The EU is a complex system of multilevel governance. Decisions impacting on NCDs, and on the regulation of the products and the industries that are their key vectors, occur at subnational, national and supranational levels. As we have seen in the case of tobacco control, the EU possesses significant powers to regulate health-harming products in the context of its internal market. A single regulation or directive adopted at this level can set policy for approximately 450 million people, bypassing the political vicissitudes and industry opposition of multiple, national policy processes. Because of this, industry actors invest significant resources to lobby against the adoption of such measures and to prevent their implementation. However, the EU's internal market is a double-edged sword. The supremacy of EU law places restrictions on national governments'

capacity for policy innovation and single market law has formed the basis of legal challenges to national policies aimed at introducing so-called plain packaging of tobacco products and a MUP for alcohol. A ruling that a particular national measure runs counter to EU law can prevent its adoption anywhere within the single market. In addition, the pre-legislative TRIS procedure creates an additional potential so-called veto point for policies to tackle NCDs and an opportunity to delay and water down the content of proposed laws and opportunities for industry actors seeking to prevent the adoption of policies aimed at addressing the consumption of their products.

The case studies provide insights into ways that industry can exploit the opportunities afforded by the EU single market and the types of arguments they deploy to try to block, delay or weaken policies they oppose. Those seeking to bring about policy change in the interests of public health can use these case studies to inform their own counter-strategies and identify the opportunities that EU legal and governance structures create to protect and promote public health, while recognizing their contextual nature.

Policy considerations

- National governments and health policy advocates should be cognizant of single market implications in the design of health policies.
- The EC and national governments should facilitate the engagement of civil society actors in the TRIS procedure and ensure that health as well as commercial interests are considered.
- The EC and national governments could consider the adoption of more robust public health exemptions from single market provisions to minimize the potential for health policies to be delayed, watered down or prevented on these grounds.

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Chapter 11.

The commercial industry taking advantage of crises and emergencies



Key highlights

- Businesses can make positive contributions to society through CSR activities.
- Such activities are promoted by the business as a form of marketing.
- Businesses helping as part of an emergency response is usually used as a CSR marketing opportunity by the business.
- The health and well-being of individuals in an emergency situation are especially vulnerable.
- Emergency responses should be appropriately planned for by the state without the need to involve businesses.
- Businesses operating in sectors that negatively influence health should never be permitted to use emergency responses as marketing opportunities.
- Inappropriate CSR activities used as emergency responses potentially breach the human rights responsibilities belonging to businesses.
- Emergency response is an inappropriate context for CSR activities.

The UN defines a disaster as an “occurrence when hazards, whether natural or human-made, interact with vulnerable populations”.





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Introduction

The UN defines a disaster as an “occurrence when hazards, whether natural or human-made, interact with vulnerable populations”. Emergencies are “occurrences when the dimensions of the disaster exceed the coping capacity of the affected community. The international community is called upon to respond when the disaster's effects exceed the coping capacity of the country concerned” (1). In emergency and disaster management, an emergency is “an event that can be responded to using the resources available at hand, implying that there is no need to request external assistance”. A disaster, on the other hand, is characterized by “impacts that overwhelm the capacities of local responders and place demands on resources which are not available locally. Hence, an event is declared as a ‘disaster’ when there is a need for external assistance to cope with its impacts” (2).

The actions of businesses during emergencies can determine health outcomes in several ways. First, there are proximal effects, which mean that decisions have an immediate impact. An example is when the actions of a business interfere with citizens accessing lifesaving goods or services. Second are the distal effects; these are not immediately obvious, and the effects may take some time to appear. An example is when a business uses an emergency to promote health-harming products, and the continued custom, or new trade, has adverse health outcomes over time. Third are situations where proximal and distal outcomes overlap, so the example is when scenarios one and two above happen simultaneously. Here, the actions of a business prevent immediate access to goods or services that adversely affect the morbidity and mortality of the victims of an emergency while also encouraging the custom or use of a health-harming product with long-term adverse health effects.

Corporate Social Responsibility (CSR)

To successfully operate, a business must earn support from society. The cost of obtaining a social license to allow operation varies significantly depending on the institutional field of the business. For example, a customer-facing business must ensure harmonious relationships with society. In contrast, a business that operates at a greater distance from the public will not necessarily be as concerned with public opinion – not least because there will be less interest in such an entity than in one more familiar to the populace. This contractual-type relationship between business and society can be best understood through a concept within organizational studies called organizational legitimacy.

Organizational legitimacy can be defined as:

... [the] degree of cultural support for an organisation – the extent to which the array of established cultural accounts provides explanations for its existence, functioning and jurisdiction, and lack or deny alternatives...a completely legitimate organisation would be one about which no question could be raised (3).

Organizational legitimacy, therefore, is a tool to measure conformity with established norms and values and a social judgment relating to the appropriateness of the business's characteristics and conduct (4). A business is deemed legitimate if it complies with society's expectations, which gives rise to legitimacy (5). Failure to comply with these expectations can mean a business will struggle to survive. This societal agreement is referred to as a social contract or license (6). A social contract is an acknowledgment that the business has an obligation to shareholders to make a profit. In return for permission to make a profit, the business must fulfil its obligation to all stakeholders by acting socially responsibly. Moral legitimacy theory further develops the concept of a social contract by arguing that a business should go beyond being objectively responsible. In other words, operating within the boundaries of laws, rules, policies and customs; producing profits for shareholders; providing jobs; and paying taxes are the minimal standards expected of a business. For a company to obtain moral legitimacy, it must contribute positively to society in a way that goes beyond such normative expectations.

Most businesses use CSR to achieve moral legitimacy and purchase social licenses (see Chapter 7). While various academic conceptualizations of CSR exist, the so-called business-case model is the most popular. The logic of the business-case model aligns with moral legitimacy because it frames reasoning for CSR engagement as the understanding that corporate support of social issues translates into profit via consumer support for the business when it behaves ethically and with a social conscience (7).

This means that businesses often use CSR as a reputational management tool. On the face of it, a business giving back to society in return for support can be perceived as a win-win scenario. And there is no doubt that mutually beneficial CSR programmes are in operation. However, the so-called washing of corporate harms through CSR practices is well-documented. The phenomenon of “greenwashing” is a good example of this and is explained by the UN as follows: “[By] misleading the public to believe that a company or other entity is doing more to protect the environment than it is, greenwashing promotes false solutions to the climate crisis that distract from and delay concrete and credible action” (8). Greenwashing, first coined in 1986 (9), explains the corporate washing of harms in environmental areas. So-called social washing describes practices that businesses engage in to draw attention away from negative social impacts by “promoting themselves as socially responsible and ethical. This might include a grand gesture or donation to draw attention away from something else they are doing” (10). Social washing is broader than greenwashing and relates to any social issue. An example of social washing is when companies publicly celebrate International Women’s Day and are subsequently called out for internal gender pay gaps.¹²

The harm caused by businesses, and obscured through washing, can range from minor to wide-reaching and devastating. Some business harms are so devastating that, in 2011, the UN adopted an instrument to help states and businesses address, mitigate and remedy the harm businesses can have on human rights.

¹² For a real-time example of this, the “Gender Pay Gap Bot” on X (Twitter) live tweets companies using the International Women’s Day hashtag with their gender pay gap. See here for more: <https://twitter.com/paygapapp?lang=en>.

Business and human rights

The United Nations Guiding Principles (UNGPs) are the decisive international instrument on business and human rights responsibilities (11). The framework, adopted by the UN in 2011, consists of three pillars and 31 principles. The three pillars are the following.

1. The “state duty to protect human rights” recognizes states as the duty bearers of human rights. This duty is a legally binding obligation under international law.
2. The “corporate responsibility to respect human rights” establishes, for the first time in international law, businesses' responsibility to not infringe on the “human rights of others” and to “address adverse human rights impacts with which they are involved”.
3. “Access to remedy” requires states to ensure victims of corporate human rights abuses have access to instruments that can provide remedies for the harms suffered.

The UNGPs do not impose additional legal obligations regarding human rights responsibilities on businesses. International law is usually only binding on states, not individuals or groups (12). However, they are instrumental in setting international expectations for businesses' responsibilities in the human rights sphere. One example of the UNGPs' increasing importance is the judicial use of the pillars. The UNGPs were cited in *Milieudefensie et al. v Royal Dutch Shell* [2021] (13) and *Kaliña and Lokono Peoples v Suriname* [2015] (14).

Pillar two, as the device that establishes business responsibilities for human rights, is the pivotal pillar to rely on when drawing boundaries for business behaviour in society when such behaviour might harm human rights. Principle 17 states:

In order to identify, prevent, mitigate and account for how they address their adverse human rights impacts, business enterprises should carry out human rights due diligence. The process should include assessing actual and potential human rights impacts, integrating and acting upon the findings, tracking responses, and communicating how impacts are addressed.

The human rights of victims of an emergency are more vulnerable than ever. If a company decides to invoke a CSR policy to donate or in some way get involved with an emergency, it has an existing responsibility under principle 17 of the UNGPs to ensure it has carried out due diligence on both actual and potential human rights impacts of its involvement. The entire bedrock of CSR is built on brand association and trading on good actions in return for continued or new trade. Logically, when a business intervenes in an emergency and uses brand logos on donations or informs the public about the intervention, CSR is in action. In fact, using emergencies or disasters as a CSR initiative is of such interest to the business community that blogs and advice on how to do so are available through professional networks, such as LinkedIn (15). As stated earlier, business support in such times can be critical, but if the company's activities or product harms or potentially harms, human rights, such as health, then this is a business and human rights issue and contravenes principle 17 of the UNGPs.

This chapter will present case studies wherein businesses have used emergencies as CSR tools and, in doing so, potentially breach their responsibility under the UNGPs. Case study 25 examines McDonald's involvement in offering free meals to hungry children during the COVID-19 pandemic in the United Kingdom (note, this is a collision of two emergencies, as the emergency was during the COVID-19 pandemic, and this was underpinned by the cost-of-living crisis in the United Kingdom.) Case study 2 will unpack Philip Morris International's donation of intensive care unit (ICU) beds to Greece during the COVID-19 pandemic. Case study 3 uses the example of commercial milk formula (CMF) companies distributing infant formula during the Ukraine war.



Case study 25. The intervention of McDonald's in the cost-of-living crisis

The United Kingdom has had a cost-of-living crisis since late 2021 (16). This crisis has been called a “public health emergency” that can affect the entire population, but the most vulnerable are “young children, single parents, multi-generational families” (17). Applying the UN’s definition of an emergency (that an affected community cannot cope with their situation) supports the argument that, in the United Kingdom, these vulnerable groups live in a state of emergency. In 2022, it was reported that one million children and 2.8 million adults were living in destitution in the United Kingdom (18). The Joseph Rowntree Foundation (JRF) explains destitution as:

People are considered destitute if they have not been able to meet their most basic physical needs to stay warm, dry, clean and fed. This can be because they either lack necessities like clothing, heating, shelter or food. Or because their income is so extremely low that they are unable to purchase these items for themselves.

In June 2023, the UN Committee on the Rights of the Child raised concerns for children living in the United Kingdom over poverty, among other issues (19). The Committee noted “with deep concern the large number of children living in poverty, food insecurity and homelessness... (20)”. In 2022–2023, the food charity, United Kingdom-based Trussell Trust, supplied 2.99 million emergency food parcels to people suffering from hunger in the United Kingdom (21). A 2023 report by the Food Foundation, a food charity based in the United Kingdom, found that health inequalities are worsening in the United Kingdom and were worse than comparable countries (22).

In a public health emergency, such as a cost-of-living crisis, a gap is created if the state cannot or does not provide adequate support to citizens (23). CSOs usually fill this gap, and due to the expenses involved, CSOs often turn to businesses for funding assistance.

continued

FareShare is a charity network in the United Kingdom that distributes food to those at risk of hunger (24). The network has partnered with McDonald's since 2020 in a classic CSR collaboration. McDonald's, one of the world's largest and most recognizable fast-food chains, promotes its support of FareShare on various platforms and, in return, FareShare receives financial and production support to enable it to do its charitable work (25, 26). An example of how McDonald's promotes itself on social media as being a good corporate citizen. Note the hashtag says, "#EndChildFoodPoverty (27)".

Child hunger is a cause that resonates strongly with the public and, so, is valuable reputational capital. This alone is valuable marketing for McDonald's, but to further attract custom, the company launched a rewards initiative in 2022. In addition to its initial pledge of one million meals, McDonald's announced that, during the FIFA (Fédération internationale de football association) World Cup, for every order made via its app on match days in United Kingdom (England and Wales), the company would donate 100 reward points.¹³ McDonald's stated that this equated to the "redistribution of two meals for every five orders made through the app (26)". In the notes to editors' section of the press release, further information clarified that "Every 1500 Reward points = £1.50, or the equivalent of six meals for FareShare."

This initiative is part of a suite of marketing tools for McDonald's that encourages loyalty to a company that profits from selling so-called fast food, which is known to be unhealthy (28). It encourages customers to use McDonald's and, in this example, McDonald's benefits from the increased custom, brand visibility, and association with (i) a charitable organization [FareShare] and (ii) a sporting event [the World Cup]. And by having customers download the app, the company potentially has direct access to customers via their mobile phones, further embedding the corporation into the lives of customers.

CSR is widely accepted as a marketing tool to encourage support and loyalty from customers to a business. A classic CSR charity partnership – McDonald's and FareShare – demonstrates how a business takes advantage of an emergency to insert the brand as a saviour to those suffering in the emergency (29, 30). McDonald's is not the only company to do this. For example, Iceland, a supermarket specializing in selling processed frozen foods, initiated a scheme to "ensure no schoolchild goes hungry" by publicizing that it would accept "free school meal vouchers" (31). This scheme operates similarly to the McDonald's case study in that it offers a short-term solution to a social issue without tackling the root cause of the problem.

¹³ Reward points is a McDonald's customer loyalty scheme whereby customers can claim points when purchasing McDonald's items. The website states, "For every penny you spend on eligible products at a participating restaurant, you will receive 1 point." Customers can exchange the points for McDonald's items when they reach a certain amount. For example, 1500 points entitle the holder to a "small fries, medium salad, mini McFlurry®, hash brown, a regular drink or donate £1.50 to one of our partner charities". Customers can donate their points to a charity and choose which McDonald's charity partner will benefit (among the charities is FareShare). See here for more information on McDonald's points: <https://www.mcdonalds.com/gb/en-gb/good-to-know/in-our-restaurants/my-mcdonalds-app/rewards.html#:~:text=First%2C%20go%20to%20the%20Rewards,and%20C2%A35.50%20for%205500>. For the FIFA promotion, McDonald's stated on their website, "McDonald's is also donating 100 Reward Points for every single order made via the McDonald's app on Wales and England football match days between 19th November and 19th December 2022. This equates to the redistribution of two meals for every five orders made through the app. Every 1500 Rewards points = £1.50, or the equivalent of six meals for FareShare". See more information on the McDonald's FIFA promotion here: <https://www.mcdonalds.com/gb/en-gb/newsroom/article/redistribution-of-over-1million-meals.html>.

Case study 26. Philip Morris International and the COVID-19 pandemic

The Global Centre for Good Governance in Tobacco Control (GGTC)¹⁴ published a series of case studies exemplifying how the tobacco industry used the COVID-19 pandemic to wash its reputation (32). The GGTC states (32):

The tobacco industry which is known to be the vector of the tobacco epidemic, causing at least 1.4 trillion dollars of economic losses annually along with 8 million deaths, is now further contributing to an increased burden on the health-care system during the COVID-19 pandemic. To ensure that its culpability goes undetected during the crisis, the tobacco industry launders its image through donations, particularly to governments and through government officials, in cash, personal protective equipment (PPE), and medical equipment such as ventilators and vaccine research/supply. Notably, the tobacco industry's donation, a form of CSR activity, is disproportionate to the value of the damage it brings to the economy. Tobacco industry's so-called CSR practices allow it to market its dangerous and addictive products and undermine governments' credibility and commitment to implement the global tobacco control treaty, WHO FCTC. According to Article 5.3 of the treaty, governments must protect its public health policy from the commercial and vested interests of the tobacco industry, which involves denormalizing so-called CSR of the tobacco industry.

Within the case studies presented by the GGTC, examples of the tobacco industry using CSR strategies during the COVID-19 pandemic were given from across various jurisdictions, such as Canada, India and the United States. In Europe, examples included Bulgaria, Italy, Serbia and Ukraine. This chapter uses the example of the tobacco industry leveraging the COVID-19 pandemic to wash its reputation in Greece.

Philip Morris International (Philip Morris International) is the world's leading multinational tobacco company. During the height of the COVID-19 pandemic, public health guidelines advised people to stop smoking because the practice was linked to poorer outcomes in pandemic patients (33). At the beginning of the spread of the COVID-19 pandemic in Europe, on 18 March 2020, Philip Morris International's director of communications for Greece tweeted that Philip Morris International had sourced, purchased, and would deliver ventilators to ICUs in Greece to "help flatten the curve (34)". At the time, the health minister for Greece publicly thanked Philip Morris International for its donation (35).

The criticism of this move by Philip Morris International was immediate. Below are some of the recorded responses (35).

Deborah Arnott, Chief Executive of Action on Smoking and Health,¹⁵ criticized Philip Morris International's motives, "This is a shameful publicity stunt by Philip Morris International, which owns Papastratos¹⁶ and has a 40% share of the Greek tobacco market."

Constantine Vardavas, a research associate at the University of Crete's School of Medicine, said, "If smoking does predispose people to having adverse outcomes during COVID-19 it is a funny position to be giving ventilators but selling a product that leads to worse outcomes."

¹⁴ GGTC is a CSO based in Thailand. They "collaborate with advocates, governments, and institutions worldwide to tackle the single greatest obstacle in tobacco control implementation: tobacco industry interference". Their mission is "to provide the world with strategies and tools to counter tobacco industry interference and promote policy coherence in tobacco control at the national, regional, and global levels". Reference: GGTC. In GGTC/About GGTC [website]. Bangkok: GGTC; 2024 (<https://ggtc.world/about-ggtc>).

¹⁵ Action on Smoking and Health is a United Kingdom-based public health charity. Reference: Action on smoking and health. In: ash/About ASH [website]. London: ash; 2024 (<https://ash.org.uk/>).

¹⁶ Papastratos is an affiliate of Philip Morris International and the largest tobacco company in Greece. Reference: Greece. In: Philip Morris International/Greece [website] (<https://www.Philip Morris International.com/markets/greece/en/overview>).

Case study 27. The commercial milk formula industry in the Ukraine war

Infants and young children are particularly vulnerable in emergency situations (36). Breastfeeding protects these populations as human milk provides nutritious and reliable food that prevents infection (37). The widespread availability and untargeted distribution of CMF, a type of human milk substitute, reduces the propensity to breastfeed, thereby increasing the risk of disease and death among infants and young children (38).

Donations of CMFs contribute to poor distribution practices in emergency situations (39). The Infant and Young Child Feeding in Emergencies Operational Guidance prohibits the donation and acceptance of donated infant formulas and related products (40).¹⁷ Despite this, the CMF industry actively participates in formula donations during emergencies (41, 42), with some companies advertising this practice, exhibiting their CSR. Rather than being entirely benevolent, this practice may instead seek to create future markets (43).

For example, in the immediate and longer-term aftermath of the 2022 full-scale invasion of Ukraine, extensive and unregulated donations of infant and child CMF products negatively impacted infant and young child feeding programmes (44). However, before the invasion, breastfeeding was supported and widely practiced in Ukrainian society and its health system. Just over 50% of infants were breastfed exclusively to six months of age (the World Health Assembly 2025 target for exclusively breastfed infants aged is 50%, so Ukraine's pre-war performance is considered good), and only 14.8% were exclusively formula-fed (44). In addition, 92% of maternity and 66% of paediatric hospitals were accredited by the Baby Friendly Hospital Initiative (45).¹⁸

At the outset of the emergency, in response to the Ukraine war, a joint statement issued by a consortium of organizations, including the United Nations Children's Fund (UNICEF), Office of the United Nations High Commissioner for Refugees (UNHCR), and NGOs, specifically proscribed the solicitation, acceptance or distribution of donations of breast milk substitutes, such as CMFs and commercial complementary foods (46). An agreement between the Ukrainian Ministry of Health and UNICEF provided an official system for the targeted distribution of CMFs to those requiring them. Despite this institutional support, large-scale donations of infant CMFs and commercial complementary foods, including those directly from the CMF industry, were made outside this official system by other organizations. The widespread availability and unregulated distribution of donated CMFs have been identified as a critical barrier to appropriate emergency feeding practices, such as the early initiation of breastfeeding in newborns, continued breastfeeding, and re-lactation (44).

¹⁷ This guidance was developed by the Emergency Nutrition Network (ENN). Reference: Our Work. In: ENN/Our work [website] (<https://www.enonline.net/operationalguidance-v3-2017>).

¹⁸ Accreditation means the hospital is accredited as a baby-feeding-friendly hospital. Baby Friendly accreditation is based on interlinking evidence-based standards for maternity, health visiting, neonatal and children's centres services. It is a UNICEF initiative. Reference: Accreditation. In: unicef United Kingdom/Accreditation [website]. London: UNICEF (<https://www.unicef.org.uk/babyfriendly/accreditation/>).

When states cannot or do not provide resources and funding to protect vulnerable citizens from the effects of emergencies, charitable organizations are needed to fill this gap.



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Summary

When states cannot or do not provide resources and funding to protect vulnerable citizens from the effects of emergencies, charitable organizations are needed to fill this gap. However, charitable organizations do not have the funds to do this work alone. While involving businesses in providing relief in emergencies may appear beneficial, there can be health and human rights-related issues attached to such gestures. Juxtaposing brands that profit from unhealthy or health-harming products with messages about solving social issues is a marketing strategy that must not be allowed. Governments have a duty to respond to emergencies and a responsibility to do so without requiring businesses to be part of the response.

HFI already face marketing restrictions in the European region. Increasingly, fast-food companies are prohibited from directly marketing to children.¹⁹ Therefore, it is logical for the regulatory process to evolve to ensure that one marketing conduit is not cut off only to allow another to expand.

One recommendation stemming from a review of the Ukrainian emergency response (as explored in Case study twenty-six) is that the global community needs to strengthen approaches and regulatory frameworks to “prevent harmful and inappropriate donations” (44) of CMF products to protect infants and young children in future emergencies. While it is recognized that CMF products can save lives in emergencies, the advice to regulate approaches in emergencies for this industry is especially important given the vulnerability of infants and young children. The need for collaboration to set standards for business involvement in emergency responses is applicable to all industries that have the potential to influence health outcomes.

Planning is critical for emergencies. The solutions to the many issues that arise from emergencies must come from adequate state funding and HFI should not form part of emergency responses. In the future, emergency preparedness plans should establish policies regarding the role of businesses in emergencies. Ideally, states should be able to manage the health and well-being of citizens without support from for-profit businesses through adequate tax regimes and so on. Where this is not the case and support from for-profit businesses is necessary, states should extend guidelines that prohibit or restrict marketing by specific industries to apply in emergencies. In other words, companies should not be allowed to create marketing loopholes or advertising opportunities via emergency situations.

¹⁹ As part of the United Kingdom government’s strategy to cut obesity rates, legislation was introduced to restrict advertising on certain foods high in fat, salt, or sugar (HFSS). Fast-food companies, such as McDonald’s, fall into this category. See the Health and Care Act 2022 321 (1)(b) at: <https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted>, accessed 10 April 2024. See also countries, such as Portugal (the first country in the EU to enact regulation on the digital marketing of unhealthy foods to children) in “Future steps to tackle obesity: digital innovations into policy and actions. Conference report (29 June 2021)” available here: [WHO-EURO-2022-4764-44527-63040-eng.pdf](https://www.who.int/euro/2022-4764-44527-63040-eng.pdf) accessed on 11 April 2024. See also the Blueprint Directive written by leading experts in obesity prevention that presents how the EU could regulate the marketing of health-harming products in the EU: [blueprint-eu-directive-protect-children-against-the-marketing-of-nutritionally-poor-food-final-november2021.pdf](https://www.who.int/euro/2022-4764-44527-63040-eng.pdf) (epha.org), accessed 10 April 2024.



Policy considerations

- Emergency preparedness plans must consider the influence of business involvement in responses.
- Existing domestic laws regulating marketing to vulnerable populations should be extended to include emergency situations.
- Businesses involved in emergency responses should not be linked to health-harming products.
- Existing international codes and instruments should be consulted when drafting emergency preparedness plans. Among the most important are the:
 - International Code of Marketing of Breastmilk Substitutes
 - UN Guiding Principles on Business and Human Rights.

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Chapter 12.

Taking action to address the commercial determinants of NCDs in Europe



Key highlights

- CDoH have an influence on population health at multiple levels: individual, environment, public policy and political economic system. This requires comprehensive approaches that target all levels.
- Actions are required to safeguard policies and the policy-making process from commercial influence. This includes the use of mechanisms to address and manage the influence of commercial actors on political and scientific practices.
- Investing in health systems, especially for strengthening leadership, governance and regulatory functions, is necessary to counter the negative influence of industry on population health.
- The root causes of ill health are linked with the current political economic system, which privileges and is influenced by the interests of powerful commercial actors over those of public health. Hence, the importance of addressing that political economic system, and rethinking capitalism, cannot be ignored.



Addressing the CDoH requires actions directed at both specific industries and their practices, as well as the systems that are shaped by and shaping commercial practices. Commercial influence is exercised at different levels: the individual, the environment, public policy and the political economic system. The present report has noted the many ways through which that influence is exercised. Hence, actions to address the CDoH need to target these different levels.

Existing attempts to address the CDoH, for a great part, narrowly focus on the individual level and do not do enough to address systems and the environment. Moreover, public policies and population-level interventions often target individuals with the aim of changing behaviours, for example, with warnings on the front of packs of cigarettes and food products or social marketing campaigns (1).

Public policies that target the environments in which people live can include marketing restrictions and taxation on harmful products. The health, social, and environmental impacts that result from commercial activities could also be subject to taxation. Decreasing the subsidies for harmful products or practices is another important action. These actions on the environments in which people live are of utmost importance to address the CDoH, particularly from a health equity perspective.

At the system level, actions are needed to safeguard policies and the policy-making process from commercial influence. Considering the existing power imbalances between commercial actors and the public health community, public policies themselves need to be protected from the CDoH. This includes the use of mechanisms to address the “reputation management” and “political” and “scientific” practices of commercial actors (2, 3). These mechanisms relate to transparency (e.g. register of lobbyists, or a minister’s diary disclosures), monitoring and education (e.g. training on the CDoH for policy-makers), the management of interactions with commercial actors and COI (e.g. limits on donations to political parties), and mechanisms that exclude engagement with commercial actors (e.g. policy prohibiting governments to endorse, support, partner with or participate in industry-sponsored activities, notably of the tobacco industry) (2). Carefully considering the risks and benefits of interacting with commercial actors is important for policy-makers. Useful tools include the “Good governance toolkit for Commercial Determinants of Health” (4) or WHO guidance recently launched at the 77th World Health Assembly to support governments to make informed decisions on engaging with the private sector (5, 6).

The FCTC is a good model to address the different levels of influence of a given industry. It includes actions to limit the marketing, “reputation management” and “political” and “scientific” practices of commercial actors (3), with an explicit reference to the need to isolate public policy from the negative influence of the tobacco industry. A convention to address the CDoH could draw from such efforts.

In addition, the root causes of ill health are linked with the current political economic system, which privileges and is influenced by the interests of powerful commercial actors over those of public health. Hence, the importance of addressing that political economic system, and rethinking capitalism, cannot be ignored. Importantly, it is crucial from a public health perspective that governments meet the basic needs and human rights of their population, including social needs, without breaching our ecological and climate boundaries (1). There are alternative economic models in Europe, which could serve as examples, including the well-being economy and doughnut economy (see Box 8).

Box 8. Well-being economies in the United Kingdom (Wales) and Finland

The Well-being of Future Generations (Wales) Act is a cornerstone of Welsh policy. It introduces measures to ensure that the well-being of current and future generations is preserved through social, economic, environmental, and cultural initiatives (7). A key component in overcoming industry interference has been the role of the Future Generations Commissioner, who advocates for sustainable practices and holds the government accountable to the Act’s goals.

Finland’s approach integrates extensive social welfare and health systems, designed to provide universal benefits, which help limit the influence of harmful industry practices by promoting public health and general welfare over corporate profits (7). The emphasis on collaborative governance and the integration of well-being metrics into policy and decision-making is crucial in addressing broader social determinants of health (8).

Both examples reflect an ongoing commitment to prioritizing well-being through innovative governance and legislation, aligned with sustainable development goals (7). These initiatives aim to create societal systems that value health, environment and welfare beyond mere economic metrics. However, the effectiveness of these policies depends largely on their enforcement and the continuous engagement and education of communities about the benefits of a well-being-focused economic system (9).

Case study 28. Joint Annual Review of Kyrgyzstan's health sector: a coordination mechanism for NCDs

NCDs are the leading cause of mortality and morbidity in Kyrgyzstan, linked to approximately 83% of all deaths (10). There is a national coordination mechanism in the health sector of the country to discuss key health issues and solutions, called the Joint Annual Review (JAR), between the Government of Kyrgyzstan, Ministry of Health, developmental partners, NGOs and health experts working in the health sector. The DPs include the Swiss Agency for Development and Coordination, UNICEF, United Nations Population Fund (UNFPA), World Bank, and WHO.

This coordination mechanism came from previous experience with the coordination of comprehensive health reforms, focusing on financial protection, quality of care, and strengthening primary health care and public health services. The commitments of the development partners and the Government were formulated in a Joint Statement of the Partnership in 2019 (11).

This mechanism was established to better coordinate external aid received for the health sector, including for preventing and addressing NCDs, and to discuss joint planning, implementation, revision and reporting under the tasks and interventions formulated in national strategic documents.

The JAR serves as a platform to analyse best practices as well as obstacles and barriers to progress towards those best practices. It helps improve the information flow among partners and provides joint reports to support the national strategy "Healthy people – Prosperous Country, 2019–2030" (12). This is also a platform to share the latest surveys and other research conducted in the country and to provide additional data to health workers. The data from the surveys and the health statistic data are also used for further dialogue with the Ministry of Finance and Ministry of Economy. The JAR covers discussions on governmental expenditures for health, quality of care, public health services, medicine management, e-health, laboratory services, human resources, recommendations to increase excise taxes for tobacco and alcohol products, and revisions of regulatory documents and laws, including the Tobacco Law. Moreover, the reports produced by the JAR are received by the Cabinet of Ministers, which helps align the health strategy with other priorities of the national development programme.

Commercial actors, such as laboratories, pharmacies, tobacco and alcohol producers, and others, are not involved in the JAR, but relevant decisions and recommendations of the JAR are of use to them. As such, the JAR, as a public mechanism, leads to coordinated efforts in the health sector and has been successful at working with other sectors of the Government to better control NCD risk factors. This coordination can lead to a more systemic approach to policy-making, with less potential for loopholes to be exploited by industry.



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Case study 29. Coalition-building and policy dialogue: Estonia's sugar-sweetened beverage tax

Background

Estonia has a liberal market economy and a powerful food industry, whose many positions are derived from European umbrella trade associations. The prospect of a tax on SSBs in Estonia began in 2013 with the development of a green paper from the Ministry of Social Affairs on policy options for addressing obesity (13). In 2016, with a change in government, a potential SSB tax was on the agenda, which progressed through draft stages and was approved by Parliament but was ultimately rejected by the President in 2017. Roundtable discussions during this first attempt to pass the law were dominated by industry voices and the co-opting of health partners (13). The more recent attempt to pass the law in February 2024 was led by the Ministry of Social Affairs, rather than the Ministry of Finance, which meant a strong focus on involving health actors in the policy dialogue process (14). Prior knowledge about the upcoming draft law roundtable was kept closed to a small group of public sector actors to minimize the opportunity for the food industry to be alerted of the upcoming roundtable ahead of time, strategize their response, and thus to negatively influence the process.

Industry strategies

The industry employed several strategies to directly oppose the tax (14). This involved a public relations (PR) campaign against the tax, including negative opinion polls, writing articles in opposition of the tax, and naming and discrediting specific health partners, such as the WHO Country Office in Estonia, to shape public opinion. Within the roundtable meeting, industry representatives were a dominant presence and presented diverse arguments against the SSB tax, such as claims of job losses, industry bankruptcy, and illegal trade. The industry also attempted to divert attention away from the role of SSBs in NCDs to other factors, such as physical inactivity, and claimed that the tax had not worked in other countries, citing increasing obesity rates (14). The industry also employed a lobbying and PR firm and legal firm to present legal arguments about the anti-constitutional nature of the tax.

continued

Counter-strategies

Learning from past experiences, the Ministry of Social Affairs prepared a structured plan for managing the roundtable discussion (14). At the roundtable itself, industry and other representatives had their places at the table pre-assigned in an alternate seating plan, with each industry representative seated beside a health partner, rather than as one group. This prevented excessive interruption and third-party group conversations between industry representatives. Each invited organization was given a limited time to present their arguments, which was strictly adhered to. In addition, proponents of the draft law formed coalitions between health partners, such as dentists, nurses and physicians, ensuring diverse arguments across multiple united fronts.

Although the industry invited many smaller producers to the meeting to increase their presence, only umbrella organizations were permitted to present arguments to support or oppose the proposed tax. These additional producers were only permitted to contribute if they were adding new information. This gave industry a fair but limited platform and prevented the most numerous and vocal from dominating the discussion. Using these principles and strategies from a WHO policy dialogue tool, the Policy Dialogue Preparation and Facilitation Checklist (15) allowed the debate to be more orderly and contained, without affording more airtime to industry voices.

Policy considerations and lessons learned

There were several key elements to the bill successfully reaching the parliamentary reading stage in this second attempt at adopting the tax. Using the Policy Dialogue Preparation and Facilitation Checklist (15) during the roundtable discussion was key to ensuring an ordered discussion. It was also important to build a coalition of health partners, each of which contributed to arguments both at the roundtable and in a public awareness campaign through appearing in the press. Now that the bill has reached Parliament, the ability to shape public opinion – and the opinion of members of Parliament – remains the biggest barrier to overcoming industry interference, as this will determine whether Parliament votes for the bill or not in the upcoming readings.

Overall, a clear strategy for managing the roundtable consultation process with the aid of a coalition of health partners was essential for facilitating Estonia's draft tax law progress. Their experience underscores the importance of coalition-building and structured policy dialogue.

Case study 30. European regulatory mechanism and manufacturers' price influence on inhalers for asthma and COPD treatment and other NCD medicines

In the EU, ensuring affordable access to asthma and chronic obstructive pulmonary disease (COPD) inhalers is a priority due to high drug costs. However, despite legislation, availability and affordability issues persist (16), leaving some financially vulnerable patients relying solely on short-acting β_2 -agonists over prescribed inhaled corticosteroids, even though the latter are central for improving symptoms and reducing risks of exacerbations and consequently improving the quality of life of patients with asthma and COPD (17, 18).

Official drug prices on inhalers are set by manufacturers based on factors such as research and development, manufacturing costs, and market competition. These prices, also referred to as list prices, should reflect the actual ex-factory listed drug prices (19). The final cost to patients is influenced by manufacturers' list prices and other factors, such as insurance, pharmacy benefit managers and pharmacy fees (20).

However, some countries, such as France, Germany and United Kingdom (England), negotiate prices to be lower than the official price with the manufacturers; such discounts are known as rebates and, in most of the cases, these are confidential (20, 21). While some argue that confidential rebates reduce high-cost drug spending and improve patient access, they also obscure actual prices, potentially distorting the market and causing overpayment (20–22). For example, a United States white paper showed that increases in rebates are associated with a roughly dollar-for-dollar increase in list prices and concluded that the rebate practices of intermediaries, such as pharmacy benefit managers and insurers, deserve greater regulatory scrutiny in the quest for lower drug prices (23).

In addition, disparities in access to newly approved medicines between western, larger Member States and eastern, smaller Member States have been noted in the EU (24). National regulatory authorities are aiming to control drug prices in order to reduce patients' spending and to minimize price differences within the EU Member States, while taking into account different levels of purchasing power/GDP per capita in the countries (20, 24–26).

Although some progress in Europe has been made with the effective implementation of some regulatory mechanisms, such as negotiating the price with the manufacturer based on a transparent value-based pricing tool, the secrecy around drug pricing in Europe remains controversial. WHO emphasizes the importance of pricing transparency, including for research and development costs, as key to fair negotiations and governance (27, 28).

Summary

There are multiple actions to address the commercial determinants of NCDs in Europe and beyond. Decision-makers need to fully consider the spectrum of actions discussed here and think beyond a focus on individuals to encompassing the political economic system and public policy-making process itself. As a society, there is also a need to reconsider how we measure progress. Accordingly, in The Lancet Series on CDoH, there was a vision to “rethink social progress, contemporary capitalism, and the role of the commercial sector within it, [and] we imagine societies in which public and private actors prioritise environmental sustainability, human rights, basic needs, health and wellbeing, and a normative shift away from harmful consumptogenic systems” (1). Citizens and CSOs could be catalysts for change in that regard, as discussed in the next chapter.

Policy considerations

- Actions to address the CDoH should include all levels through which commercial actors influence health: individual, environment, public policy, and the political economic system.
- Human rights, including those for health and well-being, could be prioritized by governments willing to address the CDoH, and several mechanisms already exist in Europe and elsewhere, such as the well-being economy and doughnut economy models.
- There is a crucial need to question power asymmetry and the current political economic system as the root causes of ill health.

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Chapter 13.

The power of people's voice matters: the actions that citizens and civil society can take to reduce commercial determinants of NCDs



Key highlights

- Citizens and civil society organizations (CSOs) are crucial in addressing commercial determinants of NCDs. They help build coalitions, represent affected populations, serve as watchdogs for accountability, can shape policies, and empower communities.
- CSOs are active both at national and international levels, driving change through frameworks, such as the EU legislative system, supporting or challenging the work of policy-makers, and aiming to broaden systemic changes across Member States.
- The success and sustainability of public health measures depends on integrating insights from a broad range of actors, including CSOs, policy-makers, experts from academia, and other actors, in the policy development process to co-create health policies that are more effective and tailored to diverse community needs.
- Shifting the public health narrative away from focusing solely on individual responsibility in NCD prevention and control, including from CSOs, is key. Instead, citizens and CSOs could advocate and hold governments and commercial actors accountable for the protection and promotion of environments, public policies and a political economic system that are conducive to good health, addressing the systemic issues that underline NCDs.



Citizens and CSOs play a pivotal role in addressing the commercial determinants of NCDs (1). CSOs include nongovernmental organizations and advocacy groups along with community-based organizations, including patients, health-care workers, and marginalized and vulnerable population groups. By amplifying citizen concerns within public policy debates, CSOs can enhance the sustainability, equity and effectiveness of policies. Often CSOs actively involve the very individuals affected by these interventions (2). These organizations build coalitions, initiate change, shape policies and empower communities. They also differ from traditional lobbying groups in that they often operate on non-profit models. CSOs engage in advocacy to influence public policy in a way that benefits wider society, not just specific industries or commercial actors (3). This chapter presents the spaces where citizens and CSOs have been particularly effective in the WHO European Region: nationally, regionally, and in questioning the existing narrative around NCDs.

From national success to regional action

The first two case studies (case study 31 and 32) showcase successful CSO campaigns and initiatives at the national level. These examples demonstrate how focused action, often supported by the broader international civil society community, can lead to significant public health advancements. Notable instances include the role of the Women's Council of the Kyrgyz Republic in raising national public opinion and supporting tobacco control legislation, and the adoption of amendments in Slovenia regarding tobacco legislation via international mobilization. These cases provide insights into effective strategies and collaborative efforts that can be replicated and adapted in other contexts.

National actions, although impactful, can be limited in their effectiveness due to the global scale and influence of commercial actors. These commercial actors often operate and exert pressure across multiple countries, making isolated national efforts insufficient. CSOs often operate within the broader context of EU legislation and policy-making, where collective efforts can significantly influence health policies internationally, including across the entire EU. The support from international civil society communities is essential in facilitating these advocacy efforts within the centres of international governance, such as the EU headquarters.

This approach has already proven effective in the past, as seen with the Framework Convention on Tobacco Control (FCTC). During the negotiations that led to the FCTC, civil society was instrumental in shaping the outcomes. This significant role is acknowledged in the treaty itself, where Article 4, guiding principle point 7, states that the participation of civil society is essential in achieving the objectives of the Convention and its protocols (4). Such acknowledgment highlights the vital role of these organizations in global health governance. Inspired by this success, further initiatives, including the blueprint directive on the protection of children from the marketing of unhealthy food products, discussed in case study 33 of this chapter, aim to replicate the collaborative impact of civil society. These efforts illustrate how international frameworks can support comprehensive public health strategies.

Another crucial way for civil society to influence health policies at an international framework level is through active engagement in policy-making processes. By supporting equitable and evidence-driven policies, CSOs can affect the priorities and agenda points of institutional work programmes. This strategic involvement ensures that health considerations remain at the forefront of policy discussions and development. One example is the ongoing collaboration with the Subcommittee on Public Health of the European Parliament

(SANT), as addressed in case study 35 of this chapter, which aims, among others, to tackle health inequities across the EU.

However, the pervasive influence of commercial actors often extends beyond the regulatory reach of any single framework, making it difficult to secure comprehensive public health protections. This issue is compounded by the inconsistent implementation and enforcement of policies across nations, leading to uneven health outcomes. The global nature of commercial determinants of NCDs means that actions confined to the EU framework may be insufficient to address the broader, systemic issues that contribute to NCDs. Therefore, as discussed in the previous chapter, a society-wide, system approach is needed.

Reshaping the narrative of personal responsibility

CSOs play a pivotal role in challenging and reshaping the narrative that overly emphasizes individual responsibility for health, which often neglects the impact of socioeconomic, cultural, environmental and commercial determinants on living environments (5, 6).

For example, current food environments tend to promote unhealthy choices, requiring regulatory measures to promote health and sustainability. A critical chance for the EU to spearhead this essential transformation is the legislative Framework for Sustainable Food Systems (7). CSOs have been pushing for the implementation of this framework, highlighting its potential to significantly improve public health and sustainability, thereby positioning themselves as key stakeholders in the push for comprehensive regulatory reform in food systems (8).

This narrative shift, from individual culpability to policy- and system-driven solutions, advocates for the establishment of environments where living healthy lives is the default for everyone. This policy-oriented approach not only aims to boost public health and environmental stewardship but also strives to bridge the divide between the WHO European Region's aspirations and the real needs of its citizens, particularly in light of the escalating cost of living. The primary ambition is to make healthy and sustainable diets effortlessly accessible and affordable for all, paving the way towards a more equitable and health-conscious society.

To achieve this, it is crucial to strengthen the capacities of CSOs, ensuring they are robust enough to advocate effectively and participate in governance (9). This includes ensuring that civil society remains free from COI, which can be supported through adequate public funding and the implementation of stricter transparency measures in funding and lobbying activities. A critical point of concern is the reported number of approximately 25 000 lobbyists in Brussels alone (10), with a notable imbalance between corporate lobbyists and those from civil society. Corporate interests, including the pharmaceutical industry, dramatically outspend civil society groups in their lobbying efforts. For instance, the pharmaceutical sector alone spends significantly more than CSOs, underscoring the financial disparity in influence over EU policy-making (11). Case study 35 in this chapter illustrates why tackling this issue is vital for ensuring equitable access to medicines.

Box 9. Adequate funding of CSOs to ensure independence

Through collective action and strategic advocacy, civil society can make significant strides in promoting healthier environments and mitigating the impact of harmful commercial practices. To achieve this, it is crucial to ensure that civil society remains stable, sustainable, and free from commercial influence. Civil society can play a crucial role in positively influencing policy-making and will be indispensable in shifting public and policy narratives towards systemic solutions that address the root causes of ill health, access to appropriate care, and environmental issues. Without stable funding, there is a risk that industry interests might influence CSOs (9). Additionally, CSOs may face a loss of legitimacy and representation (12). The EU and national governments must recognize and support the pivotal role of civil society in this ongoing challenge to ensure it remains effective and independent.

Case study 31. Adoption of amendments in Slovenia regarding tobacco legislation

In February 2023, Slovenia introduced a proposal to amend its tobacco control legislation, aligning it with EU Directive 2022/2100 (13). Key provisions included banning flavours in e-cigarettes (except certain tobacco flavours), introducing health warnings on HTPs, and phasing out smoking rooms over five years. This initiative was broadly supported by Slovenian CSOs, the Ministry of Health and the National Institute of Public Health during a public consultation period.

Throughout 2023, these entities actively engaged with the media and policy-makers to foster public support for the amendments. Despite resistance from vape shop owners and vapers' groups, who argued that flavoured e-cigarettes aid in smoking cessation, the health coalition maintained its stance against these claims.

In the autumn of 2023, as the legislative process progressed (14), Slovenian NGOs, such as the Slovenian Coalition for Public Health and Environment and Tobacco Control (NTAKK), supported by international partners from the European Public Health Alliance (EPHA), Association of European Cancer Leagues (ECL), Network for Smoking and Tobacco Prevention (ENSP) and SmokeFree Partnership (SFP), rallied further support, asking their members to sign and send letters to Slovenian decision-makers, emphasizing the need to protect public health over commercial interests. As a result, 24 foreign CSOs from 20 different countries sent letters of support, with some members adding additional facts and links to research. Although it's unclear if these efforts alone influenced the decision, by March 2024, the National Assembly voted unanimously to adopt the tobacco legislation amendments (15).

The revised legislation, effective from April 2024, notably bans all flavours in e-cigarettes and HTPs (except tobacco flavour) and introduces a shortened transition period for the ban on smoking rooms, set to end by December 2025 (16). These changes are celebrated as aligning with Slovenia's constitutional provision Article 72 to prioritize public health and promote healthy living environments, serving as a model for other nations looking to strengthen tobacco control (17).



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Case study 32. The role of the Women's Council of the Kyrgyz Republic in raising public opinion and supporting tobacco control legislation

Women's councils in the Kyrgyz Republic have played an important role in advocating for strong tobacco control laws through civil society activism and support from the Ministry of Health. The Women's Council Network, comprising some 400 councils across the country, countered strong tobacco industry lobbying and opposition to new tobacco legislation and promoted public health interests through public debate, roundtables, and conferences. Notably, the Women's Councils (Ayaldar Kenesh) were instrumental in supporting the development and adoption of Law No. 121 on tobacco control.

The tobacco industry strongly opposed the law and devoted significant resources to launching smear campaigns against anyone who promoted the bill to damage their reputation (18). They paid for newspaper and social media articles to create a negative image of those promoting the law. They also created a working group with the participation of officials from the Ministry of Economy, claiming to be protecting their business interests and arguing that the law would reduce revenue flowing into the Kyrgyz Republic. Some health-care workers were also recruited to minimize the perceived impact of products such as e-cigarettes (18).

Civil society strategies

Using their previous experience campaigning for women's rights and social justice (19), the Women's Council organizations joined forces and mobilized their combined networks to put pressure on the Government to support changing the law. Activities included traveling to villages and regions of the Kyrgyz Republic to collect signatures for petitions; holding forums to raise awareness; engaging prominent female speakers, such as athletes, writers, respected doctors and university professors; and writing letters to legislators, asking for support (18). They also worked with local authorities in the remote Batken region, where most chewing tobacco, known as natvay, is produced, trying to persuade both producers and consumers of its harmful effects.

continued

Result and impact

Law no. 121 “On protecting the health of citizens of the Kyrgyz Republic from the effects of tobacco and nicotine consumption and from the effects of environmental tobacco smoke and aerosols” (20) was debated for more than three years, both in Parliament and in the media, before it was finally adopted. This was considered a major victory for tobacco control in the Kyrgyz Republic, thanks to the joint efforts of women's organizations and other civil society groups across the country. Since the enactment of this law, the Women's Council has continued to promote public education and communication activities to maintain public awareness of the dangers of tobacco (18).

Policy considerations and lessons learned

All advocacy work carried out by the Women's Council and its networks is done on a voluntary basis; financial support for this and similar organizations is important to continue to support their work in the future. Wide representation of women at all levels of government – national and local – is also key. Although some local councils have a Women's Council involved in committee processes, this needs to be systematized to increase women's participation at the local level. Despite efforts by the Women's Council and local authorities to transition from tobacco production to livestock activities in Batken region, this remains difficult because the production of oral tobacco is seen as an effective way of supporting vulnerable communities in the former Soviet Republic's poorest, water-stressed and border regions.

Case study 33. Ensuring affordable access to medicines in Europe and beyond: the example of CDCA-Leadiant

Civil society can be fundamental in raising alarms when industry profits are being prioritized over patient interests by, for example, submitting these concerns to relevant regulatory authorities. The Pharmaceutical Accountability Foundation (PAF) is a non-profit organization hoping to ensure that medicines and medical technologies are made available in a socially responsible and sustainable matter; they take action to combat unjustifiable price gouging, meaning prices are increasing a lot, by companies abusing market monopolies through the provision of advice to governments or through legal action around excessively high-priced medicines.

Excessive pricing of chenodeoxycholic acid (CDCA)

Chenodeoxycholic acid (CDCA) is used for the treatment of cerebrotendinous xanthomatosis (CTX), a rare genetic metabolic disease. CDCA was originally marketed as a treatment for gallstones, at a price of €0.28 per capsule. Beginning in 1999, the medicine began being prescribed off-label for CTX at a cost of €308 per patient per year. Pharmaceutical company Leadiant acquired CDCA in 2008, obtained a market authorization from the European Medicines Agency in 2017 to market it as an orphan drug, and increased its price 500-fold to €140 per capsule, hiking treatment costs to €153, 300 per patient per year.

continued

The orphan medicine designation conferred ten years of monopoly protection to Leadiant, although CDCA was not a new molecule. Leadiant also took several actions to prevent competition to its newly high-priced CDCA; for example, by complaining to the Dutch Health Inspectorate about pharmacies producing their own CDCA to avoid Leadiant's high prices. Leadiant also acquired competitors and signed an exclusive deal with the main raw material producer.

The case affected approximately 60 patients in Netherlands (Kingdom of the) and over 200 in other EU countries. The 260 patients needing treatment represent an annual burden of €39 million for European health systems.

Pharmaceutical Accountability Foundation takes action

On 7 September 2018, the PAF submitted a competition law enforcement request to the Netherlands' Authority for Consumers and Markets (ACM) (21). In 2021, ACM fined Leadiant €19 569 500 for abuse of a dominant market position to overcharge CDCA patients. The fine in 2023 after an appeal by Leadiant (22). According to ACM's statement, "Leadiant abused its dominant position" in the market to charge "... an excessive price... that was exorbitantly high because the price in combination with the low costs and the low risks resulted in exorbitant return." (22) It was also "... unfair because the drug, under a different trade name, had already been on the market for years at a much lower price, while patients benefitted very little from the registration as an orphan drug." Additionally, competition authorities in Israel, Italy, and Spain have also investigated Leadiant, and issued fines, reaching a total between the four countries of €33 million.

Following the Leadiant 500-fold price hike, the Government of the Netherlands and Health Inspectorate specifically permitted pharmaceutical compounding by hospital pharmacies as an emergency solution for patients, and the country's Health Minister proposed a reduction of the exclusivity period in the EU review of the EU orphan drug directive.

Barriers to overcoming industry interference included complex legal procedures, a lack of pricing transparency and industry lobbying. Facilitating factors included health actor collaboration, public pressure and regulatory interventions – and the role of CSOs is crucial in holding governments and commercial actors to account.

Case study 34. Call for a blueprint directive on the protection of children from the marketing of unhealthy food products to children: an alliance for change

The impact of marketing unhealthy products or services is disproportionately higher among children from socioeconomically disadvantaged backgrounds (23, 24), who often experience greater exposure to marketing while simultaneously having less access to healthier and affordable diets (25).

As a response, in 2021 a coalition of 20 international CSOs proposed an EU-wide blueprint directive aimed at protecting children from the marketing of unhealthy food products (26). This directive calls for public health and consumer protection across various media channels, including digital and broadcast media, and addresses marketing techniques specifically designed to appeal to children. This represents a collective call to European policy-makers to unite in safeguarding children's health and future against commercial interests and underscores the EU's responsibility to regulate cross-border marketing to ensure public health, consumer and children's rights protection.

The proposed directive seeks to harmonize national efforts and to establish a unified framework that ensures fair conditions for food companies while prioritizing public health and children's rights. By advocating for this directive, CSOs are not just challenging the status quo but are laying the groundwork for a healthier, more equitable future for all children across Europe.

National-level approaches and the need for multinational directives

Considerable progress has been made at the national level, where several countries have independently advanced legislation to curb the marketing of unhealthy foods to children, recognizing the urgent need to protect the youngest and most vulnerable members of society. Initiatives from Germany, Norway, the United Kingdom and Spain have each introduced measures to restrict the advertising of high-fat, sugar, and salt (HFSS) foods to children (27–29).

The United Kingdom's situation is detailed in Chapter 2 of this report. Norway notably approved legislation in June 2023 to ban the marketing of unhealthy foods and drinks to children under 18, marking a significant legislative milestone (30). In Germany, the Federal Ministry of Food, Agriculture and Consumer Protection outlined a plan in 2023 to protect children from the advertising of unhealthy food products (29). This draft restricts HFSS advertising across all child-relevant media, including outdoor advertising near schools and other child-centric environments, though it is still under development. In Spain, the Royal Decree draft presented by the Ministry of Consumers Affairs proposed banning the marketing of foods, such as chocolate bars, pastries, and ice creams, and set limits on fats, salt, sugar and calories in products like salty snacks and breakfast cereals. However, this legislative proposal was never published (27).

Although these efforts demonstrate awareness and willingness to tackle this issue across several countries, these siloed national approaches risk being limited and ineffective. The actions taken at the national level, fuelled by the dedicated work of national and international NGOs and CSOs, often arise as a response to the lack of action from European legislators. These efforts highlight significant discrepancies in the regulatory frameworks and their successful implementation across various countries, particularly among EU Member States, and underline the need for more unified and effective regulatory approaches within the EU to ensure equitable health outcomes across all Member States. These differences threaten the integrity of the EU's single market by creating a fragmented regulatory landscape, and affect equity within the EU; disparate levels of consumer protection lead to inconsistent health safeguards for children across various regions.

The momentum for such multinational regulation has been significantly driven by citizens and civil society, underscoring the profound impact of advocacy in shaping public health policies. Building upon these national stories, it becomes apparent that, to achieve a more comprehensive and systemic approach to public health, an expansion of efforts to regional and international frameworks, such as the EU, is essential.

Case study 35. Civil society's contribution to EU Parliamentary activities on NCD prevention and management

The newly established EU Parliamentary Public Health Subcommittee (SANT) comprises 30 full members and 30 substitute members and dedicates its efforts to enhancing European pharmaceutical sovereignty and tackling health inequities across the EU, including disparities between urban and rural areas. Since its inception in February 2023, the subcommittee's first two initiatives were the drafting of own-initiative reports on mental health and NCDs. An own-initiative report allows a committee within the European Parliament to express its position on matters not necessarily arising from existing legislative proposals, often influencing future policies and legislation. Civil society has praised the efforts of this newly formed committee for advancing these two key topics further up the public health policy agenda in Europe.

The European Public Health Alliance (EPHA), alongside its CSO members, expert advisors, and allies, has significantly contributed to shaping health policies at the EU level within the SANT framework. This has led to impactful amendments and recommendations on the draft NCDs report from the SANT Subcommittee, focusing on the wording and data around alcohol consumption, social determinants of health, and the marketing of unhealthy products to minors (31). This collaborative effort successfully influenced the final version of the report, improving health policy formulations and recommendations to ensure more effective, inclusive and sustainable health outcomes across Europe. This is evidenced by EPHA, along with several other CSOs, being officially recognized as contributors to the final version of the report, which was voted on and adopted in December 2023 (32).

Commercial influence in public health recommendations

However, in addition to CSOs, commercial actors were also included in this process and recognized as contributors, sparking debate over potential conflicts of interest. To address this, there is a growing call for stricter regulations to ensure that contributions from such actors are transparent and that the potential COI concerning them and Members of the European Parliament themselves are adequately managed to safeguard public interest (33).

While the proactive and persistent participation of CSOs has been crucial, the final report failed to fully incorporate the most reliable evidence, particularly regarding alcohol consumption. For instance, the term "harmful use of alcohol" continues to be used despite clear scientific evidence supporting that there is no "safe level" of alcohol consumption and its associated risks (34, 35) (read more in Chapter 6). This phrasing is not only found in the NCD report from the SANT subcommittee but also in documents from the Parliamentary Special Committee on Beating Cancer (BECA), which spearheaded Europe's Beating Cancer Plan (36). These inconsistencies highlight the ongoing debates within public health policy-making and emphasize the vital role of civil society in advocating for language that accurately reflects scientific understanding. It highlights the need for a more developed framework to ensure the structured inclusion of CSOs, allowing for a more effective contribution to policy-making.

Summary

CSOs play a vital role in addressing the commercial determinants of NCDs. They can bridge the gap between individual citizens – and therefore individual responsibility – and policy-making, advocating for systemic changes that prioritizes public health over commercial interests. To achieve this, stronger international frameworks, such as the EU's legislative system, are required to support effective and equitable public health strategies. The FCTC exemplifies successful international collaboration, suggesting a model for future efforts, such as the legislative Framework for Sustainable Food Systems, which aims to transform the EU's food environments. Ultimately, CSOs play a strong role in shaping health policies, ensuring that health and well-being are placed at the forefront of policy agendas.

Policy considerations

- Establish a formal structure within the WHO European Region and national legislative processes to consistently include citizens and CSOs. This framework should define clear roles for CSOs, ensuring their involvement in policy discussions and the systematic integration of their contributions into policy decisions.
- Provide funding and resources to build and sustain CSOs through multiannual operating grants. This approach would facilitate capacity-building, sustained advocacy efforts, networking opportunities, and evidence-based training, and would be critical to prevent commercial interests from influencing public health policies.
- Implement robust monitoring systems to track the effectiveness of public health policies and CSO contributions. Regular evaluations can help refine strategies and ensure they are delivering the intended health outcomes.
- Implement national and international transparency regulations to equalize lobbying influence, ensuring that corporate lobbyists and CSOs operate on an equal footing. This would involve mandating the disclosure of lobbying activities and financial contributions, promoting fairness, and reducing disparities in policy influence.

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Conclusion.

Addressing the commercial determinants of NCDs in Europe: an agenda for action



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The urgency for action in Europe

The burden of disease due to NCDs continues to grow in Europe, with a substantial proportion of this burden linked to commercial action. For example, barring an acceleration of tobacco control, it is projected that the WHO European Region will have the highest level of adult daily smokers, at 23%, among all WHO regions (1). The region's adults above the age of 15 years are already the world's heaviest alcohol drinkers per capita (2). The prevalence of overweight and obesity continues to grow, and the growth in childhood obesity suggests that the condition will also affect the next generation (3). In addition, commercial forces influence other aspects of health, such as the multiple case studies across this publication that illustrate the influence commercial interests exert on the price and marketing of medicines.

Commercial factors therefore have a range of influences on NCDs, including the generation of commodities, such as cigarettes and alcohol, the design of addictive and heavily marketed forms of food, the marketing of ineffective forms of cancer screening, and the promotion of cancer medicines with marginal benefit but ever-increasing prices.

Resistance from industry to change that could be health-promoting has also grown more sophisticated over time. Earlier efforts were exemplified by the tobacco industry denying that nicotine was addictive or that there was no evidence that tobacco was harmful to health. The adoption of similar strategies across multiple industries highlights the commonality of the playbook being used by commercial sectors to privilege profit generation even at the expense of health.

The increase in NCD burden coupled with the growing evidence about the commercial contribution to this burden led to this publication – part of an effort to alert governments, civil society and academia to a new front for public health action in Europe. Previous generations of public health advocates have won major victories to limit harmful commercial influences on health, ranging from the WHO Framework Convention on Tobacco Control (FCTC) to the global strategies and action plans on alcohol, diet, and physical activity to resolutions to regulate behaviours, such as the marketing of foods to children or the illicit trafficking of tobacco. A new generation of public health professionals must build on the lessons of the past and evolve a new set of tools to address the commercial determinants of NCDs, developing a new agenda for action. This book has tried to map what such an agenda might include: reinforcing the gains of the past, suggesting new approaches, and disseminating lessons at scale.

Towards an agenda for public health action

What might such an evolving action agenda look like from the point of view of public health actors: governments, civil society, and academia? This book suggests a range of promising directions.

Coalitions and values

Public health actors should build common cause with emerging thought in economics – an economics based on thriving in the biosphere and finding a safe and just space for humanity. This might mean that we go beyond traditional metrics of productivity and profit, emphasizing well-being over monetary return on investment (4). By aligning NCD prevention and control with economic models that prioritize ecological sustainability and social equity, public health actors can promote policies that support both public health and environmental goals, creating a more holistic approach to societal well-being (5).

Developing a narrative based on the core values of equity, sustainability and resilience involves connecting corporate behaviours to their negative effects on these values. For example, public health actors must highlight how industries that engage in tax avoidance reduce public funds available for health, exacerbating health inequities. On the other hand, pricing strategies on tobacco, alcohol, and sugar-sweetened beverages raise revenue, reduce consumption and exert progressive effects if the money raised is invested in services to reduce disparities. Emphasizing the environmental degradation caused by corporate practices, such as the prevalence of single-use plastics in the delivery of health-harming products, can link public health advocacy with broader sustainability goals. Framing these issues around core values allows public health actors to build stronger support for effective regulatory measures.

Competencies

Public health actors need to increase their capacity to work in areas of economics and trade, regulation and litigation, and the enforcement of rules on transparency and COI. Equipping public health professionals with skills to engage in economic and trade discussions ensures that health considerations are prioritized in trade agreements. Training in regulation and litigation empowers public health actors to challenge industry practices legally. Enforcing transparency and managing COI prevents industries from unduly influencing public health policies. NCD advocates need to equip themselves with the skills, for example:

- of using the Codex Alimentarius (6) to improve food quality,
- of using Article 5.3 of the WHO FCTC to insist on transparency and accountability in dealing with the tobacco industry,
- of using the policy process at the national and international level to control the marketing and labelling of alcohol, and
- of finding ways of inserting themselves into the process of negotiating and drafting national regulations that are evidence-based, pragmatic, and easily enforced.

NCD advocates must be skilled in recognizing and managing COI, identifying industry tactics, using data to evaluate the impacts of commercial determinants, and assessing alternative policies and agreements to mitigate these harms. Public health can work to enforce strict transparency requirements and develop mechanisms to identify and mitigate COI. Understanding common industry tactics, such as lobbying, targeted marketing, and misleading corporate social responsibility (CSR) initiatives, is crucial. For instance, industries often manipulate scientific research to downplay health risks, so public health actors must critically assess industry-funded studies and advocate for independent research. The WHO Regional Office for Europe has already published a Tobacco Industry Playbook and is finalizing an Alcohol Industry Playbook, both of which provide evidence of standard arguments used by these industries, with the responses available to NCD advocates. The Nutrient Profile Model has also been published as a foundation for effective regulation on the marketing of foods to children, among other applications.

Additionally, public health actors must leverage data and build a body of evidence that reveals the true extent of industry influence on health, using evidence to support stronger regulations. A host of new techniques using machine learning, systems analysis, and research on complex systems, for instance, can be used to strengthen alliances in favour of NCD outcomes, identify promising points of intervention, and describe coalitions of those who would oppose public health for profit.

Public health actors should also be familiar with economic and legal frameworks that govern industry practices, including trade and investment agreements that might hinder public health policies. By advocating for health considerations in these agreements and proposing alternative frameworks, public health can ensure it is prioritized. Continuous education and capacity-building are essential to stay ahead of evolving industry tactics, ensuring that collaborative efforts effectively counteract the influence of HHI and promote health-enhancing policies. This extends beyond the realm of NCD prevention and into management; the way the price of medicines is determined in a country has direct impact on the affordability and accessibility of essential medications for cancer, cardiovascular disease, diabetes, and chronic respiratory disease. NCD advocates and policy-makers must extend their portfolio to consider the commercial determinants of screening, treatment, rehabilitation, and palliation.

Concrete action

The NCD movement in Europe should protect the gains of the past and strengthen the enforcement of current, hard-won public health legislation. Health policy-makers must fully implement the measures outlined in the WHO FCTC, as well as the global strategies and action plans on alcohol, and on diet and physical activity. For example, health policy-makers can raise taxes on tobacco products, enforce plain packaging laws, and implement comprehensive advertising bans to reduce smoking rates. Civil society can advocate for stringent regulations, similar to the United Kingdom's ban on marketing unhealthy foods to children, and resist industry efforts to undermine these measures through lobbying and other tactics.

Public health actors must seize the narrative in the policy process to favour health promotion and protection. By framing discussions around NCDs in a way that emphasizes health benefits and exposes industry tactics, they can control the narrative. For example, rebranding inappropriate "harm reduction" strategies, promoted by industries, as "harm perpetuation" can shift the focus to the negative consequences of watered-down public health approaches. By doing so, public health actors ensure that policies protect public health rather than accommodate industry interests. NCD advocates can probably make stronger use of the precautionary principle in building common cause with environmental health and in ensuring that the regulatory environment protects the health of current and future generations.

To limit the ability of industry to wrest power from governments, health policy-makers must address behaviours such as monopolistic practices, tax avoidance, and reputation management through CSR efforts. Enforcing antitrust laws prevents market concentration, as seen in the food and beverage industries where a few powerful firms dominate. By closing tax loopholes and implementing robust tax policies, health policy-makers can prevent corporate tax avoidance, ensuring sufficient public funds for health care. Public health actors need to scrutinize and regulate CSR claims to prevent industries from using these initiatives as mere reputation management tools. In the current mood where governments are accused of nannying the population and where international organizations are accused of taking over national sovereignty, little opportunity is being taken to demonstrate to the public how their NCD-related choices and sovereignty are being determined by a small group of transnational corporations acting in their own interests.

Forging national agendas on the CDoH requires the NCD movement to establish teams of trained staff, legislative frameworks, and coalitions across public health causes and across national boundaries. Health policy-makers should develop comprehensive CDoH strategies that integrate various public health initiatives. For example, promoting healthy, secure food supplies can align with climate change activism, highlighting the co-benefits of such approaches. National agendas should include training programmes for public health professionals, robust legislative measures to regulate harmful industries, and coalition-building efforts to unite different public health advocacy groups under a common cause.

In summary, this book aims to build on the surge in recent public health interest in CDoH, to suggest innovative approaches that can build a practicable agenda forward that works with governments and industries to align all sectors towards promoting health. Such work recognizes the inextricable role that commercial actors play in shaping the world around us, and, as such, their responsibility for actions that may harm health, and public health's responsibility to create structures that maximize corporate actions that promote health and minimize ones that harm health.

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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**World Health Organization
Regional Office for Europe**
UN City, Marmøvej 51,
DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe

