Taking control over the commercial determinants of NCDs

Strengthening the persuading power of health in multi-sectoral governance

Dori Patay
Menzies Centre for Health Policy, School of Regulation and Global Governance, The Australian National University

NCD crisis of the Pacific fueled by the commercial determinants of health

A rapid rise in the premature deaths caused by non-communicable diseases (NCDs) marks the global burden of disease. 70% of all deaths around the world happen because of NCDs, and the quickest increase is happening in low- and low-middle income economies, where an astounding 13-14% growth in mortality due to NCDs was shown between 2000 and 2015 (1). In the Western Pacific Region this rate is even worse than the global trends: in 2016 86% of total deaths in this region occurred due to NCDs, compared to the rate of 79% in 2000. Cardiovascular diseases cause 46% of these deaths, while cancer and respiratory diseases add up to 36% in 2016 (2). In the first eight places of countries with the highest diabetes prevalence in the world six are occupied by Pacific Island Countries (PICs) (3). Some PICs are among the countries with the highest prevalence of tobacco use and obesity globally (4,5). 54% of deaths caused by NCDs in PICs[1] are premature deaths.

The burden of disease caused by NCDs does not only places health systems under considerable strain; the socioeconomic costs of morbidity, resulting disability and premature mortality add up through the loss in productivity to poverty, hinder development, and widen inequalities. The rise of NCDs is a significant threat to fulfilling the UN Sustainable Development Goals all over the world – both in developed and developing countries (6).

"The NCD epidemic is driven by poverty, globalization of marketing and trade of health-harming products, rapid urbanization, and population growth" (7). Moodie (8) calls NCDs profit-driven diseases: "Through the sale and promotion of tobacco, alcohol, and ultra-processed food and drinks, transnational corporations are major drivers of global epidemics of NCDs." The term commercial determinants of health has emerged in the literature to name "the strategies and approaches used by the private sector to promote products and choices that are detrimental for health" (9). Commercial influence on population health comes from two directions: the literature describes the ways trade and investment liberalization has been contributing to the rise of NCDs (10–16) and gives an account on the various market and non-

[1] The WHO Health Observatory Database provides data on this indicator from only 8 of the 22 PICs: Fiji, Kiribati, Federated States of Micronesia, Papua New Guinea, Samoa, Solomon Islands, Tonga and Vanuatu.

market activities unhealthy commodity corporations have been deploying to build demand, supply and supportive policy environment for their products (8,17–23).

The Pacific Region is especially susceptible for commercial influence. Its colonial history has placed these economies dependent upon external trade and development aid; both which makes it difficult to fend off pressure to liberalize their trade and allow the imports of unhealthy commodities. The weak bureaucratic system of these countries arising from their smallness and low-income economy make them easy targets for commercial influence, aggravating the negative impact of trade and investment liberalization. Studies show that the rapid rise of NCDs in the Pacific are in strong correlation with trade and investment liberalization (24–35). While PICs are excellent examples of how trade and investment liberalization and unhealthy commodity corporations fuel the NCD crises, we know little about the ways these countries govern the commercial determinants of NCDs. There is an urgent need to understand how commercial influence can be tackled if we want to rein in the global NCD epidemic; the example of PICs can be useful not only to other small island developing states but to any other countries struggling with government fragmentation, regulatory capture or constrained regulatory space due to vested interests. Thus, this research aims to fill this gap by improving the understanding of how the commercial determinants of NCDs can be better governed in PICs.

Tobacco kills more people than any other unhealthy commodity (6), thus the attention on tobacco companies has been in the forefront among the unhealthy commodity industries. The establishment of the WHO Framework Convention on Tobacco Control is the first global treaty focusing on an aspect of commercial determinants of NCDs (36), and it is considered to be a great achievement for governance for health. While the regulation of alcohol and unhealthy foods are more complex, as people need to eat and the harmful effects of alcohol consumed in small quantity is debated opposed to tobacco which has no safe use limit (37), the majority of global health experts believe that these unhealthy commodities should be regulated with a similar approach, because these industries have been applying similar strategies to the tobacco industry in their efforts of maximizing their profits (17,38). Therefore, to understand how the commercial determinants of NCDs can be better governed in the Pacific, this research used tobacco governance as its case study.

Taking control over the commercial determinants of NCDs – the case of tobacco in Fiji and Vanuatu

In order to collect in-depth and accurate data to understand the ways health lobby managed to persuade the non-health government departments to control the commercial determinants of NCDs, this research employed a qualitative methodology, seeking to understand governance mechanisms in two purposively selected PICs. The applied methods involved literature review, in-depth interviews and document analysis. Fiji and Vanuatu were selected as case study countries, based on their high performance in tobacco control according to the MPOWER indicators (39) (indicating that the country is doing a good job in tobacco control), their high smoking prevalence (indicating that smoking is or was actually a problem), and their relatively large population size in the Pacific region. More than 65 representatives of government bodies, civil organizations, and development partners were interviewed. The document analysis involved openly accessible tobacco control national policy and legal documents, reports of Fiji and Vanuatu. The analysis on the collected data is still under progress, therefore this paper aims to

introduce the literature on the ways the commercial determinants of health impacts on the rise of NCDs and highlight some of the preliminary findings.

Where does the commercial influence come from?

The literature identifies two sources of commercial influence in particular relation to NCDs. The first source, trade and investment agreements increase the availability and affordability of unhealthy commodities (a) by lifting tariff and non-tariff barriers of unhealthy commodities, and (b) by the facilitation of services and investment; and (c) by shrinking domestic policy space and governance. Labonte (10) adds a fourth to this list: by increasing economic insecurity. Furthermore, strong intellectual property protection as part of the investment liberalization principles constrains access to treatments of NCDs (40–42).

Unhealthy commodity industries are the second source of commercial influence on health. The role transnational corporations play in fueling trade and investment liberalization has been documented by multiple authors (43), and the "influence of tobacco, alcohol and food companies in globalizing risk factors associated with NCDs is at risk being over-analyzed" (25). Unhealthy commodity industries operate with larger budgets than entire countries, thus they have formidable economic power in their hand to create demand and market for their products and to influence domestic and global policy makers (37,44,45).

These commercial influences directly challenge governments in three ways: by fragmenting governments, inducing regulatory capture, and constraining regulatory space (8,10,11,17,18,21,43,46–54). Without addressing these issues, governments are likely to become helpless in tackling the commercial determinants of NCDs.

Strategies to tackle the commercial determinants of NCDs in Fiji and Vanuatu

The literature review has shown that the scholarship on unhealthy commodity industries, trade and investment liberalization and health is wide and is growing in relation to the Pacific. Governance scholars address the issue of regulatory capture, and there is a slowly growing amount of literature on how the policy incoherence and government fragmentation over the interests of trade, economy or agriculture and health should be tackled. Most of the global governance for health literature suggest institutionalist reforms to control commercial influence, while the development literature argues that in developing countries and in the Pacific such reforms are rarely successful. The literature explaining the ways PICs govern the commercial determinants of NCDs is little, and it could not explain how these small island developing countries face the political economy underlying the NCD epidemic.

The data collected in Fiji and Vanuatu was aimed to fill this gap. When interviewees recounted the strategies behind the success stories when they managed to persuade non-health government bodies to pursue policies aligned with public health interests, they highlighted the importance of four approaches.

Firstly, the demonstration of the socio-economic costs of NCDs has proven to be an effective way to persuade non-health government departments to engage into the regulation of unhealthy commodities.

Secondly, exerting political pressure from two directions simultaneously forces politicians and high level government officials to respond to the problem. International pressure can be applied in the form of

global or regional frameworks, standards and forums. By engaging the public, the media and the civil society organizations a bottom-up pressure can be created. The way the issue is framed is crucial in moving both the public and the politicians.

Thirdly, increasing cooperation among various actors from different sectors and political affiliation, involving NGOs, faith-based organizations, development partners and private actors can magnify the influence of the health lobby. The coordinated action of a large and multi-faceted constituency can accumulate surprising amount of power to elevate the voice of health.

Finally, it is important to understand where the access points are to influence policy-planning, decision-making and legislative processes. In most countries the procedures of the government and the parliament allow the public, NGOs, development organizations and private actors to express their opinion and suggestions. Often these access points are not known or not used by these actors, yet a careful strategy can have good chance to influence governance this way.

Conclusions

The preliminary results arising from the collected data in Fiji and Vanuatu show that some of the recommendations of the literature can be applied in the context of PICs. Many officers within government bodies, civil organizations and development partners who consider themselves actors of the health lobby are mindful of the importance of representing health interests in multisectoral policy making. They are also aware of the recommended strategies, the institutional frameworks are often in place, and they share success stories when the commercial determinants of NCDs were reined in through their concerted actions. However, the data also shows that there are many cases when no considerable action is taken to elevate the voice of health in multisectoral policy making, even though the pathways to step up are open. It is crucial to understand the reasons behind this inactivity as it allows us to understand the hidden barriers of raising the power of health in governance. By the time the analysis of the collected data is completed, hopefully this research will be able to provide an explanation of these underlying factors.

References

1. WHO. Global Health Estimates 2015: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2015. Geneva, Switzerland; 2016.

2. WHO. Global Health Estimates 2016: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2016. Geneva, Switzerland; 2018.

3. Index Mundi. Diabetes prevalence (% of population ages 20 to 79) - Country Ranking [Internet]. Index Mundi. 2018 [cited 2018 Dec 29]. Available from: https://www.indexmundi.com/facts/indicators/SH.STA.DIAB.ZS/rankings

4. WHO. Age-standardized prevalence of current tobacco smoking among persons aged 15 years and older [Internet]. Global Health Observatory data repository. 2018 [cited 2018 Dec 28]. Available from: http://apps.who.int/gho/

5. WHO. Prevalence of obesity among adults. Global Health Observatory data repository. 2018.

6. WHO. Noncommunicable diseases [Internet]. Fact Sheets. 2018 [cited 2019 Jan 15]. Available from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

7. WHO. Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property. Geneva, Switzerland: WHO; 2017 Nov.

8. Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, et al. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. The Lancet. 2013 Feb;381(9867):670–9.

9. Kickbusch I, Allen L, Franz C. The commercial determinants of health. The Lancet Global Health. 2016 Dec;4(12):e895–6.

10. Labonte R, Blouin C, Forman L. Trade and Health. In: Global Health Governance Crisis, Institutions and Political Economy. Palgrave Macmillian; 2009. (International Political Economy Series).

11. Baker P, Kay A, Walls H. Trade and investment liberalization and Asia¿s noncommunicable disease epidemic: a synthesis of data and existing literature. Globalization and Health. 2014;10(1):66.

12. Friel S, Hattersley L, Townsend R. Trade Policy and Public Health. Annual Review of Public Health. 2015 Mar 18;36(1):325–44.

13. Sahal Estimé M, Lutz B, Strobel F. Trade as a structural driver of dietary risk factors for noncommunicable diseases in the Pacific: an analysis of household income and expenditure survey data. Globalization and health. 2014;10(1):48–48.

14. Schram A. When evidence isn't enough: Ideological, institutional, and interest-based constraints on achieving trade and health policy coherence. Global Social Policy: An Interdisciplinary Journal of Public Policy and Social Development. 2017 Dec 4;146801811774415.

15. Schram A, Labonté R, Sanders D. Urbanization and International Trade and Investment Policies as Determinants of Noncommunicable Diseases in Sub-Saharan Africa. Progress in Cardiovascular Diseases. 2013 Nov;56(3):281–301.

16. Walls H, Baker P, Parkhurst J. Addressing trade policy as a macro-structural determinant of health: The role of institutions and ideas. Global Social Policy: An Interdisciplinary Journal of Public Policy and Social Development. 2018 Jan 11;146801811774870.

17. Brownell KD, Warner KE. The Perils of Ignoring History: Big Tobacco Played Dirty and Millions Died. How Similar Is Big Food? Milbank Quarterly. 2009;87(1):259–94.

18. Savell E, Gilmore AB, Fooks G. How Does the Tobacco Industry Attempt to Influence Marketing Regulations? A Systematic Review. Derrick GE, editor. PLoS ONE. 2014;9(2):e87389.

19. Gilmore AB, Savell E, Collin J. Public health, corporations and the New Responsibility Deal: promoting partnerships with vectors of disease? Journal of Public Health. 2011 Mar 1;33(1):2–4.

20. Gilmore A PhD, MBBS, DTM&H, MSc, MFPH, Collin J PhD, MA, Townsend J PhD, MSc. Transnational Tobacco Company Influence on Tax Policy During Privatization of a State Monopoly: British American Tobacco and Uzbekistan. American Journal of Public Health. 2007 Nov;97(11):2001–9.

21. Fooks GJ, Smith J, Lee K, Holden C. Controlling corporate influence in health policy making? An assessment of the implementation of article 5.3 of the World Health Organization framework convention on tobacco control. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 15];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0234-8

22. Cunningham K, Kamonpatana K, Bao J, Ramos-Buenviaje J, Wagianto A, Yeap P. Unilever Nutrition Strategy and Examples in Asia. Journal of Nutritional Science and Vitaminology. 2015;61(Supplement):S39–40.

23. Green H. Global Obesity: Nestle Initiatives in Nutrition, Health, and Wellness. Nutrition Reviews. 2006 Feb;64:S62–4.

24. Ravuvu A, Friel S, Thow A-M, Snowdon W, Wate J. Monitoring the impact of trade agreements on national food environments: trade imports and population nutrition risks in Fiji. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 15];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0257-1

25. Reubi D, Herrick C, Brown T. The politics of non-communicable diseases in the global South. Health & Place. 2016 May;39:179–87.

26. Anderson IPS. The Economic Costs of Noncommunicable Diseases in the Pacific Islands: A Rapid Stocktake of the Situation in Samoa, Tonga, and Vanuatu [Internet]. World Bank; 2012 [cited 2018 Mar 15]. Available from: http://elibrary.worldbank.org/doi/book/10.1596/27219

27. Christoforou A, Snowdon W, Laesango N, Vatucawaqa S, Lamar D, Alam L, et al. Progress on Salt Reduction in the Pacific Islands: From Strategies to Action. Heart, Lung and Circulation. 2015 May;24(5):503–9.

28. Friel S, Butler C, McMichael A. Climate change and health: risks and inequities. In: Benatar S, Brock G, editors. Global Health and Global Health Ethics [Internet]. Cambridge: Cambridge University Press; 2011 [cited 2018 Mar 15]. p. 198–209. Available from: http://ebooks.cambridge.org/ref/id/CBO9780511984792A027

29. Friel S, Harris P, Simpson S, Bhushan A, Baer B. Health in All Policies Approaches: Pearls from the Western Pacific Region: Health in All Policies in the Pacific. Asia & the Pacific Policy Studies. 2015 May;2(2):324–37.

30. Kessaram T, McKenzie J, Girin N, Roth A, Vivili P, Williams G, et al. Noncommunicable diseases and risk factors in adult populations of several Pacific Islands: results from the WHO STEPwise approach to surveillance. Australian and New Zealand Journal of Public Health. 2015 Aug;39(4):336–43.

31. Kessaram T, McKenzie J, Girin N, Roth A, Vivili P, Williams G, et al. Tobacco Smoking in Islands of the Pacific Region, 2001–2013. Preventing Chronic Disease [Internet]. 2015 Dec 3 [cited 2018 Dec 21];12. Available from: http://www.cdc.gov/pcd/issues/2015/15_0155.htm

32. Snowdon W, Raj A, Reeve E, Guerrero RL, Fesaitu J, Cateine K, et al. Processed foods available in the Pacific Islands. Globalization and Health. 2013;9(1):53.

33. Snowdon W, Thow AM. Trade policy and obesity prevention: challenges and innovation in the Pacific Islands: Trade and obesity in the Pacific Islands. Obesity Reviews. 2013 Nov;14:150–8.

34. Thow A-M, Snowdon W. The effect of trade and trade policy on diet and health in the pacific islands. In: Trade, food, diet, and health : perspectives and policy options. Chichester, England: Blackwell Publications,; 2010. p. 147-168.

35. Tolley H, Snowdon W, Wate J, Durand AM, Vivili P, McCool J, et al. Monitoring and accountability for the Pacific response to the non-communicable diseases crisis. BMC Public Health [Internet]. 2016 Dec [cited 2018 Dec 22];16(1). Available from: http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3614-8

36. WHO FCTC. 2018 Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control. WHO; 2018.

37. Buse K, Tanaka S, Hawkes S. Healthy people and healthy profits? Elaborating a conceptual framework for governing the commercial determinants of non-communicable diseases and identifying options for reducing risk exposure. Globalization and Health [Internet]. 2017 Dec [cited 2018 Mar 23];13(1). Available from: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0255-3

38. Casswell S. Vested interests in addiction research and policy. Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry?: Alcohol corporate interests compared with tobacco. Addiction. 2013 Apr;108(4):680–5.

39. WHO. WHO report on the global tobacco epidemic 2017. Geneva: WHO; 2017.

40. Hoen E 't, Berger J, Calmy A, Moon S. Driving a decade of change: HIV/AIDS, patents and access to medicines for all. Journal of the International AIDS Society. 2011;14(1):15.

41. Morris K. Bridging the gap in access to medicines. The Lancet Infectious Diseases. 2010 Aug;10(8):514–5.

42. Sell SK, Williams OD. Health under Capitalism: A Global Political Economy of Structural Pathogenesis. 2018;

43. Bonnitcha J, Poulsen LNS, Waibel M. The political economy of the investment treaty regime. First edition. New York, NY: Oxford University Press; 2017. 325 p.

44. Costa H, Gilmore AB, Peeters S, McKee M, Stuckler D. Quantifying the influence of the tobacco industry on EU governance: automated content analysis of the EU Tobacco Products Directive. Tobacco Control. 2014 Nov;23(6):473–8.

45. Lee S. What hinders implementation of the WHO FCTC Article 5.3? – The case of South Korea. Global Public Health. 2016 Oct 20;11(9):1109–20.

46. Lencucha R, Drope J, Labonte R, Zulu R, Goma F. Investment incentives and the implementation of the Framework Convention on Tobacco Control: evidence from Zambia. Tobacco Control. 2016 Jul;25(4):483–7.

47. Thow AM, McGrady B. Protecting policy space for public health nutrition in an era of international investment agreements. Bulletin of the World Health Organization. 2014 Feb 1;92(2):139–45.

48. Barraclough S, Morrow M. The political economy of tobacco and poverty alleviation in Southeast Asia: contradictions in the role of the state. Glob Health Promot. 2010 Mar;17(1 Suppl):40–50.

49. Ayres I, Braithwaite J. Tripartism: Regulatory Capture and Empowerment. Law & Social Inquiry. 1991;16(3):435.

50. McGrady B. Trade and Public Health. Cambridge University Press; 2011.

51. Clifford D, Hill S, Collin J. Seeking out 'easy targets'? Tobacco companies, health inequalities and public policy. Tobacco Control. 2014 Nov;23(6):479–83.

52. Ruckert A, Schram A, Labonté R, Friel S, Gleeson D, Thow A-M. Policy coherence, health and the sustainable development goals: a health impact assessment of the Trans-Pacific Partnership. Critical Public Health. 2017 Jan;27(1):86–96.

53. Shaffer ER, Brenner JE, Houston TP. International trade agreements: a threat to tobacco control policy. Tob Control. 2005 Aug 1;14(suppl 2):ii19.

54. Stigler G. The Theory of Economic Regulation. The Bell Journal of Economics and Management Science. 1971;2(1):3–21.