

City University of New York (CUNY)

CUNY Academic Works

Publications and Research

CUNY Graduate School of Public Health &
Health Policy

2020

Addressing the commercial determinants of health begins with clearer definition and measurement

Kelley Lee
Simon Fraser University

Nicholas Freudenberg
CUNY School of Public Health

[How does access to this work benefit you? Let us know!](#)

More information about this work at: https://academicworks.cuny.edu/sph_pubs/267

Discover additional works at: <https://academicworks.cuny.edu>

This work is made publicly available by the City University of New York (CUNY).
Contact: AcademicWorks@cuny.edu

Editorial

Addressing the commercial determinants of health begins with clearer definition and measurement

Kelley Lee¹ and Nicholas Freudenberg²

The challenge of non-communicable diseases (NCDs) continues to grow worldwide, increasing from 43% to 54% the global burden of disease between 1990 and 2016 (1). In 2018, NCDs accounted for 71% of total deaths globally, with 81% of those deaths caused by four disease types – cardiovascular diseases, diabetes, cancers and chronic respiratory diseases (2). By 2025, the World Health Organization estimates, 85% of NCD annual deaths will occur in low- and middle-income countries (3).

The costs of treating NCDs have become enormous in all countries. For cardiovascular diseases alone, in the European Union, healthcare costs totalled €110 billion in 2015 (4). Adult (>20 years) cases of diabetes worldwide have risen, from ~171 million to 463 million people between 2000 and 2019, accounting for 10% of healthcare expenditure (5,6). Moreover, given that this economic burden is likely to be especially heavy for disadvantaged and marginalised people and communities than in groups with higher socioeconomic status across all countries (7), NCDs are now a key driver of rising health inequities (8). Finally, as the COVID-19 pandemic shows, high rates of NCDs put millions of people at higher risk of other threats to health.

Given the substantial and rising costs, as Buse *et al.* note, ‘we cannot treat our way out of the NCD epidemic (9)’. Instead, more effective prevention strategies focused on reducing the risk factors associated with these diseases are urgently needed (10). A risk factor is ‘any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury (11)’. However,

public health action to prevent NCDs has to date primarily focused on metabolic (e.g. hypertension, hyperlipidaemia) and modifiable behavioural risk factors – tobacco use, harmful alcohol use, unhealthy diets and physical inactivity (2,12). As a result, as Horton describes, ‘progress has been inadequate and disappointingly slow. . . .An advocacy strategy based on four diseases and four risk factors seems increasingly out of touch. . . .Many political leaders believe that NCDs are just too big and too complex a challenge. And so they are paralysed. We need a different approach (13)’.

A profoundly different approach is the emerging concept of the *commercial determinants of health* (CDoH). It has long been recognised that NCD prevention strategies must address the ‘circumstances in which people are born, grow, live, work, and age, and the systems put in place to deal with illness (14)’. Since the late 20th century, it is arguable that the commercial (for-profit) sector has figured most heavily in shaping such social circumstances (15–18). West and Marteau define CDoH as ‘factors that influence health which stem from the profit motive (19)’. Similarly, Kickbusch *et al.* write that CDoH are ‘strategies and approaches used by the private sector to promote products and choices that are detrimental to health (20)’. Buse *et al.* focus on ‘risks inherent from consumption of, or exposure to, commercial products – such as ultra-processed foods and beverages, tobacco and alcohol (21)’. These definitions contrast with recent WHO documents that consider nongovernmental organizations, philanthropic foundations, academic institutions and for-profit businesses all as ‘non-state actors’ and potential partners in NCD prevention and control

1. Canada Research Chair Tier I. Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, Canada
2. CUNY Graduate School of Public Health & CUNY Urban Food Policy Institute. City University of New York, NYC, USA

Correspondence to: Kelley Lee, Simon Fraser University, Blusson Hall, 8888 University Drive, Burnaby, B.C.V5A 1S6, Canada. Email: kelley_lee@sfu.ca

(22), a framing that masks potential conflicts of interest for commercial actors.

While this shift in attention to commercial factors is welcome, current definitions offer limited understanding of the complex pathways between CDoH and NCDs; do not take account of the variable and dynamic nature of CDoH over time and space; and do not consider the potential for positive and/or negative impacts on specific populations. As such, the concept of CDoH has not yet been operationalised to inform public health action effectively (9,21). Indeed, mainstream public health approaches remain focused on metabolic and behavioural risk factors such as screening for hypertension, healthy eating, smoking cessation and improved food-labelling strategies (23). However, interventions aimed at metabolic and behavioural risk factors, without taking account of ‘the inter-relationships of social structure, context and agency in their impact on health and well being (24)’, have limited impact. The CDoH concept potentially integrates metabolic, behavioural and structural risk factors but, to do so, clearer definition beyond a focus on specific health-harming products and industries, along with analytical tools to measure CDoH as a composite of risk factors, are urgently needed.

Understanding the CDoH as a composite of risk factors, and how these risk factors interact with each other, is critical to the development of effective public health interventions to prevent and control NCDs worldwide. First, this approach shifts the dominant emphasis in research and policy on clinical management and behavioural change, which are costly and limited in effect, to prevention based on both societal- and individual-level change. Second, a composite CDoH approach bridges research and policy silos dividing different disease areas, population groups and types of interventions. Instead, these holistic approaches can amplify change through integrated strategies for NCD prevention. Finally, measuring the CDoH as a composite of risk factors allows clearer identification of relative vulnerabilities by specific populations over time and place, and across other variables (e.g. age, gender, socioeconomic status). This could provide a powerful dataset to develop targeted interventions and resources to reduce such risks to health and health equity.

A practical interdisciplinary CDoH framework can also incorporate new insights from systems

science, political economy and political science, creating new bodies of knowledge that can inform public health practice. Systems science can help to create more coherent and grounded understanding of how dynamic systems of power and governance shape the pathways through which CDoH influence health (25). Political economy can help to trace the impact of the rise in neoliberalism on the role of commercial actors while political science can help to identify the social actors who have the power to modify CDoH (26).

Overall, despite clear evidence of the alarming rise in NCDs globally, and high-level political commitment to address this leading public health challenge, the public health community (including health promotion professionals) has achieved only limited consensus on effective preventive action (13,27). The CDoH concept promises a more holistic, integrated and targeted approach.

References

1. Benziger C, Roth G, Moran A. The global burden of disease study and the preventable burden of NCD. *Glob Heart*. 2016; 11: 393–397.
2. World Health Organization (WHO). Noncommunicable diseases. Fact Sheets [Internet]. Geneva: WHO; 1 June 2018 [cited 2020 April 27]. Available from: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>.
3. WorldHealthOrganization(WHO).Noncommunicable Diseases Progress Monitor. Geneva: WHO; 2015.
4. European Commission. Cost of non-communicable diseases in the EU [Internet]. Health Promotion and Disease Prevention Knowledge Gateway. 2019 [cited 2020 April 29]. Available from: <https://ec.europa.eu/jrc/en/health-knowledge-gateway/societal-impacts/costs>.
5. Wild S, Roglic G, Green A, Sicree R, King H. Global prevalence of diabetes: estimates for the year 2000 and projections for 2030. *Diabetes Care* [Internet]. 2004 [cited 2020 April 29]; 27(5): 1047–1053. Available from: <https://www.who.int/diabetes/facts/en/diabcare0504.pdf>.
6. International Diabetes Federation. Diabetes Atlas, 9th edition [Internet]. 2019 [cited 2020 April 29]. Available from: <https://diabetesatlas.org/>.
7. Bollyky T, Templin T, Cohen M, Deileman J. Lower-income countries that face the most rapid shift in noncommunicable disease burden are also the least prepared. *Health Aff* [Internet]. 2017 [cited 2020 April 28]; 36(11). Available from: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0708>.
8. Di Cesare M, Khang YH, Asaria P, Blakely T, Cowan MJ, Farzadfar F, et al. Inequalities in non-communicable diseases and effective responses. *Lancet*. 2013; 381: 585–597.

9. 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. *Global Health*. 2017; 13: 34.
10. Bertram M, Sweeney K, Lauer J, Chisholm D, Sheehan P, Rasmussen B, et al. Investing in non-communicable diseases: an estimation of the return on investment for prevention and treatment services. *Lancet*. 2018; 391: 2071–2079.
11. World Health Organization (WHO). Risk factors [Internet]. Geneva: WHO; n.d. [cited 2020 April 29]. Available from: https://www.who.int/topics/risk_factors/en/
12. WHO Independent High-Level Commission on NCDs. Think piece: why is 2018 a strategically important year for NCDs? Geneva: WHO; 2018 [cited 2020 April 29]. Available from: <https://www.who.int/ncds/governance/high-level-commission/why-2018-important-year-for-NCDs.pdf>.
13. Horton R. Comment: NCDs – why are we failing? *Lancet* [Internet]. 2017 [cited 2020 April 29]; 390: 346. Available from: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)31919-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31919-0/fulltext).
14. Marley T, Metzger M. A longitudinal study of structural risk factors for obesity and diabetes among American Indian young adults, 1994-2008. *Prev Chronic Dis*. 2015; 12: 140469.
15. Buse K, Lee K. Business and global health governance. Discussion Paper No. 5. Geneva: WHO and LSHTM; 2005.
16. Lee K, Smith J. The role of business in global health politics. In: McInnes C, Lee K, Youde J (eds). *Oxford Handbook of Global Health Politics*. Oxford: Oxford University Press; 2020: 387–408.
17. Mercer AJ. Updating the epidemiological transition model. *Epidemiol Infect* [Internet]. 2018 [cited 2020 April 28]; 146(6): 680–687. Available from: <https://www.cambridge.org/core/journals/epidemiology-and-infection/article/updating-the-epidemiological-transition-model/D7933473050AC3A093C10DF34B779492/core-reader>.
18. Freudenberg N. The manufacture of lifestyle: the role of corporations in unhealthy living. *J Public Health Policy* 2012; 33: 1–13.
19. West R, Marteau T. Commentary on Casswell (2013): the commercial determinants of health. *Addiction*. 2013; 108: 686–687.
20. Kickbusch I, Allen I, Franz C. The commercial determinants of health. *Lancet Glob Health*. 2016; 4: e895–e896.
21. 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. *Glob Health*. 2017; 13: 34.
22. World Health Organization (WHO). Framework of engagement with non-State actors (FENSA). Sixty-Ninth World Health Assembly; May 28, 2016. WHA69/10.1.
23. World Health Organization (WHO). Time to deliver: report of the high-level commission on non-communicable diseases. Geneva: WHO; 2018 [cited 2020 April 29]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/272710/9789241514163-eng.pdf?ua=1>.
24. Williams G. The determinants of health: structure, context and agency. *Sociol Health Illn* [Internet]. 2003 [cited 2020 April 29]; 25: 131–154. Available from: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/1467-9566.00344>.
25. Milsom P, Smith R, Walls H. A systems thinking approach to inform coherent policy action for NCD Prevention; Comment on ‘How neoliberalism is shaping the supply of unhealthy commodities and what this means for NCD prevention’. *Int J Health Policy Manag* [Internet]. 2020 [cited 2020 April 29]. Available from: http://www.ijhpm.com/article_3700.html.
26. Smith J. Towards critical analysis of the political determinants of health; Comment on ‘How neoliberalism is shaping the supply of unhealthy commodities and what this means for NCD Prevention’. *Int J Health Policy Manag*. 2020; 9: 121–123.
27. Freudenberg N. Defining appropriate roles for corporations in public health research and practice. *Am J Public Health*. 2018; 108: 1440–1441.