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Editorial

Public health, corporations and the New Responsibility Deal: promoting partnerships with vectors of disease?

The products of tobacco, alcohol and food industries are responsible for a significant and growing proportion of the global burden of disease. Smoking and alcohol combined account for 12.5% of global deaths and 19.5% in high-income countries, while six diet-related risk factors account for 13.6 and 17.5% of deaths, respectively.[1] Arguably the greatest challenge and opportunity for public health lies in reducing the contributions of tobacco use, unhealthy diet and harmful alcohol consumption to the rising global burden of non-communicable diseases.[2] This demonstrates a pressing need to improve our understanding of how corporations contribute to this disease burden, both directly through the promotion of products damaging to health and indirectly through influence over public policy. The concept of an *industrial epidemic*—an epidemic emerging from the commercialization of potentially health-damaging products—lends itself to this purpose.[3,4] Adapting traditional public health constructs, it identifies the role of the host (the consumer), agent (the product, e.g. cigarettes, alcohol), environment and, crucially, the disease vector (the corporation).

The vector analogy was first described in relation to the tobacco epidemic,[3] and tobacco control remains the only field where the commercial vector has been systematically studied. Analysis of millions of internal tobacco industry documents[5] has revealed the multiple strategies via which the tobacco industry has sought to and, often successfully, undermined public health policies.[6,7] Consequently, serious attention has been given to managing the conflicts of interest between public health and the tobacco industry. At global level, the World Health Organization (WHO) has actively sought to monitor and contain industry influence, with Article 5.3 of the Framework Convention on Tobacco (FCTC, WHO's first global public health treaty) requiring all 172 parties to the treaty, including the UK, to protect health policies 'from commercial and other vested interests of the tobacco industry.'[8] Yet WHO's approach to food and alcohol industries is strikingly different, with both its Global Strategy on Diet, Physical Activity and Health[9] and new global alcohol strategy[10] assuming scope for partnership and cooperation that the FCTC precludes.

Similarly in the UK, the food and alcohol industries have recently been invited to join a 'partnership' with government[11] from which the tobacco industry is excluded. The 'Public Health Responsibility Deal', on which, at the time of writing, limited details have emerged,[11,12] is heavily reliant on the concept of corporate social responsibility, with a clear presumption in favour of partnerships and voluntary regulation. Businesses will reportedly be funding government campaigns in return for 'an expectation of non-regulatory approaches',[11] with the Deal operationalized via five networks with heavy industry representation including from the food and alcohol sectors.[13]

While the tobacco industry's exclusion from this model, a requirement under the FCTC, is welcome, it is apparent that broader lessons from tobacco have been implicitly rejected. Tobacco is clearly an exceptional product; no other consumer product kills one in two users when used exactly as intended. But there is little to suggest that, as a corporate actor, Big Tobacco differs fundamentally from Big Food or Big Booze.[14,15] Indeed, the fiduciary responsibilities of all corporations *require* them to maximize profits regardless of consequences to health, society, or the environment and thus to oppose policies that could reduce their profits.[16] There are, therefore, significant limits to the compatibility of industry interests with public health. Food companies, for example, have two basic strategic options to enhance shareholder revenue: to persuade consumers to eat more or to increase profit margins.[17] As much higher profits come from processed compared to fresh foods, promoting the latter, advising people to eat less or eat more healthily contradicts the core business models of many food companies.[17]

It is unsurprising, therefore, to find that the tactics employed by major food and alcohol companies to sell their products and influence their regulatory environment closely mirror those employed by the tobacco industry.[14,15,18–22] They include focusing on personal responsibility, claiming government intervention infringes individual liberty, vilifying critics, labelling studies contrary to their interests 'junk science', using corporate social responsibility to enhance reputation and promote brands, opposing effective binding regulation and promoting self-regulation via voluntary codes. There is also evidence that food and alcohol companies have worked collaboratively with the tobacco industry, for example in sharing youth marketing tactics and managing regulatory risks.[14,23] In one instance, many major companies, including some earmarked for involvement in the Responsibility Deal, were involved in successful efforts led by British American Tobacco to alter policy making in the European Union, efforts expressly aimed to make it harder to enact public health policies.[23]

Evidence on the involvement of industry in educational campaigns, another element of the Deal,[11] causes further concern. Independent evaluations of the tobacco industry's notorious 'Youth Smoking Prevention' programmes, typically run in partnership with government, shows they do not reduce and may even increase youth smoking while internal documents reveal their intended role: to forestall and fight legislation worldwide.[24,25] Similar evidence suggests that alcohol industry funded public awareness and educational programmes are ineffective and potentially counter productive.[14,20] Thus, while the desire to contain government expenditure on campaigns through corporate involvement is understandable, this needs to be balanced against the costs that arise from alcohol use and obesity.[26,27]

In total, the evidence presented above, alongside that of limited genuine efforts of food and alcohol companies to engage in or comply with voluntary initiatives,[19,28,29] raises serious concerns about the New Responsibility Deal. The core of these concerns is the apparent failure to acknowledge the essential conflicts of interest involved when corporations engage in activities and policies ostensibly aimed towards reducing the harmful behaviours on which their profitability depends. The Deal also appears wholly inconsistent with existing evidence of public health effectiveness, instead being closely aligned with industry preferences. It implicitly rejects the application of broader lessons from the remarkable national and global successes in tobacco control, including evidence that voluntary approaches are inadequate while legislative approaches, contrary to industry arguments, are effective and do not harm economies,[30] and that industry interests are antithetical to effective tobacco control policy-making.[6]

This editorial certainly does not suggest that working in partnership with corporations can never deliver public health gains,[31] or that dialogue with industry, one of the justifications for the current approach,[32] be precluded. It does, however, argue that legitimate engagement with industry does not require that corporations be given such a prominent seat at the policy-making table, but instead requires that conflicts of interest are actively managed within health policy. Given evidence that rates of tobacco use have fallen by 25% in the UK in the last decade, while obesity rates and morbidity and mortality from alcohol use continue to rise, the starkly contrasting approaches to tobacco versus food and alcohol corporations and their roles in policy-making are cause for alarm. There is a growing movement to monitor the conduct of corporate disease vectors;[3,4,8,33] such monitoring will be essential for the rigorous management of conflict of interest and for evaluating the impacts of the New Responsibility Deal.

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References

1 World Health Organization. *Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks*. Geneva: WHO, 2009. http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf (December 2010, date last accessed).

2 World Health Organization. *2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Non communicable Diseases*. Geneva: WHO, 2008. http://whqlibdoc.who.int/publications/2009/9789241597418_eng.pdf (December 2010, date last accessed).

3 Jahiel RI, Babor TF. Industrial epidemics, public health advocacy and the alcohol industry: lessons from other fields. *Addiction* 2007;**102**:335–9.

4 Jahiel RI. Corporation-induced diseases. Upstream epidemiological surveillance and urban health. *J Urban Health* 2008;**85(4)**:517–31.

5 Collin J, Lee K, Gilmore A. Unlocking the corporate documents of British American Tobacco: an invaluable global resource needs radically improved access. *Lancet* 2004;**363**:1746–7.

6 World Health Organisation. *Tobacco Industry Interference with Tobacco Control*. Geneva: WHO, 2008. http://www.who.int/tobacco/resources/publications/Tobacco%20Industry%20Interference-FINAL.pdf (December 2010, date last accessed).

7 Grüning T, Gilmore A, McKee M. Tobacco industry influence on science and scientists in Germany. *Am J Public Health* 2006;**96**:20–32.

8 World Health Organisation. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control: on the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry. http://www.who.int/fctc/guidelines/article_5_3.pdf (December 2010, date last accessed).

9 World Health Organization. *Global Strategy on Diet, Physical Activity and Health*. Geneva: WHO, 2004. http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf (December 2010, date last accessed).

10 World Health Organization. *Draft Global Strategy to Reduce the Harmful Use of Alcohol*, 2010. http://www.who.int/substance_abuse/alcstrategyaftereb.pdf (December 2010, date last accessed).

11 Lansley A. A new approach to public health. *Speech*, 7 July 2010. http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117280.

12 Department for Health. Healthy lives, healthy people. *White Paper*, 20 November 2010. http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm (December 2010, date last accessed).

13 Lawrence F. Who is the government's health deal with big business really good for?. *Guardian*, 12 November 2010.

14 Bond L, Daube M, Chikritzhs T. Selling addictions: similarities in approaches between Big Tobacco and Big Booze. *Australas Med J* 2010;**3**:325–32.

15 Brownell KD, Warner KE. The perils of ignoring history: big tobacco played dirty and millions died. How similar is big food?. *Milbank Q* 2009;**87**:259–94.

16 Wiist WH. Public health and the anticorporate movement: rationale and recommendations. *Am J Public Health* 2006;**96**:1370–5.

17 Ludwig DS, Nestle M. Can the food industry play a constructive role in the obesity epidemic?. *JAMA* 2008;**300(15)**:1808–11.

18 Wiist WH (ed.). *The Bottom Line or Public Health*. New York: Oxford University Press, 2010.

19 Hastings G, Brooks O, Stead M *et al*. Failure of self regulation of UK alcohol advertising. *BMJ* 2010;**340**:b5650

20 Anderson P. Global alcohol policy and the alcohol industry. *Curr Opin Psychiatry* 2009;**22**:253–7.

21 Bond L, Daube M, Chikritzhs T. Access to confidential alcohol industry documents: from 'Big Tobacco' to 'Big Booze'. *Australas Med J* 2009;**1(3)**:1–26.

22 McCreanor T, Casswell S, Hill L. ICAP and the perils of partnership. *Addiction* 2000;**95(2)**:179–85.

23 Smith KE, Fooks G, Collin J *et al*. 'Working the System'—British American Tobacco's influence on the European Union Treaty and its implications for policy: an analysis of Internal Tobacco Industry Documents. *PLoS Med* 2010;**7(1)**:e1000202. doi:10.1371/journal.pmed.1000202. http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000202.

24 Landman A, Ling P, Glantz S. Tobacco industry youth smoking prevention programs: protecting the industry and hurting tobacco control. *Am J Public Health* 2002;**92**:917–30.

25 Wakefield M, Terry-McElrath Y, Emery S *et al*. Effect of televised tobacco company funded smoking prevention advertising on youth smoking-related beliefs, intentions and behaviour. *Am J Public Health* 2006;**96**:2154–60.

26 Anderson P, Chisholm D, Fuhr DC. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet* 2009;**373**:2234–46.

27 McCormick B, Stone I, Corporate Analytical Team. Economic costs of obesity and the case for government intervention. *Obes Rev* 2007;**8(Suppl. 1)**:161–4.

28 Lang T, Rayner G, Kaelin E. *The Food Industry, Diet, Physical Activity and Health: A Review of Reported Commitments and Practice of 25 of the World's Largest Food Companies*. Centre for Food Policy, 2006. http://www.city.ac.uk/news/press/The%20Food%20Industry%20Diet%20Physical%20Activity%20and%20Health.pdf (December 2010, date last accessed).

29 van den Broeck A, de Bruijn A. Effective alcohol marketing regulations: policy report. Dutch Institute for Alcohol Policy—STAP, 2010. http://www.eucam.info/content/bestanden/policy-report-alcohol-marketing.pdf (December 2010, date last accessed).

30 Jha P, Chaloupka F (eds). *Tobacco Control in Developing Countries*. Oxford: Oxford University Press, 2000.

31 Stahl T, Wismar M, Ollila E et al. (eds). *Health in all Policies: Prospects and Potentials*. Ministry of Social Affairs and Health, 2006. http://www.euro.who.int/__data/assets/pdf_file/0003/109146/E89260.pdf (December 2010, date last accessed).

32 From parish pump to Pepsi-Cola (interview with Ann Milton). *BMA News Saturday,* 27 November 2010.

33 Babor TF. Public health science and the global strategy on alcohol. *Bull World Health Organ* 2010;**88**:643.