Tackling risk factors for non-communicable diseases: the pros and cons of a more integrated approach

Contents

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Summary of key findings

This qualitative study explored the scope for public health stakeholders to take a more integrated approach to addressing risk factors for non-communicable diseases (principally tobacco, alcohol and obesity) and their commercial determinants.

The 14 participants identified a range of good reasons for taking a more integrated approach:

- In the pursuit of change, collective action may be more effective than single-issue advocacy both because there are more voices asking for change and because those voices represent wider interests, bringing more people to the table.
- A coordinated approach makes plain the similarities between the commercial determinants across risk factors, and between the measures available to address them, enabling greater alignment in policy and campaigning and a more efficient and persuasive approach overall.
- The opportunity to work across risk factors enables learning between stakeholders about the effectiveness of policy measures, advocacy strategies and industry tactics.
- A more integrated approach shifts the focus towards the commercial determinants that affect different risk factors in similar ways, reframing the policy and campaigning agenda with a greater emphasis on addressing the behaviour of corporate actors.

They also identified the following problems:

- A more integrated approach risks losing the focus and targeted campaigning of single-issue advocacy.
- Differences across risk factors in public health policy progress, public attitudes, and industry access to government, mean that policy development and advocacy still have to be tailored to individual risk factors to some degree.
- Tackling commercial determinants is potentially a huge task, given their power and complexity, and may conflict with economic strategy.
- Bringing together diverse stakeholders with many interests presents familiar practical challenges.
- Current political uncertainty and turbulence in England inhibits any strategic population view of health.
- Familiarity with the 'commercial determinants' is not universal and the language remains contested.

These pros and cons played out differently in different contexts. The three participants close to government in England all expressed doubts about taking a more integrated approach to addressing NCD risk factors, given the habit and preference of the government in Westminster to advance public health through single-issue proposals. In contrast, the one participant in Scotland was optimistic about a government-level approach. The four participants at regional level in England saw the value of reframing the debate about risk factors in terms of commercial and wider determinants, and of ensuring that lessons are shared across risk factors for the benefit of local population health.

Participants had mixed views about how the commercial determinants relate to the wider determinants of health. Most acknowledged that the commercial determinants have been neglected in public health debates about the wider determinants.

Introduction

The SPECTRUM Consortium seeks to generate new evidence to inform the prevention of non-communicable diseases (NCDs) caused by unhealthy commodities, including tobacco, alcohol and unhealthy food and drink. It has a particular focus on health inequalities and the commercial determinants of health.

This small study, funded by the SPECTRUM Research Innovation Fund and led by the Smokefree Action Coalition, Obesity Health Alliance and Alcohol Health Alliance, explored the scope for government, public health professionals and health advocates to take a more integrated approach to tackling the main risk factors for NCDs. In practice, this can take various forms ranging from greater coordination between partners, through coherence to full integration of campaigning or policy-making[1]. This report uses the short-hand of 'more integrated approaches' to encompass all of these possibilities.

As smoking, drinking and the consumption of unhealthy food and drink all have powerful commercial determinants, there is a case for tackling these determinants in a more joined-up way. It has been argued that the commercial determinants of health are addressed most effectively not through siloed efforts to reduce consumption of health-harming products, but instead as a set of integrated strategies to reduce exposures to health-harming commercial actors and activities[2]. One of the obstacles to taking such an approach is the lack of consensus about the importance of the commercial determinants in driving health inequalities. Public health debates often focus on models of the social determinants of health which do not routinely include commercial determinants, with the result that the role of the private sector in shaping the health of the public may be obscured[3].

There is also some debate about what 'the commercial determinants' encompass. They can be defined pragmatically as 'those activities of the private sector that affect the health of populations'[4], a useful definition which focuses clearly on corporate behaviour and actions. Arguably, however, the commercial determinants include not only the specific activities of corporations in producing and marketing unhealthy products but also the macro-level conditions that shape this activity including trade globalization, regulatory systems, and neoliberal and capitalist ideologies within the political sphere[5]. Freudenberg et al. have proposed a definition which seeks to encompass this broad scope of interests: the commercial determinants of health are 'the social, political, and economic structures, norms, rules, and practices by which business activities designed to generate profits and increase market share influence patterns of health, disease, injury, disability, and death within and across populations'[6].

This definition illuminates the sheer size of the potential public health task in addressing these commercial determinants. The commercial actors involved – principally transnational corporations – are extremely powerful and already work together to defeat public health legislation that threatens their interests[7]. Collective action may be just as important to public health stakeholders if they are to be effective in confronting this power[8].

In practice, approaches to tackling multiple NCD risk factors are diverse. Examples include the Scottish Parliament's Cross-Party Group on Improving Scotland's Health, the merging of the tobacco and alcohol regional offices in the northeast of England, the Prevention Green Paper in England[9] and, locally, the development of integrated 'healthy lifestyle' services. Internationally an integrated approach is central to the work of the NCD Alliance.

This qualitative study sought to describe the current reality of professional experience of, and attitudes to, tackling NCD risk factors within a variety of these contexts. It offers some further insight into the challenges and opportunities of taking a more integrated approach to this task.

Methods

This was a qualitative study which sought to gain insight from the experience and knowledge of selected stakeholders in public health. It did not seek to gain representative data. Fourteen individuals with senior roles in public health were selected for interview through the networks of the Smokefree Action Coalition, Obesity Health Alliance and Alcohol Health Alliance. They were asked to participate either because they had experience and knowledge of tackling the commercial determinants of health or because they had a strategic view of the opportunities for doing so.

Participants included:

- individuals from statutory and non-governmental organisations
- individuals operating at national and regional level
- individuals in England and one person in Scotland

Of the 14 participants:

- three were, or had been, employed within government at national level in England
- four were employed by regional bodies with public health responsibilities in England
- six were, or had been, employed by national advocacy NGOs in England including one who was employed by a public health professional membership body
- one was employed by a national advocacy NGO in Scotland

A topic guide was prepared by the study team prior to the interviews. This provided a loose structure to the interviews, each of which followed its own course depending on the interests and experience of the participant.

All interviews were conducted via Zoom. Thirteen of the fourteen participants consented to the recording of the interview. Audio files of the interviews were transcribed using Otter.ai. Notes were made of all interviews including the interview that was not recorded.

The analysis involved an iteration between the transcripts and the core concerns of the study, namely: participants' attitudes and beliefs about taking a more integrated approach to tackling NCDs, the perceived pros and con of doing so, and current obstacles and drivers. Differences in participants' experience and attitudes were identified in order to tease out the complexity within each of these areas of interest. Quotes were selected which best described specific positions or views, or which illuminated the diversity of participants' experience.

Findings

Overview

This was a small, exploratory study with relatively few participants. Nonetheless it captured a diverse range of views about the potential value of taking a more integrated approach to tackling multiple commercially-driven risk factors. The differences in participants' views reflected, in part, differences in

- their experience of tackling commercially-driven risk factors;
- their attitudes and beliefs about where and how to intervene to achieve public health outcomes;
- the locus of their work and the breadth of their interests.

These differences are explored below, followed by a description of the perceived benefits and problems of taking a more integrated approach, and finally by an account of current drivers and opportunities.

Experience of tackling multiple commercial risk factors

Some study participants were approached to contribute to the study precisely because they had experience of taking a more integrated approach to multiple commercially-driven risk factors. Others were approached because they had a strategic overview of public health nationally or regionally, but not necessarily specific experience of taking an integrated approach.

The following experiences were cited:

- In Scotland, a coalition of advocacy organisations persuaded and supported members of the Scottish Parliament to set up a cross party group on improving Scotland's health with a focus on preventing non-communicable diseases, looking particularly at tobacco, alcohol and unhealthy foods. The coalition published a performance report on progress in implementing policy on health-harming products in January 2022[10] and a new Case for Action in September 2022[11].
- In the Yorkshire and Humber region, The Association of Directors of Public Health launched a programme of work called Healthier and Fairer Futures, 'a programme advocating for a pro-health economy, guiding action to address the commercial determinants of health.' It seeks to build an alliance that tackles tobacco, alcohol, gambling, and unhealthy food and drink, mitigating the strategies used by the private sector to promote products that are detrimental to health.
- In the Northeast region, the regional tobacco office (Fresh NE) and the regional alcohol office (Balance) have been run as one team with one Director since 2017, though they retain separate public profiles.
- The Royal Society for Public Health has a programme of work called Health on the High Street. The focus on the high street draws attention to the diversity of commercial determinants at the heart of everyday life including fast food outlets, bookmakers and pubs, as well as positive influences such as gyms and libraries.
- The Health Foundation has an ongoing programme of research and funding focused on the wider determinants of health. This includes supporting an advocacy alliance called the Collaboration for Health and Wellbeing. The Foundation recently published a report on the leading risk factors for ill health which includes a call to government to act on the commercial determinants of health[12].
- The Mental Health Foundation has undertaken research and advocacy to better protect young women and men from the combined effects of the cosmetics, surgery, advertising, food and social media industries, with some success in changing advertising practice.

These experiences encompass advocacy, research, policy, and the design and delivery of public health programmes. They reflect no more than the experience of the participants in the study. Participants acknowledged that, in the wider sphere, commercial risk factors are not addressed in an integrated manner as a matter of course:

> *To be honest, they seem to be approached very much as individual areas, despite the fact that they share a lot in common, particularly around the social determinants or the commercial determinants of health. I think the only time they come together is when you're talking about something separate that they're all relevant to. For example, around the time of the government's green paper on prevention, there was a little bit more of a concerted effort to bring together different themes. But it's been very much driven by trying to achieve policy*

change separately in each of those areas, and there hasn't been a concerted effort to look at some of the commonalities between those areas. (UK NGO role)

Attitudes and beliefs about where and how to intervene

The case for taking a more integrated approach to tackling multiple commercially-driven risk factors can be made in a number of ways. Participants discussed:

- the clustering of risk factors at an individual level;
- the combined effect of these risk factors in exacerbating health inequalities;
- the place of commercial risk factors within the wider socio-economic determinants of health.

From the clinical perspective, there is a case for a more integrated approach, given that risk factors tend to cluster at the individual level. This clustering informs an argument for more person-centred, holistic services:

Diabetes prevention programs are integrating psychological and mental health support because oftentimes there is a mental health component. People are grappling with relationship to food, stress, eating, depression and anxiety as a result of obesity. So there's a benefit from integrating clinical services but also thinking more holistically about the risk factors as well: recognizing that individuals are more than a sum of parts, and that if you're dealing with one condition, there are often other conditions which may be accompanying it, by virtue of that person's demographic backgrounds, social economic status, and their experiences of navigating this world. (England regional role)

This is first and foremost a clinical view about how best to deliver person-centred services. However, as this participant acknowledges, it implies that multiple risk factors should be addressed at a level beyond the individual. Another participant noted the limitations of this individualistic view and the common failure to link it to a strategic view of the drivers of need:

Within government and in local authorities, and across public health, they are still seen as topic areas on their own. They don't go across those commodities. All that people talk about is: if you're a gambler, you are more likely to drink alcohol, and you're more likely to smoke. If you take drugs, you're more likely to smoke. (England regional role)

The inequalities argument takes the point about clustering to the population level, acknowledging that communities with high rates of smoking and drinking, and poor access to healthy food, are most likely to suffer poor long-term health outcomes. Once again, however, this epidemiological perspective begs the question about how best to intervene.

Within this study, which explicitly sought to engage individuals interested in the commercial determinants of health, answers to this question were principally located in the debates about tackling the wider determinants of health associated with the work of Michael Marmot. Participants' attitudes to this worldview were diverse and nuanced.

The following is one participant's fully-fledged articulation of the case for addressing the wider determinants of health to improve population health outcomes:

We now know that underpinning a number of these chronic diseases, and the risk factors that cause them are social and economic factors, and those same factors are responsible for creating risk for a range of different health outcomes. So by moving upstream, you're able to have multiple impacts downstream… And what are some of those high-level interventions where you're able to have multiple effects downstream? Clearly, economic interventions

because poverty is at the root of so much of what we see. So poverty alleviation, and creating a stronger safety net, can have a huge impact downstream. Then issues such as planning, and how we create healthier places, because by intervening with the building sector, developers, planners, regeneration experts, you can have a huge impact on mental health, physical health, non-communicable diseases downstream. And obviously, creating healthier homes, which has a huge impact on health and wellbeing as well. And then finally, thinking about the things that we do with industry in terms of how we use and incentivize healthier behaviours within the industry, especially the food industry, but you can also begin to think about how you incentivize healthier products within other industries as well. And all of those interventions become part of what needs to be on the table, if we're moving towards better population health outcomes. (England regional role)

In this account, the commercial determinants of health are part of the wider determinants but are presented as being secondary to the tasks of tackling poverty and transforming the built and public environment. This illuminates some of the complexity of the issue: commitment to tackling the wider determinants may be commonplace in some public health circles but attitudes to the place of the commercial determinants within this worldview, and how they should best be addressed, vary.

The 'commercial determinants' are not clearly established within Marmot's approach to understanding the wider determinants of health inequalities. One of the participants had deliberately introduced the language of the commercial determinants into local discussions in order to leverage support for tackling smoking and alcohol use among professionals whose focus was further upstream:

I've gone down the commercial determinants route with our directors of public health. They are very interested in the wider determinants of health and they have been increasingly dismissing tobacco as a topic area. So I introduced the commercial determinants of health with them, just getting them to think about it: we could take the commercial determinants under the wider determinants, or they could be another determinant alongside them, running parallel to the wider determinants of health. It's more around the commercial drivers of ill health, because the commercial determinants can have a positive as well as a negative impact on health. Very much an ill health perspective on multinationals. So we've got that going and it's got some traction with our directors of public health. (England regional role)

In contrast, a public health lead in another region reported that local directors of public health remained committed to tackling smoking, alcohol and obesity, and that this was consistent with a commitment to tackling the wider determinants of health. Other participants did, however, cite the tension between the desire to tackle the fully 'upstream' determinants and traditional topic-focused public health interventions:

There's this idea that if you want to get rid of health inequalities, you've got to get rid of inequalities. That's the Michael Marmot argument, isn't it? Fixed income policies and things like that. Lots of stuff free at the point of use: education, transport, what have you. But in the absence of that, if you can't get rid of the socioeconomic inequalities, then what can you do about health inequalities? And that's where you get to food, smoking and obesity. (UK NGO role)

One participant in England, with experience close to government, identified the emphasis within public health on the wider determinants of health as an obstacle to engagement with government:

Public health is a very divided space between two different groups. There's a group led by Michael Marmot, which is very much in the structural social determinants of health space, where there's very strong compelling evidence that if you raise people's incomes, if you tackle

things at a structural level, you can improve public health outcomes. The government often finds itself in the second group, which is more in the condition- or areas-specific fields of public health, because it struggles to translate that structural stuff into actual policy. (England government role)

The locus of action and engagement

The last quote takes this discussion to the locus of participants' action and engagement. Here there were some clear differences between the participants:

- the three participants who were, or had been, closest to government in England had the greatest doubts about the value of taking a more integrated approach to tackling multiple risk factors;
- the one participant close to government in Scotland was enthusiastic and committed to this approach;
- the four participants working at regional and local level were optimistic about the added value of taking such an approach;
- the participants in the non-governmental sector had mixed experience but were generally supportive and keen to do more in this space.

The participants who were, or had been, close to government in Westminster all stressed the importance of highly focused advocacy in bringing about policy change in government, which typically progressed through specific, targeted policy proposals.

Nationally, I think it gets very, very difficult because the national government sees these things as "Right, what's our next activity on smoking?" I think it [a collaborative approach] would show a united front, and everyone would feel like they were working collaboratively which everyone in the world wants. At the same time, would it make their policy asks undeliverable because the system they are talking to doesn't work in the way that they are presenting themselves? It may work if there's something that the groups can agree on, which is quite specific, which they can then use as their platform. (England government role)

Whether or not the Scottish Government is also prone to this siloed approach to policy-making, the existence of a parliamentary mechanism for considering the public health issues common to non-communicable diseases at least provides an opportunity for a more strategic view of their determinants.

At regional and local levels, there is a stronger focus on the complexity of the needs of local communities. This complexity invites a more strategic view of the drivers of these needs and how they should be addressed.

I think local councils and local communities are more open to taking a joined-up structural approach and looking at how they can maximize budget funding pots to create a more healthy, community-based environment. And some of the actual practical decision-making around those commercial determinants are locally-led, like obesity: chicken shops near schools, those sorts of like planning proposals, green spaces. I think that the local model of engagement could be quite fruitful. (England government role)

The study participants from non-governmental organisations all had a national brief but were better placed than government in Westminster to take a long-term view of the scope for intervention. They all saw the value of tackling upstream commercial determinants.

The study participants from non-governmental organisations all had a national brief and were well placed to take a long-term view of the scope for intervention. They all saw the value of tackling upstream commercial determinants.

> *We have become more interested in how different commercial determinants impact on mental health, specifically thinking about different population groups. We've done quite a lot of work in the past three years in relation to body image and social media and other powerful industry forces like advertising and fashion, cosmetics and the food industry. This is part of the broader cultural context that is important to take into account when we think about shaping mentally healthier lives. (UK NGO role)*

Benefits of taking a more integrated approach

Participants identified the following potential benefits of a more integrated approach to tackling multiple risk factors:

- a stronger voice and wider buy-in
- greater alignment of policies or campaigns and more efficient ways of working
- learning from each other
- opportunities for reframing

Within the world of advocacy, the value of building coalitions and gaining a stronger collective voice is well understood. A coalition with a broad agenda will potentially attract a wider range of stakeholders than a single-issue campaign, magnifying any call for change while also engaging a wider constituency of decision-makers.

> *There's no doubt that there are people around the table who may not have come to the table if we had just been talking about alcohol, for example, but they're interested in smoking, or they're interested in obesity. You broaden the conversation and bring people into the conversation who wouldn't otherwise be around the table. Then there are MSPs who are interested in cancer, for example: "Oh, so, Cancer Research are putting their weight behind this report?" It gives us greater clout, and broader reach. (Scotland NGO role)*

Tactically, one voice rather than many may also be important if, as one participant put it, 'there's only a certain amount of bandwidth for public health' in government.

Given the similarities between the advocacy agendas across risk factors, an integrated approach enables alignment of policy or campaigning interests and more efficient ways of working:

> *Surely there must be a way that you can think about how you align campaigns and messaging and relationships. So it's not different people knocking on the door: "Hi, we're the tobacco folk", "We're the obesity folk", and "We're the alcohol folk". And you all say, "Oh, we need taxes, we need labelling". You're saying all the same stuff. So surely, there's a way that you could find to be more creative and compelling about that. And find efficiencies of how you work with natural allies, and work at messaging about your common enemies. (UK NGO role)*

Likewise in local government, a joint approach may be both more efficient and more persuasive.

> *It makes sense for us to go to health and wellbeing boards, for example, and speak on both agendas. And, you know, there's been a lot of progress within the northeast on tobacco, so having that as an illustration helps us to move forward on the alcohol side. I think it's sometimes quite persuasive. So when trying to influence local authorities, it does help to join up the agendas. (England regional role)*

Participants also identified joint polling, joint communications, and the slow process of building public support as potential efficiency gains of working together.

The value of sharing knowledge, insight and evidence between coalition partners was identified by almost all participants. However, several participants noted that the benefits of mutual learning were not equally shared. Because progress on tobacco is more advanced than in other areas, tobacco control tends to be regarded as the primary source of experiential insight.

> *The other big advantage for us is learning around campaigns. If you're looking at the alcohol and the tobacco agendas, clearly alcohol feels like it's a long way behind. The evidence base around tobacco campaigns is much better developed. So, through tobacco we've tried to translate to the alcohol side and we are seeing certain indications of success now. (England regional role)*

> *It's helping develop our understanding of the drivers but also of the solutions. We're looking at tobacco and going: "Okay, so how did they achieve that? How long did it take them? Crikey, can we not do it a bit quicker?" You have to be impatient but also humble about what you can achieve. (Scotland NGO role)*

> *We need to learn from the behaviour of big tobacco that their gamebook will be followed by big alcohol, and big food to an extent. You realize that they're following the same patterns. For example, the Alcohol Education Trust, with the industry behind it, goes into schools and people are saying "Oh, we've had this fantastic team in all week in our school and they spoke to 1000 kids". And of course we know from tobacco control that this is the classic thing: the solution to stopping kids smoking is to go into primary schools and give talks. Absolute nonsense! (England regional role)*

There are, however, many stakeholders beyond tobacco control who can potentially contribute to a shared understanding of the collective task.

> *There's only so much we can do as a mental health organisation to understand all the evidence that links things together. So, if we can present the mental health evidence and ask others to present the broader health evidence, it becomes a lot stronger. (UK NGO role)*

The process of mutual engagement and learning is not simply one of giving and taking lessons on good practice. In time, a deeper understanding is also gained of mutual interests and needs, which in turn helps to underpin partnerships in the long term.

> *There's the Venn diagram of overlap that defines common ground. And with the opportunity to learn from others, your Venn diagram might actually enlarge as you realize you've got more in common. (UK NGO role)*

A shared focus on multiple risk factors can expose the differences in policy progress between them, which may be helpful in making the case where policy lags. This also creates a space in which to reframe the argument for decision-makers, steering their focus towards the more upstream commercial determinants, notably the actions of the companies selling and promoting unhealthy products.

> *Increasingly we're saying, hang on government, why are you viewing tobacco and alcohol so separately? Alcohol is a class A carcinogen, it has a huge impact on driving health inequalities, and a significant impact on morbidity, and crime and disorder, and domestic violence, and all of the other things. Why is it that over a succession of government for the last two decades, there's been a lot of regulation passed, and essentially nothing for alcohol? (England regional role)*

> *One of the most fundamental things is the framing. The narrative is dominated by industry: 'It's just these people over here that don't know how to control themselves'. That kind of individualized blaming and shaming, versus: these are multibillion dollar industries who are ramming this stuff down people's throats. We shouldn't expect companies to be moral beings, but the bottom line is that the power and influence that they have is undermining people's human rights and causing death and misery. That's the reality. Helping people understand that is like peeling the scales back from their eyes. (Scotland NGO role)*

Reframing the problem with a focus on commercial drivers enables the promotion of models such as the 'four Ps' (price, promotion, product and place) which bring clarity to the task for public health across all commercial risk factors, regardless of their different stages of development.

> *What I've been saying to the directors of public health is have a look at the fours Ps – I call it 'demarketing'. So it's the companies' job to market these products by using the four Ps. And it's our job to see how we can de-market and denormalise. I point out that there are things that they are looking to do already within their local authorities around advertising, within their policies and their commissioning protocols, such as ethical commissioning and procurement. A framing around that would be helpful. (England regional role)*

Problems with, and obstacles to, taking an integrated approach

Participants identified the following potential problems with a more integrated approach to tackling multiple commercially-driven risk factors:

- the dilution of the power of single-issue advocacy
- the differences in policy progress across risk factors, and in public attitudes towards them
- the differences in government's relationships with industry
- the complexity and economic costs of tackling commercial determinants
- the practical challenges of bringing together people who have diverse knowledge and interests
- political uncertainty and turbulence
- language and communication issues

There may be contexts – notably government in Westminster – where single issue advocacy is the norm and suits the way government works. Shifting to a more integrated approach to advocacy at this level risks diluting the power of the targeted voice. Where a singular focus in advocacy has been effective, as in tobacco control, there is a case for retaining it.

> *There's potential for a loss of focus, for some issues getting lost in the complex system of the way that they all interact. Does that wider focus across them have unintended consequences? (England government role)*

> *You've got to look at what outcome you would then expect to get from this. You may lose the detail of the single issue advocacy, which can be very helpful. And possibly you lose the knowledge of what works for particular risks. Smoking has been successful, because the prevalence is falling overall – but it isn't for inequalities. So it needs not to get diluted, but a bit more focused on the groups that are not making that success. And that's in itself very, very useful for public health, because we know where we need to target and what the problem is. And we actually have effective interventions. (England government role)*

A more holistic approach within government itself would facilitate a more integrated approach to advocacy. But currently, in England, this seems remote.

You have to have supportive government and across government as well. Departments can spike each other, so it has to really come from the cabinet. And this was recognized back in 2013, when a cabinet sub-committee was set up to ensure this didn't happen and that departments did cooperate. And it lasted less than a year I think. It just sort of fell apart. (England government role)

In the discussion of benefits, differences in policy between risk factors were cited as being helpful when making the case for greater action where policy lags. However, these differences can also be an obstacle to developing integrated policy proposals. More generally, the differences in public attitudes to different products, and in their status within modern consumer culture, complicate the task of developing consistent and integrated policy positions.

You get some kickback that food is not tobacco, alcohol is not tobacco, that tobacco is this anomaly. So I push back saying that it's not always been like that: the time when half the population smoked wasn't so long ago. (England regional role)

Our relationship with obesity and our relationship with smoking are very different. Smoking is much more about how we stop anyone smoking, because fundamentally it's not a great health choice. The relationship with food is so much more complicated, and I think that creates some tensions. You need to have opportunities for a really broad conversation, and opportunities for quite a specific, tailored conversation. (UK NGO role)

The language of 'commercial determinants' may help to focus minds on the common commercial drivers of these diverse risk factors, but switching to a focus on the industry is complicated by the differences in how these industries are viewed and treated within government.

For me, the biggest frustration is the way that the industries are perceived differently at a national level. The tobacco industry is very much excluded from policymaking, whereas the alcohol industry is much more embedded with government. Arguably the biggest challenge is trying to shift those perceptions. (England regional role)

As these industries have a great deal of power, an integrated approach to lobbying against their interests carries its own risks.

There's the risk that you have an even bigger fight on your hands, because you're not just picking off the alcohol industry, you've got all of them. Of course, many of them are interconnected and owned by the same companies ultimately. But the risk is that you have an even bigger range of opponents arraigned against you. (Scotland NGO role)

Shifting the focus of intervention more 'upstream' to the commercial determinants of health and illness can also make the task seem much bigger and more complex. Public health professionals may be less easily dissuaded from adopting this perspective than government, but the challenges presented by a focus on the commercial determinants can still be daunting, especially when the economic costs of constraining the commercial sector are raised.

One issue with commercial determinants and these industry forces is that, for many people, they feel too big. They feel too difficult to address or change. What I have found, in my experience, is that there are actually areas where you can achieve small shifts, and these could have big benefits. (UK NGO role)

The more upstream you move, the more challenging it becomes. You may need to engage the commercial partners, people who are involved with producing unhealthy food, or town planners who are designing physical activity and active travel, or producers of tobacco and alcohol. You begin to deal with more politically challenging actions, and you begin to weigh

different costs and benefits for intervention. And the costs will include, is there a negative economic impact, either nationally or locally, that can occur by virtue of intervening at that level? And how are those economic costs weighed against the health and economic benefits of intervention? Those are often very difficult conversations to have, and very difficult to gather evidence of impact for. (England regional role)

These questions become more complex when seeking to address multiple risk factors, each of which has specific social and economic impacts and costs. The following is an example of a conflict between public health and economic development objectives which illuminates the specificity of the economic issues for alcohol:

The tensions that we see from an alcohol perspective are in terms of regeneration. Newcastle is very much a vibrant night-time economy, and it's marketed in that way. So there are those internal tensions within local authorities: the drive towards healthy cities and this essential need for regeneration and economic growth. (England regional role)

At a practical level, there are inevitably challenges to taking a broader view while also maintaining a strong operational focus. While the opportunities for learning between partners are considerable, the differences in knowledge, interests and values between partners can also inhibit the development of specific policy proposals.

Building on the cross-risk factor stuff with academics is probably a good starting place. However, you go off on every single direction you can imagine. Everyone's got a different background themselves. Whereas ASH will keep that that operational bit: what can we do now? Slightly different from the academics, but they'll bring the academics in. (England regional role)

One of the barriers is our lack of understanding about one another's worlds in detail. You might take it as a given that I know all there is to know about tobacco regulation but my knowledge and understand about that is actually pretty limited. You're so immersed with what you're doing in your day to day, and that's technical and complicated sometimes, and staying on top of the detail is tricky. (Scotland NGO role)

Several participants drew attention to the uncertainties of the current political environment, and the impact of the national restructuring of public health agencies. Inasmuch as these are problems, not opportunities (see below), they are clearly problems for all of public health, not just those concerned with the commercial determinants.

I think we're in a very challenging time in England politically. There's too much detracting from the healthcare conversation. It's a volatile situation. We want to make sure that public health agencies are seen as friendly advisors who are supporting the correct decisions to be made, not antagonistic. (UK NGO role)

The splitting of the public health system has done immense damage because we had a highly effective and very skilled group of people who are working on this [obesity], and trying to work with government. And of course, they've got rid of them or they've left in despair. And the people who are left are worried about losing their jobs. So that is a hopeless situation to be in. And it's probably our biggest problem now. (England government role)

Finally, participants had mixed feelings about using the language of 'commercial determinants':

I always say to colleagues, language matters. And we need to understand that we have our technical language, and we have language that resonates with politicians and people. Now,

I'm not saying that I know what the right term is, but I know what the right term isn't. And it's not 'commercial determinants of health'. (England regional role)

I think the 'commercial determinants' are what people understand a bit more. The 'wider determinants' feels very far into removed from them. The interventions for the commercial determinants are much more straightforward, they're more understandable. (UK NGO role)

The language of 'commercial determinants', although it's not quite right, it tends to land with the public quite well, because people know what you're talking about. Whereas the 'wider determinants', is more of a professional discussion. (UK NGO role)

Drivers and opportunities

Participants identified the following drivers and opportunities for taking a more integrated approach to tackling multiple risk factors:

- declining funding for NGO advocacy organisations
- integrated care systems (ICS) in England
- the planned public health bill in Scotland
- existing activity in local government
- the 'levelling up' agenda
- the health disparities paper in England
- new national public health agencies and recovery from the pandemic

The first of these was the only negative driver identified but may be the most important if NGO advocacy organisations and coalitions have to rethink their approach due to the long-term impact of COVID on the resources of their funders.

I think you should get on the front foot and do this yourself and come up with a proposal rather than wait for the funders to do it to you. Because the money's going to get less and you need to come up with something that's going to convince them. (UK NGO role)

Participants' views of integrated care systems were mixed. They were welcomed as the source of new money for work on tobacco on alcohol but their locus within the NHS was perceived as limiting their contribution to public health, given that local authorities remain the leaders on public health locally.

We see the integrated care systems as a huge opportunity to get the NHS on board and supporting the work that we do. Politically, though, it can be quite tricky at times navigating the system and understanding the tensions between local authorities and NHS ICS partners. But yes, certainly we will say it's an advantage going forward. (England regional role)

They will be primarily hospital-based systems and services. The idea that they're going to be able to integrate everything is wildly optimistic. They may be able to bring together elements of different healthcare institutions to have more joined up thinking about how patients move through a system. But on the public health agenda, I still think it's going to be very much driven by local government, and local communities. (England government role)

The one participant in Scotland identified the Scottish government's forthcoming public health bill as a major opportunity for advocacy across commercially-determined risk factors.

We have a Scottish government commitment to a public health bill, which is in the lifetime of this Parliament. Our understanding is that it's going to cover marketing of novel tobacco products, of alcohol, and of unhealthy food promotions. Which enables us try and stretch that:

What's our wish list for this public health bill? How do we try and get more out of it? (Scotland NGO role)

At a local level, opportunities may already exist in the activity of local government. The task is then to reframe this activity in a way that identifies the role of the commercial determinants:

They're doing things already, but they're not pulling them out as commercial determinants of health. So they might be doing a healthy weight declaration. We're getting local authorities to sign up to advertising codes, so their local authority is not advertising high salt and fat foods. And I'll say "That's doing something to the commercial determinants of health, or the commercially drivers of ill health, you're trying to restrict advertising." (England regional role)

Although raised as a possible policy hook, 'levelling up' was perceived to be too broad an agenda to enable the specific goal of tackling the commercial determinants of ill health. In contrast, the promised white paper on health disparities was seen as a significant opportunity.

'Levelling up' is so wonderfully vague that you can attach everything to it, which is why it's such a good political slogan. Health, I think has never been particularly central to it, or it was it wasn't until the pandemic, and now I think they are basically saying, "Right, we've got to include a health element". (England government role)

I don't think any of us could have thought five years ago that we'd be developing the first paper on health disparities for England, with a resolute focus on what we need to do to reduce inequalities and improve health in our country. Seeing the impact of health inequalities laid bare, in a way that none of us can either escape or deny, has meant that we are now looking at recovery through the lens of equity. These windows of opportunity provide us with a chance as public health practitioners and experts to say, we can help you to achieve what you want to achieve – here are some things that we have in terms of the evidence base, and our learning and experience from across the country. (England regional role)

The latter quote points to the broader opportunities arising from the creation of new public health agencies and the effort to rebuild following COVID, in contrast to the obstacles created by this period of change, cited above.

There are opportunities in terms of how we truly leverage the rich partnerships that we've created over the course of the pandemic: working between the NHS, local government and regional agencies in ways that we've not worked like before. We have the transformation of the public health system, the creation of new national public health agencies, to really begin to think about how we improve population health outcomes as a key determinant of economic development. And we've come out of the pandemic with a much more engaged populace who have been grappling with the impacts of the pandemic. (England regional role)

Discussion

This was a small qualitative study with selected, invited participants. The participants were chosen because they had experience of the public health challenge of tackling NCD risk factors in leadership, advisory or advocacy roles. Although the narrative that emerges from this study is particular to these individuals, it nonetheless illuminates some of the issues faced by public health stakeholders who are seeking to take a more strategic approach to addressing the commercial determinants of health.

The findings reveal the complexity and contingency of the contexts in which professionals, politicians and advocates are addressing NCDs, NCD risk factors, and the commercial determinants of health.

Although there are good reasons for taking a more integrated approach to tackling NCD risk factors, the potential problems of doing so are also significant, and the balance between the two plays out in different ways in different contexts.

There is no doubt that risk factors such as tobacco, alcohol and unhealthy food and drink are all sensitive to the same population measures such as taxation[13] and marketing controls[14]. The 'four Ps' model of the marketing mix has been widely used for single risk factors to mitigate industry marketing strategies which focus on price, promotion, product and place[15]. However, the variable policy progress across risk factors complicates the task of developing an integrated strategy. While these differences are valuable in illuminating the scope for change where progress has been slow[16,17], they also mean that proposals for new measures have to be calibrated to each risk factor. This calibration has to take account of differences in the political environment, including the profound differences in the involvement of industry in policy-making across risk factors[18].

Regardless of these differences, a view across risk factors necessarily involves a shift in perspective, away from the particularity of how risk factors affect individual behaviour and towards the behaviour of the commercial actors – especially the transnational corporations – in whose interests it is to sustain health-harming individual behaviour. Many study participants acknowledged the value of this shift in perspective, especially in professional and political contexts where there is an openness to discussing the wider determinants of health. If risk factors are understood as part of a complex system of interacting actors and forces[19], the scope for intervention necessarily expands. However, this complexity can itself be an obstacle to progress if the public health task is then perceived to be too difficult. The challenge is then to identify appropriate, achievable measures within this bigger system.

Study participants described the value of collective engagement in tackling NCD risk factors. When people come together who individually have interests in specific risk factors or NCDs, there is great potential for mutual learning and the development of a shared understanding of common cause in relation to the commercial determinant of health. This in turn becomes the foundation for a collective voice for advocacy. Although there are always practical challenges in bringing people together who have diverse knowledge and interests, a well-managed process can deliver rewards for all participants.

Despite the relatively small number of participants in the study, the diversity of their roles enabled a provisional view of the differences across geographies. Participants operating at regional level were optimistic about the value of taking an integrated approach to tackling the commercial determinants of health, in part because they had an appreciation of the how these determinants actually affect local communities. Although the place of the commercial determinants within the 'wider determinants of health' is not universally understood or accepted by local public health professionals and politicians, a consensus about the importance of tackling the wider determinants enables a debate about the commercial determinants to proceed.

Nationally, in England at least, the particularity of the policy process within government dominated participants' views. Although there are examples within government of integrated thinking across risk factors, such as the Prevention Green Paper, participants perceived public health policy to be driven by proposals for single risk factors, often in the wake of single-issue advocacy campaigns. They saw little enthusiasm within government for discussions of the wider determinants of health, let alone the commercial determinants.

The experience in Scotland provides a useful contrast. Advocates in single-issue NGOs have worked hard with other agencies to build support for a process within the Scottish Parliament that explicitly looks across NCDs and their risk factors to promote the nation's health. The Cross-Party Group on

Improving Scotland's Health may take time to deliver results[20] but the existence of a formal process at government level is important.

There are doubtless many political and practical reasons why single-issue policy-making on NCDs dominates government in Westminster. The unwillingness to engage with a structural view of the wider determinants of health goes hand-in-hand with a political preference for interventions focused on the individual, such as information and education, which are prominent among recent policies for NCD risk factors in England[21]. The involvement of industry in policy-making also drives policy towards less effective interventions[22] and sustains neoliberal values within national policy-making for commercial environments where products are developed and marketed[23]. A strategy addressing commercial determinants might reasonably begin with an integrated approach to monitoring and mitigating the influence of industry on policy making[24].

The interview data highlight significant gaps within existing understandings of how to address commercial determinants of health, and point towards a research agenda that can be advanced by efforts across academic, advocacy, policy and funding communities. The broad enthusiasm for exploring more collaborative forms of working across risks factors, tempered with pragmatic concerns about their feasibility, highlight the importance of developing more nuanced frameworks for identifying which specific forms of interaction are most appropriate for shared priorities. There may be value in exploring the attitudes of advocacy organisations and policy makers to advancing goals across diverse forms of collaboration. These might run from building coordination via enhanced information exchange; promoting coherence through consistent policy objectives and target populations; sharing skills, expertise and advocacy tools which are common across the risk factors; through to ambitious attempts to integrate the mandates and priorities of organisations to prioritise new, shared goals[1,25].

There is scope for further exploration of the differences in prospects for collaboration within and across different administrations, and at national, regional and local levels. In seeking to extend support for tackling NCDs across the political spectrum, there is also a need to unpack the strengths and limitations of the terminology of commercial determinants. Experience with social determinants frameworks suggests that recognition of their analytical value may not be matched by widespread support for the interventions they illuminate. There is also scope to explore the risks and opportunities of tackling other industries that cause harm including the gambling, advertising, social media, energy, and fossil fuel industries.

Some of the current opportunities for pursuing a more integrated approach to tackling NCD risk factors and the commercial determinants of health have been described. These include institutional, policy and legislative opportunities at both regional and national level, and in both Scotland and England. Despite the many obstacles described in this study, there is scope at every level for more collaborative, integrated work on these issues. The challenge will always be to find the most appropriate and effective approach, combining the broad conversation about commercial determinants with distinct proposals for specific risk factors.

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