

A health sector response to the commercial determinants of health

Sarah Sharpe, Karen McIlhone, Summer Hawke, Shanthi Ameratunga

ABSTRACT

AIM: To develop and apply a theoretical framework to assess the rigour of a district health organisation's response to the commercial determinants of health (CDoH).

METHODS: The multi-method study incorporated literature reviews of CDoH strategies and ways in which organisations can respond; policy document review; and 12 qualitative, semi-structured, key informant interviews.

RESULTS: A theoretical framework was developed summarising CDoH and potential responses. The organisation has relevant policies, including those concerning corporate relationships and conflict of interest; however, there are opportunities to strengthen policy content and processes. Key themes were identified based on key informants' perceptions: 1) disconnect between community impacts of harmful commodities and awareness/action on CDoH drivers of these impacts; 2) power imbalance between harmful commodity industries and communities; and 3) need for a robust, values-based, Tiriti-aligned response to CDoH.

CONCLUSIONS: The health sector has an important role to play in redressing the power imbalance between harmful commodity industries and communities. Responses include: raising awareness about CDoH; strengthening policies related to interactions with corporations, and in particular considering alignment of values; supporting community actions; and advocating for legislative changes which restrict the power of harmful industries and support healthy environments and communities.

The large losses and inequities in health and wellbeing due to harmful commodities such as tobacco, alcohol, unhealthy food and beverages, and gambling products are well-established.¹⁻⁵ Acknowledging the sophisticated means by which industries producing these commodities exploit consumers, and the political economy of globalisation, Kickbusch et al. define the term "commercial determinants of health" (CDoH) as "strategies and approaches used by the private sector to promote products and choices that are detrimental to health".⁶ Through CDoH, corporations exert power and influence by shaping the societal norms and environments in which people live, grow up, work, play and socialise.^{7,8} Harmful products are normalised and consumer choices are shaped for the benefit of corporate profits. Along with the socio-economic determinants of health, racism and colonisation, CDoH are important upstream drivers of health loss and inequities in New Zealand.

The health sector has an important role to play in reducing and preventing the influence and impact of CDoH. The final report of the New Zealand Health and Disability System Review states: "there is a need for much more concerted action at national, regional and local levels to address the CDoH".⁹ Responding effectively to the CDoH can help achieve the aims of the New Zealand public health system, i.e., to protect, promote and improve

the health of all New Zealanders; to achieve equity in health outcomes among New Zealand's population groups; and to build towards pae ora (healthy futures) for all New Zealanders.¹⁰

Given a lack of guidance on how the health sector can effectively address the CDoH, the aim of this study was to develop and apply a theoretical framework to assess the rigour of a district health organisation's response to CDoH.

Methods

The multi-method study was conducted in 2021 at Counties Manukau Health (CM Health) in three phases, guided by the Institute for Health Improvement's "Plan-Do-Study-Act" cycle.¹¹ In Phase one ("Plan"), a theoretical framework was developed describing CDoH and how to respond, based on two focused literature reviews and applying principles of Te Tiriti o Waitangi—the Treaty which established the relationship between Māori, the Indigenous people of New Zealand, and the British Crown. Phase two ("Do") involved using the framework to assess CM Health's response to CDoH based on policy document review and perspectives of key informants. In Phase three ("Study"), the framework was refined and recommendations for strengthening the response, in a future "Act" phase, were formulated.

The first literature review aimed to summarise key CDoH mechanisms and strategies. Publications were included in the review if they included a conceptual theory or framework describing what CDoH are and how they exert influence. General background or discussion articles were excluded. MEDLINE electronic database was searched using the search terms “commercial or corporat* AND determinant* AND health or disease*”, and was limited to English language publications from 2000 to May 2021. Grey literature (using Google) and snowball searching was conducted. Data from included articles were summarised in table and narrative form. Key aspects of interest included definition of CDoH, type of evidence, mechanisms of influence, and outcomes.

The second literature review aimed to summarise evidence about how health sector organisations can respond to CDoH. A relevant scoping review by Mialon and colleagues published in 2020¹² identified ways to manage the influence of CDoH in the context of public health policy, research and practice. The search strategy in this article was replicated for the period 2019–2021. Expert advice was sought, and Google searching carried out to identify relevant grey literature. Data were summarised in table and narrative form, with a focus on recommended mechanisms, relevant to the health sector, for responding to CDoH.

For the document review, the CM Health intranet, including the document directory and department pages, was searched for relevant policy, procedure and guideline documents. Documents were reviewed against the “response” section of the framework (shown in Figure 1).

Next, a qualitative study explored the perspectives of three key stakeholder groups: CM Health employees, academics/experts on the topic, and people in community organisations. The 12 participants, recruited through a purposive sampling strategy, included four Māori and three Pasifika participants. The sample size was chosen for pragmatic reasons, and the concept of data saturation was not deployed in this study.¹³ Participants were provided with a participant information sheet and gave written, informed consent. Semi-structured interviews (conducted by KM) were audio-recorded and later transcribed by a commercial transcription service. Topics explored were outlined in an interview guide and included: 1) perceptions of the visibility of CDoH; 2) perceptions of the current response to CDoH; 3) suggestions for how CM Health could strengthen the response;

and 4) thoughts and feedback on the theoretical framework under development. Thematic analysis of data (KM and SS) used a constructivist approach¹⁴ and involved close reading of transcripts, coding of text, categorisation of codes and interpretation of ideas, comparison within and across key stakeholder groups, and development of themes.

Ethics approval was granted by the Auckland Health Research Ethics Committee (reference AH21918) and locality approval by the CM Health Research Office.

Results

Phase 1: development of theoretical framework

This section describes findings from the literature reviews that, together with application of Te Tiriti of Waitangi principles and refinement based on input from key informants, resulted in the framework shown in Figure 1.

Literature review: key CDoH mechanisms and strategies

Of 678 records identified, 28 were potentially relevant based on abstracts, and full texts were reviewed. Nine articles fulfilled the eligibility criteria and were included in the review (Appendix 1).^{6,15–22} All articles were descriptive in nature, included conceptual frameworks, and acknowledged impacts and consequences of CDoH. Outcomes described were broad and included political, cultural, social, environmental and health effects. Two articles took a nuanced approach to outcomes, allowing recognition of both positive and negative impacts by corporations.^{16,18}

In general, articles described CDoH as being enmeshed within broad political, economic and regulatory environments, allowing CDoH to operate and promote corporate growth.^{6,15,16,18–20} Four articles explored the concept of power, which was described as influencing decision making in three ways: 1) direct influence in decision making; 2) indirect influence on agenda setting and limiting choices (e.g., keeping controversial topics off the agenda); and 3) invisible power i.e., shaping public opinion and influencing norms and ideas.^{15,18–20} Two articles described broad “vehicles of power” through which harmful commodity industries exert their influence: political environment, preference shaping, knowledge environment, legal and extra-legal environment.^{15,19} Overall, the power exerted by corporations was described as prevail-

ing over public health governance and regulatory measures.^{6,15,16,18,20}

Five articles described specific strategies used by industries.^{6,15,16,18,20} Strategies included: participation in decision making and lobbying;^{6,15,16,18,20} marketing and advertising to enhance the appeal of harmful commodities, and shaping the broader narrative about their acceptability and normalisation of consumption in everyday life;^{6,15,16,18,20} product modification and extensive supply chains;^{6,15,16,18,20} corporate social responsibility practices to enhance public perceptions of corporations, while allowing marketing to be delivered;^{6,15,16} sponsorship/donations, funding of research and medical conferences/education to enable corporate control over decision making and the research process;^{15,16,20} and revolving door arrangements (where an individual moves between the commercial and public sectors, bringing their influence into their new position or gathering confidential information to take back to the industry) as a means to exert influence.^{15,18}

Literature review: response to CDoH in healthcare organisations

No relevant articles were found in the updated search (2019–2021). In addition to Mialon et al,¹² two journal articles^{23,24} and two World Health Organization (WHO) documents (i.e., Framework Convention on Tobacco Control²⁵ and Framework for Engagement with Non-state Actors²⁶) were identified through grey literature searching (Appendix

2). Key points summarising how health organisations can effectively respond to CDoH were incorporated into the framework (Figure 1).

Te Tiriti o Waitangi

Application of Te Tiriti o Waitangi is fundamental to responding to CDoH in New Zealand. The first iteration of the theoretical framework was guided by the Hauora principles—tino rangatiratanga, partnership, active protection, equity, and options.^{27,28} We envisioned these principles being applied across the five “response” actions, ensuring shared power in active pro-equity decision making about responses to CDoH.

Phase 2: assessment of CM Health’s response to CDoH

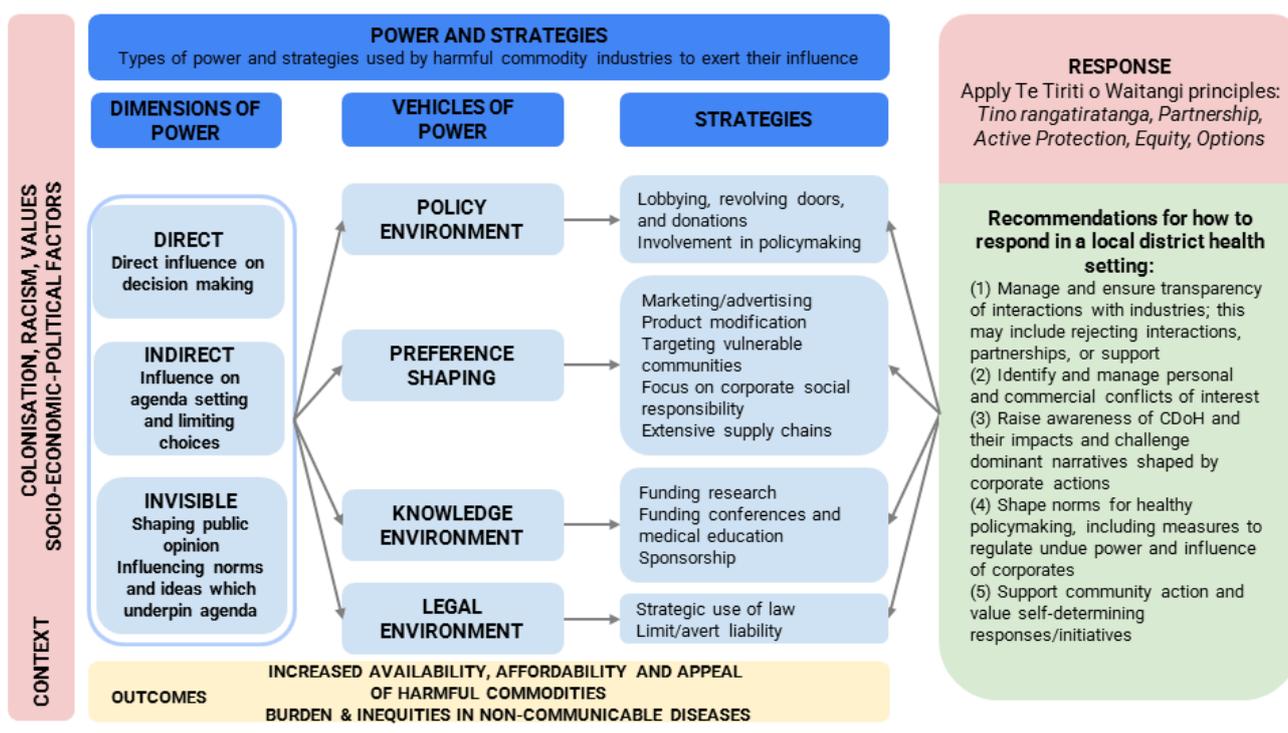
Collectively, the policy document review and stakeholder interviews provided a multi-faceted overview of CM Health’s response to CDoH.

Policy document review

CM Health has a suite of policies (see Table 1) that guide management—including decision making and transparency—of corporate interactions and conflict of interest (COI). The organisation applies the State Services Commission Code of Conduct²⁹ and has a code of conduct policy that applies to all employees.

A comprehensive COI policy provides guidance on the identification, disclosure, and management of COI and aims to “protect the integrity of CM

Figure 1: Framework summarising commercial determinants of health and how to respond in a local district health setting.



Health and its employees by helping to ensure that employees perform their duties in a fair and unbiased manner and that decisions are made unaffected by private interests or personal gain". COI is also considered in other policies related to human resources, procurement processes and research. COI and gift registers are maintained by departments.

The Corporate Relationships Policy outlines principles and considerations when establishing relationships with external organisations. It states that *"associations should be avoided with external organisations whose values, practices, products, or branding are or appear to be in conflict with the stated vision, aims, objectives or policies of CM Health."*

A range of policies address the impacts of harmful commodity industries and support healthy environments. CM Health has a smokefree policy (which includes vaping), an alcohol position statement, and follows the National Healthy Food and Drink Policy.

This policy review did not find specific documentation of responses to CDoH which apply Te Tiriti o Waitangi.

Thematic analysis of key informant interviews

Three themes were developed based on interpretation of interviewees' perceptions of the current situation (including visibility of CDoH and responses to CDoH) and opportunities for strengthening the response. Code categories and quotes that illustrate meaning are described in Tables 2, 3 and 4.

Theme 1: disconnect between community impacts of harmful commodities and awareness/action on CDoH drivers

Key informants described high visibility of adverse health outcomes and experiences of harm. They expressed frustration and anger at the injustice of the current situation, and they perceived the health system (as well as the public sector and Government more broadly) as failing people and communities, particularly Māori, Pasifika, and socio-economically deprived communities. Despite the scale of impacts, it was felt that CDoH as drivers of harm are not acknowledged or well understood. It is paradoxical that CDoH are "invisible" due to normalisation in society when they appear to be everywhere once you become more aware of them: *"how can you not see it? It's just so everywhere"* (Community member, #12). We need to increase awareness and recognise *"that commercial determinants are key drivers of ill health...it's just as important as recognising the*

broader social determinants [of health]" (Topic expert, #5).

Theme 2: power imbalance between harmful commodity industries and communities

Participants spoke about corporates having large resources and influence, including in the political sphere. In comparison, people across communities and the health sector have shared concerns about "fighting" against many barriers and change being hard and slow, despite much effort. One participant described how it felt coming before a District Licensing Committee to object to an alcohol licence application: *"I got absolutely slaughtered by lawyers representing the applicant...it was like community objectors were nothing more than a hindrance"* (Community member #8). A common perspective among participants was that the power of corporates who sell harmful products should be restricted and that CM Health could do more to contribute to this, both locally—e.g., improving healthy food choices in the hospital—as well as nationally, by advocating for stronger regulations of harmful products.

Theme 3: need for a robust, values-based, Tiriti-aligned response to CDoH

All participants thought that while CM Health was responding well in some regards (e.g., implementing the National Healthy Food & Beverage Policy), the overall response to CDoH needs to be strengthened, within the organisation as well as more broadly in the public sector and Government. Decisions should be based on our values, with Te Tiriti o Waitangi as the foundation and health and wellbeing as key priorities. It is important to consider the alignment (or not) of values when engaging with corporate entities and to ensure transparency of interactions and identification of COI. Community participants strongly supported the need to value knowledge and initiatives of community and population groups, including Māori, Pasifika and young people, and to collaborate for greater collective impact.

Phase 3: refinement of framework and next steps

The framework was refined based on testing it with, and feedback from, key informants. Overall, they strongly supported the concept and thought it was important to assess and address the health sector response to CDoH. There was broad support for the proposed descriptions of how Te Tiriti o Waitangi would apply in this setting.

Table 1: Summary of relevant policies identified in the document review.

Document name	Key points relating to responses to CDoH
Code of Conduct	Outlines the standards of behaviour and performance expected of employees in order to achieve CMDHB's Vision and Values. Employees must "behave in accordance with our shared values."
Effective Decision Making Manual	Describes decision making procedures and processes for management and executive oversight. Outlines the executive structure of decision making including the functions, responsibilities and accountabilities of the Board and Executive. Outlines how decisions are made. Effective process and transparency are important, including applying accepted practices to manage COI and applying the State Sector Code of Conduct.
Conflict of Interest	Applies to staff and contractors, and covers commercial transactions, recruitment, clinical research, and funding. Describes actual, perceived, and potential conflicts of interest and outlines ways in which these could occur and options for dealing with them. COI is defined as "when it is likely that an employee could be influenced or could be perceived to be influenced by a personal or private interest in any transaction whilst carrying out their responsibilities". Personal and private interests are interpreted broadly, and COI may exist in a range of situations, e.g., if an employee is a member of, or has an affiliation with, an organisation/group that stands to lose or gain from the matter, or if an employee is not able to act impartially and in the public interest.
Gifts, Donations and Sponsorship	The receipt of gifts, donations, and sponsorship must be carefully reviewed, and risks considered, including whether it aligns with CM Health's objectives, functions, and values. Consideration should be given to whether the party making/offering the gift, donation, or sponsorship has or appears to have values, practices, products, or branding which are in conflict with the vision, objectives, or policies of CM Health.
Recruitment	Applicants must declare potential or actual conflict of interest situations. "Revolving door" issues are not considered in the policy.
Discipline & Dismissal	Includes as examples of "serious misconduct": accepting gifts/payments while representing CM Health (without proper authorisation), breach of code of ethics, failure to declare conflicts of interest, gambling on CM Health grounds without prior authorisation, unauthorised disclosure of information relating to Counties Manukau DHB as a business.
Northern Region Procurement	Procurement process follows national "government rules of sourcing" and "principles of government procurement" which have a standard conflict of interest policy and ensures procurement processes follow the objectives outlined in the NZ Public Health & Disability Act.
Engagement of Contractors/Consultants	Follows the same principles as procurement policy. Includes section on equity—contractors must "have the skills and experience required to contribute to Counties Manukau Health's equity goal".
Research Policy	States all research involving CMDHB patients, patient records/information, facilities, resources or staff must have the appropriate ethical and other regulatory approvals in place and throughout the duration of the study. These processes review funding sources and conflicts of interest. Policy notes that it is important that transparency exists in managing funding received for supporting research activity.

Table 1 (continued): Summary of relevant policies identified in the document review.

Document name	Key points relating to responses to CDoH
Corporate Relationships	<p>Guiding principles:</p> <ul style="list-style-type: none"> a) relationships should assist CM Health to achieve its statutory objectives and functions, and support CM Health to realise its visions, values, goals, and planned activities; b) associations should not compromise CM Health's integrity or reputation; c) relationships are to be entered into in a transparent and fair manner; d) relationships should not unduly affect CM Health's impartiality or objectivity; e) relationships should not unduly prevent CMDHB from entering into relationships with other similar organisations; f) associations should be avoided with external organisations whose values, practices, products or branding are, or appear to be, in conflict with the stated vision, aims, objectives or policies of the DHB—this is likely to include (but is not limited to) situations where the proposed sponsor or associated party, product or service is strongly linked to the gambling industry, the production, sale or promotion of tobacco or alcohol, the production, sale or promotion of food or beverages where the overall or specific approach is in conflict with nutrition messages promoted by CM Health, health products whose use is not endorsed by CM Health (e.g., un-researched medicines or devices).
Smokefree	<p>States that all Counties Manukau Health employees, patients and whānau, visitors, volunteers, contractors, and all others accessing Counties Manukau Health grounds and facilities are prohibited from smoking or vaping. Tobacco products are prohibited from being sold and accepted as gifts.</p>
Reducing harms from alcohol in our communities	<p>Position statement which supports:</p> <ul style="list-style-type: none"> 1) evidence-based strategies that equitably prevent and reduce alcohol-related harm including restricting the availability of alcohol, increasing the minimum legal purchase age, increasing the price of alcohol, reducing alcohol advertising, promotion and sponsorship, and drink driving countermeasures. 2) equitable access to high quality and culturally appropriate healthcare services including assessment for alcohol use, brief and early intervention, and referral to treatment when indicated. 3) improving and refining information on alcohol use and alcohol related harm in the Counties Manukau region. 4) research and evaluation to ensure interventions for alcohol-related harm are effective and equitable.
National Healthy Food and Drink Policy, 2nd edition	<p>Developed by the DHB Healthy Food and Drink Environments Network. Outlines a traffic light system which ensures organisations and their contracted health service providers (with a healthy food and drink contract clause) promote an environment that consistently offers and promotes healthy food and drink options for staff, visitors, and the general public visiting CM Health.</p> <p>This policy has been included in contractual requirements for food vendors at CM Health and has been largely implemented.</p>
Staff Consumption of Alcohol at Special Events	<p>Staff consumption of alcohol at special events at CM Health sites is prohibited unless exemption granted by CEO.</p>
Preventing Alcohol and other Drug use within Mental Health Services	<p>Mental Health wide policy: alcohol and or other drug use are prohibited on all CM Health properties. All staff have the responsibility to prevent entry of alcohol or drugs to inpatient areas.</p>

Table 2: Theme 1 code categories with supporting quotations.

Theme 1: disconnect between the community impacts of harmful commodities and awareness/action on CDoH drivers	
Code category	Quotations from key informants
High visibility of adverse health outcomes and inequities due to tobacco, alcohol, and poor nutrition	<p>“Come and sit in our waiting room as a fly on the wall and...watch what happens here...it’s pretty ghastly...the younger and younger people with more and more severe disease.” (DHB employee, #2)</p> <p>“All our negative statistics are going up whether it’s type 2 diabetes, cardiovascular disease, tooth decay...it’s commercially driven, the industry have an open slather.” (Topic expert, #10)</p> <p>“You only need to walk across the road...to see the effects of alcohol and drugs in our community...it’s a normality, people aren’t scared of people you know because it’s normal to see a drunk person every day.” (Community member, #11)</p>
Normalisation and ubiquity of harmful products in everyday community life	<p>“It’s so normal and so accessible and so easy and so cheap to feed yourself on KFC or whatever as opposed to decent food.” (DHB employee #2)</p> <p>“Kids have to walk past bottle stores and all their signs to get to school and then they have to pass them on the way back.” (Community member, #8)</p> <p>“There’s a liquor store at every dairy...off the top of my head I can already count four or five, next to every liquor store is a bakery, cheap, very cheap, and then you’ve got your dairy with the dollar drinks, the fizzies. So, I almost feel like it’s set up...it’s very much set up in a way to ensure that that’s the norm for you.” (Community member, #12)</p>
Community experiences of racism, colonisation, and targeting by harmful commodity industries	<p>“Unhealthy commodities have bombarded our community, where a lot of Pacific people are in South Auckland.” (Community member, #1)</p> <p>“I think there is racism with the way decisions are made...particularly in South Auckland with alcohol shops being put in places of Māori communities and neighbourhoods of deprivation, bad kai in those places as well.” (Topic expert, #4)</p> <p>“What Māori are experiencing today is certainly no different to what our tūpuna, our ancestors, experienced with the availability of alcohol, the harm it was having on the people and the community, and it was just a carry on, it was an ongoing story, the unfortunate thing is that it’s got worse.” (Community member, #8)</p>
Response to CDoH is failing	<p>“Some attempts have been made, but it’s not nearly as organised and focused as it should be for an institution like ours. We invest enormous amounts of money into fire brigades and hoses and people with hard hats and jackets and training for those people, but we do nothing about the arsonists who have set fire to everything.” (DHB employee, #2)</p> <p>“We’re failing dismally not just as the DHBs but also as a government as a whole...nothing is proactive.” (Topic expert, #10)</p>
Low awareness and understanding of CDoH as drivers of harm	<p>“I don’t think people think about it. Some people might know but probably don’t really think what does it mean? And there would be a lot of people that are just totally unaware.” (DHB employee, #3)</p> <p>“I think it’s missed. I think it’s really obvious to people when they are asked to think about it.” (Community member, #11)</p>

Table 3: Theme 2 code categories with supporting quotations.

Theme 2: power imbalance between harmful commodity industries and communities	
Code category	Quotations from key informants
Corporates have large financial resources	<p><i>“There’s an imbalance in the power and I go back to the alcohol industry in particular, they are so wealthy, they have so much money to throw around, and in comparison, our communities, they’re just not comparable.”</i> (Topic expert, #5)</p> <p><i>“They’ve got so much money; they’ve got the time and the lawyers.”</i> (Community member, #12)</p>
Corporate influence	<p><i>“The commercial interests have had this [power and influence] all to themselves for so long...they are actually organised strategically about keeping it to themselves.”</i> (DHB employee, #2)</p> <p><i>“Industries are more and more engaging in the political space.”</i> (Topic expert, #5)</p>
Community effort in the face of barriers	<p><i>“We are outnumbered.”</i> (Community member, #1)</p> <p><i>“All of the liquor stores everywhere and to get rid of them takes so much effort...it’s so hard and so expensive and so long and so difficult.”</i> (Topic expert, #6)</p> <p><i>“It’s really difficult going against those kind of huge monsters.”</i> (Community member, #11)</p>
DHB effort, but more action needed	<p><i>“It’s really difficult to get them [retailers] on board and keep them on board...just really hard work [regarding implementing healthy food policy in the hospital].”</i> (DHB employee, #3)</p> <p><i>“I think there is a movement in the right direction like removing the sugary drinks and chips and chocolate things from the vending machines and also being more mindful about what our cafes serve to people, like healthy food options...but there’s still lots more work to be done.”</i> (DHB employee, #7)</p>
Need to restrict power of corporates who sell harmful products	<p><i>“There are companies that do have good [food] product, but they are just not there in the forefront. It would be really good to see them up there.”</i> (DHB employee, #3)</p> <p><i>“There should be restrictions on the power industries have on agenda setting.”</i> (Topic expert, #5)</p> <p><i>“The health sector could do a lot more in terms of influencing law and policy.”</i> (DHB employee, #7)</p>

Table 4: Theme 3 code categories with supporting quotations.

Theme 3: need for a robust, values-based, Tiriti-aligned response to CDoH	
Code category	Quotations from key informants
Values in decision making (links with all code categories below)	<p>“We’ve got to make hard choices guided by our values...and be informed by more than short term [thinking].” (DHB employee, #2)</p> <p>“Values determine how decisions are made, and who is valued in society and who isn’t...and so in that space it is all [about] discrimination, it’s sexism, ageism, racism.” (Topic expert, #4)</p> <p>“I think it’s about ensuring that whoever is making decisions is fully aware of the impact that the decision has on Pacific and Māori people.” (DHB employee, #9)</p>
Te Tiriti o Waitangi as foundation of response to CDoH	<p>“I think it would be good to look at those values which currently undermine decision-making and then looking at tino rangatiratanga and whānau being able to self-determine responses.” (Topic expert, #4)</p> <p>“For me, Te Tiriti underpins all... [regarding alcohol licencing] I would like to see partnerships where Māori have equal input into decision making.” (Topic expert, #5)</p> <p>“I will not accept Pākehā speaking for Māori because that’s my mana, that’s the mana of Māori...you should not speak for me or my people because what you’re doing is you’re claiming my mana.” (Community member, #8)</p>
Address discrimination	<p>“Are we able to demonstrate in the decision making that this is anti-racist and that we’ve got a good policy-making environment?” (Topic expert, #4)</p> <p>“Children they’re like a sponge and they see everything and soak it in. They’re walking to school, alcohol, cheap on sale...it’s set up...my partner and I we start getting mad, we want to leave just to give our kids a better chance but then at the same time, they should be getting the best chance here.” (Community member, #12)</p>
Transparency in interactions with industries	<p>“Transparency is needed...identifying the relationship and making it transparent and then having agenda setting clearly outlined so you can identify if this relationship is not going to support the agenda that we’ve agreed to then that’s a conflict of interest.” (Topic expert, #5)</p> <p>“[Regarding transparency] ...even though in the DHB we have processes I know there are things that fall through the cracks...I wonder whether we can introduce this at the welcome so from the get-go as a staff member you know your expectations and where your organisation stands, with partnerships.” (DHB employee, #9)</p>
Value and support community knowledge and initiatives	<p>“Put more money to where the resources are, and the resources are in the communities, because they know the right solutions for their own communities...they can tell you the right strategy that works for them.” (Community member, #1)</p> <p>“We want people to feel strong and healthy and empowered and in control.” (Topic expert, #6)</p>
Co-ordination and collaboration	<p>“Imagine if, on an organisational level, everyone had an understanding about this and had a drive to make change, it would be pretty impressive what we could do.” (DHB employee, #7)</p> <p>“We need to come together and we need to speak with one voice, then we’re going to have impact.” (Community member, #8)</p> <p>“What does partnership look like in terms of the community? Is it ngā mahi ngātahi? What does that look like?” (Community member, #8)</p>

The approach, initially developed based on the Waitangi Tribunal Hauora report and the guidance on incorporating Te Tiriti o Waitangi into the health system from the Ministry of Health,^{27,28} was further developed based on feedback. Interviewees highlighted the broader context of colonisation and racism leading to unequal treatment by unhealthy commodity industries, and this was incorporated into the framework (Figure 1).

Next steps supported by the literature and recommended by key informants included: raising awareness within CM Health and the community of the CDoH and the impact of harmful commodity industries; strengthening organisational policies relevant to CDoH including those related to interactions with harmful commodity industries and ensuring alignment with Te Tiriti o Waitangi; developing an organisation-wide position statement on CDoH; reviewing and strengthening COI policies, supporting community initiatives and action; and working collaboratively with others towards evidence-based policy and legislation which support healthy environments.

Discussion

This paper describes the development and use of a theoretical framework for assessing a health organisation's response to CDoH. The framework describes the strategies used by harmful commodity industries and how to respond to these, in the context of a health organisation setting. Assessment of CM Health's response to CDoH through policy document review and key informant interviews found that although there are many relevant policies, including those concerning corporate relationships and COI, there are opportunities to strengthen the content of policies (e.g., alignment with Te Tiriti o Waitangi) and processes involved in implementing them (e.g., raising awareness about them and increased transparency of their application). Three key themes were identified based on key informants' perceptions of the current response and opportunities for strengthening the response: 1) disconnect between community impacts of harmful commodities and awareness/action on CDoH drivers; 2) power imbalance between harmful commodity industries and communities; and 3) need for a robust, values-based, Tiriti-aligned response to CDoH.

From one iteration of using the framework, it appears it is able to be practically applied. However, our experience is that, in isolation, a document review is unlikely to provide a complete

view. We think policy review should ideally be combined with key informant interviews to provide a more complete assessment of a health organisation's response to CDoH.

Strengths of this research include its basis in theory and evidence related to CDoH, and the use of a range of methods (i.e., literature review, document review and key informant interviews) that were appropriate for the research aim and exploratory nature. Key informant interviews provided rich data for thematic analysis, including from Māori and Pasifika participants, whose inclusion was prioritised in the purposeful sampling method.

There are also some limitations with this study. Firstly, for practical and resourcing reasons, the scale of the study was small, involving focussed literature reviews and a relatively small number of key informants. The document review considered policies, but not processes related to them such as implementation. This was mitigated by seeking input on policy process aspects from key informants. Secondly, the authors acknowledge that in qualitative analysis there is the potential for bias due to framing and interpretations that are shaped by the researchers' assumptions, experiences, and personal beliefs,³⁰ and that a different interpretation and development of key themes may have occurred if undertaken by different researchers. Research rigour could have been improved by involving more people in the research process and incorporating formal research reflexivity practices. Thirdly, although it was possible to get valuable insights by its application in one organisational setting, the framework should be considered as developmental, and would benefit from further testing and refinement.

CDoH as a field of global health research has expanded over the last decade and has mostly focussed on the drivers and mechanisms through which corporations exert their influence. As described earlier in the results section, just a small number of published papers address how to respond to CDoH, and there is a gap in research and guidance about responding at a local, organisational level. The authors are not aware of other published literature exploring this concept in a health organisation setting. The global Governance, Ethics, and Conflicts of Interest in Public Health (GECI-PH) network, launched in 2018, has identified the need for frameworks, policies and tools that can be used to manage the influence of private sector actors on public health policy, research, and practice.³¹ The frame-

work and approach for assessment developed in this study could be used for such a purpose in health and other public sector organisations in New Zealand. It can also be used as a starting point for conversations within organisations about CDoH, their impact, and how organisations should respond. The next step indicated by this research is the implementation of a strengthened response to CDoH. Future research should address implementation issues and explore factors that are likely to enable success, such as leadership, organisational readiness, appropriate resourcing, and capability within the organisation (including legal expertise).

This paper highlights the powerful influence exerted by harmful commodity industries through CDoH, and how these drive adverse health and wellbeing impacts experienced by people and communities. The health sector has an important role to play in redressing the power imbalance that exists between harmful commodity industries and people, whānau and communities. Responses include raising awareness about CDoH, supporting community initiatives and actions, and contributing to and advocating for evidence-based policy and legislation that restrict the power of harmful industries and support healthy environments and communities. Recommended responses also

include raising awareness within organisations of organisational policies that exist to mitigate adverse impacts of CDoH; reviewing and strengthening policies related to COI and ensuring these cover both personal and commercial interests; and reviewing and strengthening policies, processes and systems to support a more transparent and values-based approach to identify and manage corporate interactions, engagements and relationships.

There is an opportunity for such responses to CDoH to be addressed within the new health entities created in the current New Zealand health reforms. The Pae Ora (Healthy Futures) Bill states that the health sector should protect and promote people's health and wellbeing, which includes undertaking preventative measures and addressing the wider determinants of health. While it is important to acknowledge progress already made in responding to CDoH, such as in the area of tobacco control (underpinned by the Framework Convention on Tobacco Control and Smokefree legislation), there is much work to be done across health and other public sectors to realise the enormous potential for gains in health, wellbeing and equity outcomes through applying a more pro-active, systematic and sophisticated response to the CDoH.

COMPETING INTERESTS

Nil.

ACKNOWLEDGEMENTS

We would like to acknowledge and thank the twelve participants of the qualitative research component, Dr Nicki Jackson (who provided early advice on the project plan) and Dr Gary Jackson (who reviewed the project report). The project was funded by Counties Manukau Health.

AUTHOR INFORMATION

Sarah Sharpe: Public Health Physician,
Population Health Directorate, Te Whatu Ora
Counties Manukau, Auckland, New Zealand.

Karen McIlhone: Public Health Registrar,
National Screening Unit, Te Whatu Ora,
Auckland, New Zealand.

Summer Hawke, Manager Population Health
Programmes, Population Health Directorate,
Te Whatu Ora Counties Manukau, Auckland,
New Zealand.

Shanthi Ameratunga: Senior Researcher,
Population Health Directorate, Te Whatu Ora
Counties Manukau, Auckland; Honorary Professor,
School of Population Health, The University of
Auckland, Auckland, New Zealand.

CORRESPONDING AUTHOR

Sarah Sharpe: Population Health Team, Te Whatu Ora
Counties Manukau, Middlemore Hospital,
100 Hospital Road, Auckland 2025, New Zealand.
E: sarah.sharpe@middlemore.co.nz

REFERENCES

- World Health Organization. Noncommunicable diseases progress monitor 2022. Geneva: World Health Organization, 2022.
- Shield K, Manthey J, Rylett M, Probst C, Wettlaufer A, Parry CDH, et al. National, regional, and global burdens of disease from 2000 to 2016 attributable to alcohol use: a comparative risk assessment study. *Lancet Public Health*. 2020;5(1):e51-e61.
- Connor J, Kydd R, Shield K, Rehm J. The burden of disease and injury attributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex. *N Z Med J*. 2015;128(1409):15-28.
- Kelly S, Swinburn B. Childhood obesity in New Zealand. *N Z Med J*. 2015;128(1417):6-7.
- Browne M, Greer N, Kolandai-Matchett K, Rawat V, Langham E, Rockloff M, Palmer Du Preez K, Abbott M. Measuring the Burden of Gambling Harm in New Zealand. Central Queensland University and Auckland University of Technology, 2017.
- Kickbusch I, Allen L, Franz C. The commercial determinants of health. *Lancet Glob Health*. 2016;4(12):e895-e6.
- Mialon M. An overview of the commercial determinants of health. *Global Health*. 2020;16(1):74.
- de Lacy-Vawdon C, Livingstone C. Defining the commercial determinants of health: a systematic review. *BMC Public Health*. 2020;20(1):1022.
- Health and Disability System Review. Health and Disability System Review - Final Report - Pūrongo Whakamutunga. Wellington: HDSR, 2020.
- New Zealand Parliament. Pae Ora (Healthy Futures) Bill 2022 [9 May 2022]. Available from: <https://legislation.govt.nz/bill/government/2021/0085/latest/LMS575405.html>.
- Langley GL, Moan R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 2nd ed. San Francisco: Jossey-Bass; 2009.
- Mialon M, Vandevijvere S, Carriedo-Lutzenkirchen A, Bero L, Gomes F, Petticrew M, et al. Mechanisms for addressing and managing the influence of corporations on public health policy, research and practice: a scoping review. *BMJ Open*. 2020;10(7):e034082.
- Braun V, Clarke V. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise, and Health*. 2019;13(2):201-16.
- Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101.
- Madureira Lima J, Galea S. Corporate practices and health: a framework and mechanisms. *Global Health*. 2018;14(1):21.
- Rochford C, Tenneti N, Moodie R. Reframing the impact of business on health: the interface of corporate, commercial, political and social determinants of health. *BMJ Glob Health*. 2019;4(4):e001510.
- Freudenberg N, Galea S. Corporate practices. In: Galea S, editor. *Macrosocial Determinants of Population Health*. New York: Springer; 2007.
- Baum FE, Sanders DM, Fisher M, Anaf J, Freudenberg N, Friel S, et al. Assessing the health impact of transnational corporations: its importance and a framework. *Global Health*. 2016;12(1):27.
- Jamieson L, Gibson B, Thomson WM. Oral Health Inequalities and the Corporate Determinants of

- Health: A Commentary. *Int J Environ Res Public Health*. 2020;17(18).
20. Wood B, Baker P, Sacks G. Conceptualising the Commercial Determinants of Health Using a Power Lens: A Review and Synthesis of Existing Frameworks. *Int J Health Policy Manag*. 2021.
 21. Knai C, Petticrew M, Mays N, Capewell S, Cassidy R, Cummins S, et al. Systems Thinking as a Framework for Analyzing Commercial Determinants of Health. *Milbank Q*. 2018;96(3):472-98.
 22. 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(1):34.
 23. McKee M, Stuckler D. Revisiting the Corporate and Commercial Determinants of Health. *Am J Public Health*. 2018;108(9):1167-70.
 24. Robertson NM, Sacks G, Miller PG. The revolving door between government and the alcohol, food and gambling industries in Australia. *Public Health Res Pract*. 2019;29(3).
 25. World Health Organization. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control. Geneva: World Health Organization, 2012.
 26. World Health Assembly. Framework of engagement with non-State actors. Geneva: World Health Organization, 2016.
 27. Waitangi Tribunal. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Lower Hutt, New Zealand: Waitangi Tribunal, 2019.
 28. Ministry of Health. Te Tiriti o Waitangi Framework 2020 [9 May 2022]. Available from: <https://www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi>.
 29. State Services Commission. Standards of Integrity & Conduct. Wellington: New Zealand Government, 2007.
 30. Subramani S. Practising reflexivity: Ethics, methodology and theory construction. *Methodological Innovations*. 2019;12(2):1-11.
 31. Nakkash R, Mialon M, Makhoul J, Arora M, Afifi R, Al Halabi A, et al. A call to advance and translate research into policy on governance, ethics, and conflicts of interest in public health: the GECCI-PH network. *Global Health*. 2021;17(1):16.

Appendices

Appendix 1: Summary of findings from literature review one.

Authors (year)	Definition of CDoH	Type of evidence	Mechanisms of influence of CDoH	Outcomes of CDoH
Kickbusch, Allen & Franz (2016) ⁶	Widely cited definition: “Strategies and approaches used by the private sector to promote products and choices that are detrimental to health”.	Narrative and descriptive article to introduce a new definition of the CDoH and framework.	Three main drivers: Internationalisation of trade and capital, demand of growth, expanding out-reach of corporations. Four main channels: 1) Marketing, which enhance the desirability and acceptability of unhealthy commodities. 2) Supply chain ensures industry influence globally. 3) Lobbying, which can impede policy barriers. 4) Corporate citizenship, which can deflect attention away from industry through emphasis on corporate social responsibility.	Health outcomes determined by influence of corporate activities on social environment in which people live and work. Environment shapes lifeworlds, lifestyle and choices of consumers.
Lima & Galea (2018) ¹⁵	Specific definition not given, however discusses the role of commercial entities in shaping their products, driving consumption, and influencing population health.	Narrative and descriptive article introducing a framework of corporate practices, building on the three dimensional view of power by Steven Lukes	Framework depicts dimensions, vehicles, practices, and outcomes of corporate power. The vehicles of power are the political environment, preference shaping, knowledge environment, legal and extra legal environments. Multiple practices of power listed. Relevant to local health organisation setting: lobbying, revolving door, donations, direct participation in committees and policy formulation, corporate social responsibility, marketing and advertising, product modification and targeting vulnerable communities.	Outcomes of power: Influence on macrosocial determinants of health, risk factors, and population health.
Rochford, Tenneti & Moodie (2019) ¹⁶	Specific definition not given, discusses “considering the impact of business on health...requires reconciling such an initiative with the other practices—both health promoting and detracting—of these corporations”.	A narrative and descriptive article introducing a ‘reframed inquiry’ framework to describe the interaction between business and health.	Domains of framework: Environment e.g., govt., political economy, civil society; Business Entities incorporating their scale, position, sector; Internal processes of business e.g. employee relations & physical infrastructure; External processes. Six main external processes: 1) Product and/or service delivery. 2) Marketing and advertising. 3) Supply chain management. 4) Political donations, lobbying and regulatory capture. 5) Funding of research, participation in standard-setting. 6) Corporate citizenship and sponsorship.	Includes a scale of effects from negative to positive, covering health, environment, political, cultural, social effects.

Appendix 1 (continued): Summary of findings from literature review one.

Authors (year)	Definition of CDoH	Type of evidence	Mechanisms of influence of CDoH	Outcomes of CDoH
Freudenberg & Galea (2007) ¹⁷	Specific definition not given, discusses corporations as a social determinant of health.	Narrative and descriptive literature review of corporate practices that harm health with conceptual framework	Four broad corporate practices that harm health: 1) Production and design, e.g., shift to production of more profitable but less healthy products, resist addition of health enhancing features in order to avoid increased production costs, redesign products to reach new markets where harm to health is greater. 2) Marketing, e.g., increase population exposure to harmful products, misrepresent health consequences of products in order to encourage consumption, target vulnerable populations for marketing, by-pass legal restrictions. 3) Retail distribution, e.g., increase access to and availability of unhealthy products. 4) Pricing, e.g., lower prices of unhealthy products to attract new customers, raise prices of health-enhancing products to increase profit.	Health outcomes: morbidity, disability, mortality, disparities. Examples of health impacts: Alcohol—motor vehicle accidents, cirrhosis, liver cancer, homicide, suicide Food and beverages—obesity, heart disease, diabetes, some cancers, tobacco—cancers, heart disease, respiratory diseases.
Baum et al. (2016) ¹⁸	Specific definition not given, states “an increasing amount of research indicates that while there are some positive effects there are significant negative impacts on health from corporate structures, products and practices”	Narrative and descriptive article discussing the health impact of transnational corporations (TNC's) and development of a corporate health impact assessment framework	Three main aspects of framework for conducting a corporate health impact assessment: 1) Political economic and regulatory context for the TNC's activities at global, national, and local levels. 2) Structure, practices, and products of the TNC, including political and business practices, products, distribution, and marketing methods and strategies. 3) Understanding the health and equity impacts of the TNC's activities, recognising both positive and adverse impacts on health in domains including workforce and work conditions, social conditions, natural environment, consumption patterns, and economic mediated impact on health.	Framework allows for recognition of both positive and adverse impacts on health by TNCs.
Jamieson et al. (2020) ¹⁹	References Kickbusch's definition and acknowledges power as an underpinning construct.	Narrative and descriptive article introducing a framework combining the three dimensional view of power by Lukes with Kickbusch's framework, in the context of oral health inequalities.	Dimensions of power: visible, hidden, and invisible. Vehicles of power/drivers: political environment (e.g., lobbying, participation in committees and policy formulation, international treaties), preference shaping (e.g., corporate social responsibility, marketing and advertising, product modification and targeting vulnerable populations), knowledge environment (e.g., funding medical education and research), legal environment (e.g., limit liability, threaten litigation). Channels as per Kickbusch, i.e., Marketing, Supply chain, Lobbying, Corporate citizenship.	Influence on macrosocial determinants of health. Risk factors for oral health inequalities—increased availability, acceptability and affordability of tobacco, sugar sweetened beverages, sugar. Oral health outcomes e.g., increased caries, periodontal disease, oral cancer.

Appendix 1 (continued): Summary of findings from literature review one.

Authors (year)	Definition of CDoH	Type of evidence	Mechanisms of influence of CDoH	Outcomes of CDoH
Wood et al. (2021) ²⁰	Discusses concepts of power being at the heart of CDoH.	Narrative and descriptive article introducing a framework based on theory of power by Foucault and synthesising key features of other CDoH frameworks.	Origins of corporate power—material, ideational. Nature of corporate power: Instrumental (direct influence over other actors), Structural (shaping the real or perceived options of other actors), Discursive (shaping the ideas and interests of other actors).	Manifestations of corporate power: corporate outcomes, social outcomes (including risk factors and population health outcomes), ecological outcomes.
Knai et al. (2018) ²¹	<i>“Unhealthy commodity industries are industries in which a significant share of their product portfolio comprises unhealthy products including tobacco, alcohol, energy-dense and low-nutrient foods and beverages, and gambling services.”</i> Refers to the strategies and approaches used to promote products and services that are detrimental to health (Kickbusch reference).	Narrative and descriptive article introducing a systems thinking framework to analyse how unhealthy commodity industries influence public health policy.	Based on Donella Meadow’s systems thinking framework, incorporating: 1) Elements of a non-communicable disease (NCD)-genic system, e.g., individual citizens, individuals’ skills, system’s physical structures. 2) How industries interact with others to shape an NCD-genic system, e.g., physical interconnections and information flows. 3) How industries influence a system’s purpose, including intended and unintended consequences. Highlights interconnections and how unhealthy commodity industries achieve their goals.	Framed in context of high world-wide burden of NCDs.
Buse, Tanaka & Hawkes (2017) ²²	References Kickbusch definition. Framed in relation to NCDs i.e., <i>“risks for many of the major NCDs are associated with the production, marketing and consumption of commercially produced food and drink, particularly those containing sugar, salt and trans fats, alcohol and tobacco.”</i>	Narrative and descriptive analysis of framework and related health governance literature.	Uses an existing conceptual framework designed to classify the involvement of the commercial sector in global governance for health. Presents three models of interaction between public and private sectors: 1) Self-regulation by industry. 2) Regulation through partnership. 3) Regulation of the private sector by the public sector.	Growing burden of NCDs, notably cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes.

Appendix 2: Summary of findings from literature review two.

Authors (year)	Type of evidence	Recommended mechanisms for responding to CDoH
Mialon et al. (2020) ¹²	A scoping review identifying mechanisms for addressing and managing the influence of corporations on public health policy, research, and practice.	Four main types of mechanisms: 1) Management of interactions with industry and of conflicts of interest, e.g., policies on engagement, conflicts of interest, funding, and gifts. 2) Transparency of these interactions and conflict of interest. 3) Identification, monitoring and education about the practices of corporations and associated risks to public health. 4) Prohibition of interactions with industry, e.g., rules related to lobbying and ‘revolving door’ practices, limit interactions with tobacco industry in line with FCTC.
McKee et al. (2018) ²³	A review article exploring the development of the concept of the corporate determinants of health and how public health professionals can respond to them.	1) Challenge the dominant narratives shaped by corporate actions. 2) Shape norms for healthy policymaking, supporting measures that impose checks and balances on corporate power. 3) Support communities that stand up to powerful corporations, evaluate and communicate successes. 4) Align with other social movements committed to challenging the concentration of power in the hands of these corporations.
Robertson et al. (2019) ²⁴	Exploratory Australian study establishing the incidence of the “revolving door” phenomenon (where individuals move between positions in government and in alcohol, food, and gambling industries).	Adopt and enforce tighter post-government employment codes for public servants, e.g., policies such as enforceable cooling-off periods before moving to industry or lobbyist roles, bans on information sharing by former government representatives.
World Health Organization (2012) ²⁵ <i>Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC)</i>	The FCTC requires all convention parties to protect public health from tobacco industry interference. This document outlines guiding principles and recommendations for implementation of Article 5.3.	1) Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties’ tobacco control policies. 2) Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur. 3) Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry. 4) Avoid conflicts of interest for government officials and employees. 5) Require that information provided by the tobacco industry be transparent and accurate. 6) De-normalise and, to the extent possible, regulate activities described as “socially responsible” by the tobacco industry, including but not limited to activities described as “corporate social responsibility”. 7) Do not give preferential treatment to the tobacco industry. 8) Treat State-owned tobacco industry in the same way as any other tobacco industry.

Appendix 2 (continued): Summary of findings from literature review two.

Authors (year)	Type of evidence	Recommended mechanisms for responding to CDoH
World Health Organization (2016) ²⁶ <i>Framework of engagement with non-state actors</i>	Outlines principles which ensure that any engagement with non-state actors (non-governmental organisations, private sector entities, philanthropic foundations and academic institutions) demonstrates a clear benefit to public health and protects the World Health Organization from any undue influence in decision making processes.	WHO's engagement with non-State actors is guided by the following overarching principles. Any engagement must: <ol style="list-style-type: none"> 1) Demonstrate a clear benefit to public health. 2) Conform with WHO's Constitution, mandate and general programme of work. 3) Respect the intergovernmental nature of WHO and the decision-making authority of Member States as set out in the WHO's Constitution. 4) Support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO's work. 5) Protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards. 6) Not compromise WHO's integrity, independence, credibility and reputation. 7) Be effectively managed, including by, where possible avoiding conflict of interest² and other forms of risks to WHO. (8) Be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect.