

GLOBAL PUBLIC HEALTH UNIT,
Social Policy, School of Social & Political Science
University of Edinburgh
Chrystal Macmillan Building,
15a George Square, Edinburgh, EH8 9LD
Tel: +44 (0) 131 651 3961
E-mail: jeff.collin.ac.uk

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**WHO's engagement with non-State actors: Comments following the informal consultation,
17–18 October 2013**

The UK Centre for Tobacco and Alcohol Studies (UKCTAS) is a research centre that includes thirteen University teams working on tobacco and alcohol research. Twelve of these teams are based in the UK at the following Universities (Bath, Bristol, Edinburgh, Kings College, Liverpool, Nottingham, Oxford, Queen Mary, Sheffield, Stirling, University College London, York) and one in New Zealand (Massey University). The Centre is one of six UK Centres for Public Health Excellence and is funded by the UK Clinical Research Collaboration. Researchers within the Centre come from a range of academic disciplines from clinical medicine to social policy and conduct work on tobacco and alcohol use throughout the lifecourse with a particular focus on informing policies and interventions to reduce the harms from both these products.

In this context we welcome the opportunity to participate in discussions about WHO's engagement with non-state actors as part of the ongoing reform process. In doing so, our concern has been to highlight the implications arising from the fundamental conflicts of interest between public health and both the tobacco and alcohol industries. Such fundamental conflict is well established in the existing commitment to maintaining a "firewall" between WHO and the tobacco industry, and we welcome the Discussion Paper's reiteration of commitments by the World Health Assembly and Executive Board that clear boundaries to engagement with non-State actors include that "WHO does not engage with industries that make products that directly harm human health, such as tobacco or arms." (paragraph 4).

Our Centre is strongly of the view that such reasoning requires that the practice of non-engagement should be extended to cover the alcohol industry. At the population level, alcohol is a product which directly harms human health; there is no alcohol using population among which this does not occur.

The global health impacts of tobacco and alcohol are comparable in terms of disability adjusted years of life lost, and the economic interests of the tobacco and alcohol industries are equally divergent from the objectives of public health.

As requested during the closing session of the meeting, we are submitting these written comments to inform future discussions within WHO and member states. They are organized according to the four themes of Participation, Resources, Evidence & Advocacy, and Technical cooperation identified by the Secretariat during the meeting. We focus particularly on participation, as responses under other categories are necessarily shaped by the core decision on with whom WHO should and should not engage.

Participation

While we strongly welcome WHO's interest in expanding the scope of its engagement with diverse non-State actors, it is essential that this process be accompanied and protected by a clear articulation of the limits for such expanded engagement. We suggest that three of the overarching principles articulated in the Discussion Paper (paragraph 3) require clear policies of non-engagement with the tobacco and alcohol industries:

- Given the divergence of interests between these two industries and public health (WHO 2008a; Casswell 2013; Matzopoulos et al 2012), collaboration with either cannot reasonably be expected to “demonstrate a clear benefit to public health”.
- The records of both tobacco and alcohol industries in seeking to distort science, manipulate evidence and actively undermine the adoption and implementation of effective policies (McCambridge et al 2013; Jernigan 2012) demonstrate that engagement with them would not “support and enhance the scientific and evidence base that underpins WHO's work”.
- The sheer scale of the global health impacts of tobacco and alcohol products in combination with economic interests in protecting and expanding their consumption mean that it is impossible for engagement with either industry to “be actively managed so as to reduce any form of risk to WHO (including conflicts of interest)”.

The tension between these overarching principles and the conduct and impact of these two industries means that any engagement with them by WHO risks severely compromising the Organisation's reputation.

In considering how to limit the scope of engagement with these industries it is helpful to consider the typology of interactions with non-state actors noted by the Executive Board in EB133/16 (WHO 2013a). Of the six broad categories of interactions described between WHO and non-State actors, there are five for which it is unambiguously inappropriate for the Organisation to engage with individuals, organisations and companies whose interests starkly diverge from those of public health: namely Collaboration, Financing, Contractual, Non-State actors in WHO's governance, and WHO as part of the governance of non-State actors. Any such interaction would threaten to introduce inappropriate influence over priorities and policy and expose WHO to very high levels of reputational risk. Current policies and practices clearly preclude such interactions with the tobacco industry, and we see the case for the extension of these principles and practices to the alcohol industry as equally compelling.

The one type of interaction cited here that may occasionally be necessary or appropriate in the case of the tobacco and alcohol industries is that of Consultation. Even in this context, however, interactions with these industries should be viewed as intrinsically problematic, be kept to a minimum, be subject to full transparency safeguards, and should not be undertaken within the context of informing policy development. The implementation guidelines for Article 5.3 adopted by parties to the WHO Framework Convention on Tobacco Control offer a valuable model (WHO 2008b); we would welcome the adoption of the best practices recommended here to cover any interactions between WHO and either the tobacco or alcohol industries. Recommendation 2 of these guidelines is particularly pertinent in guiding the establishment of measures to limit interactions with the industry and to ensure the transparency of those interactions that do occur.

The Discussion Paper notes (paragraph 19) that WHO increasingly holds consultations with non-State actors in the preparation of intergovernmental agreements, and cites the involvement of the private sector in the ongoing processes on noncommunicable diseases. We regard the inclusion of the tobacco and alcohol industries in such agenda setting meetings as inappropriate. While the discussion paper for the ongoing consultation on the Global Coordinating Mechanism for NCDs (WHO 2013b) is explicit regarding the exclusion of the tobacco industry, it anticipates continuing "dialogue with the private sector on how they can best contribute to the reduction of alcohol-related harm." That paper also notes that "(a)ppropriate

consideration will be given to the commercial interests involved and their possible conflict with public health objectives”, and that “engagement with non-State actors will follow the relevant rules currently being negotiated as part of WHO reform”. It would therefore be inappropriate for the alcohol industry’s recent engagement in the NCD process to be viewed as an obstacle to the Organisation adopting a policy of non-engagement in the future.

Some written submissions and contributions to discussion during the meeting, particularly from business-oriented NGOs, have proposed that the broad structure of the current informal consultation should be replicated by WHO in the future via a ‘multi-stakeholder’ forum. Such efforts to bring together member states, civil society organisations and the commercial sector can only be expected to be successful where there is a broad and clear consensus regarding the legitimacy of all participants. The Public Health Responsibility Deal in the UK is sometimes cited as a model for broad participation, but the inclusion within this framework of the alcohol industry has been accompanied by claims of undue influence and has led to the withdrawal of a number of prominent public health organisations (Triggle 2011; Limb 2013). The reputational dangers for WHO if confronted by similar withdrawals would be particularly significant.

Resources

The increasing role of non-state actors in funding the work of WHO is well-recognised, and it is clearly a key part of the reform process that the terms of such funding relationships be clarified. Where possible and appropriate, this process should make it easier for WHO to access financial and other resources from a broader range of potential contributors. We are, however, particularly concerned about the framing of the section of the Discussion paper that addresses these issues (paragraphs 20-24).

We would strongly advise against accepting “project-based funding, non-earmarked contributions, or contributions earmarked at a high level” from any organisation whose interests clearly diverge from those of public health. While the acceptance of funding from tobacco companies is not envisaged, the assertion in paragraph 21 that WHO might accept funding “for activities where funding from individual entities could represent a conflict of interest” is of particular concern in the context of the alcohol industry. The anticipated provision for pooled funding would not be sufficient to guard against the risks of accepting alcohol industry funding, including dependency, distorting priorities, and the reputational benefits to the industry that would be associated with any such funding arrangements. At national level, such “arms

length” arrangements have proved inadequate in ensuring that funding is not used to advance ineffective health interventions and protect industry interests (McCambridge et al In Press).

While we welcome the commitments to strengthening due diligence, managing risks of engagement, and increased transparency and public scrutiny, such measures should not be viewed as capable of transforming a relationship characterised by pronounced conflicts of interest. There is no procedural silver bullet that can legitimise inappropriate interactions. In this context we would also propose that any offers by the alcohol or tobacco industry to provide “human resources, whether as formal secondments or in the form of pro bono work” would carry unacceptable risks for the reputation of WHO and the effective conduct of its programmes.

Evidence and advocacy

We regard it as important that the current practice of excluding individuals working for the private sector from serving in guidelines development groups should be maintained, as noted by paragraph 25. This implicit acknowledgement of the distinctive issues regarding engaging with commercial actors in this context highlights the broader value of differentiating between this sector and other non-state actors when considering wider terms of engagement with WHO.

The accompanying suggestion in paragraph 26 that WHO will more systematically conduct public hearings where private sector expertise is relevant to guidelines development raises two broad concerns. Firstly, the particular phrasing used to suggest that such hearings will provide a context in which “private sector representatives can present the evidence” is troubling. Where the interests of commercial sector actors are concerned, which is clearly the context envisaged, it seems unrealistic to suggest that data they present can be described as “the evidence”. This rather naïve formulation ignores the ways in which commercial actors necessarily engage with science and evidence to advance or protect economic interests (WHO 2008a; McCambridge et al 2013). Both the tobacco and alcohol industries have established records of funding research that has served to undermine consensus around effective public health policies and thus influenced the policy process (WHO 2008a; Jernigan 2012).

We are unconvinced by the subsequent contention that such fora would allow for consultation with private sector representatives without them “becoming part of the actual process of developing the guidelines”. This dividing line is likely to prove extremely problematic. If such consultations are to be meaningful they

will necessarily contribute to shaping the agenda, and as such would constitute part of the process of guidelines development. Thus the distinction between consultation and participation in guidelines development isn't analytically or practically tenable. Actors consulted in this way will undoubtedly see their contributions as part of the broader developmental process, and will inevitably use this limited participation as an opportunity to influence it.

WHO's engagement with non-state actors in advocacy and awareness raising need not be restricted to those whose interests and objectives are "wholly convergent with those of WHO". Yet it is equally clear that the scope of such engagement should not extend as far as those whose interests and objectives are essentially divergent from those of the Organisation. In the cases of the tobacco and alcohol industries, we would see any relationships as likely to be beneficial to the companies concerned in ways that pose both a reputational risk for WHO and substantive dangers for public health.

Any ambition to engage with organisations whose activities and products harm public health in the hope of helping them to "improve their own activities to better protect and promote health" is liable to prove to be naïve and excessively optimistic. Such collaborations at national and international levels have consistently privileged the interests of the private sector actors involved via (inter alia) conferring strategically significant reputational benefits (Barbor & Robaina 2013), producing interventions that don't jeopardise core economic goals, and pursuing agendas associated with marginal health gains (Fooks et al 2013; McCambridge et al 2013). This approach misunderstands the constraint placed on commercial sector conduct by legal obligations to shareholders and divergent economic interests, and ignores the intrinsically peripheral and tokenistic nature of health-oriented improvements by such industries.

Technical Advice

Consistent with the case for non-engagement with the tobacco and alcohol industries outlined above, we do not see such organisations as having a legitimate or helpful role to play in providing technical advice to member states as part of the development of health policy. While this is clearly recognised for the tobacco industry in Article 5.3 of the WHO Framework Convention on Tobacco Control, we regard the case as equally compelling in relation to the alcohol industry. We would draw attention to the established track record of alcohol industry interference in the policy process with the objective of undermining measures that might impact significantly on consumption and profitability (Jernigan 2012; Bakke & Endal 2010).

In this context we strongly endorse the comments of the Director General in her opening address to the 8th Global Conference on Health Promotion, Helsinki, Finland in June 2013. In describing industry efforts to shape health policies that affect their products, she warned that “(w)hen industry is involved in policy-making, rest assured that the most effective control measures will be downplayed or left out entirely... In the view of WHO, the formulation of health policies must be protected from distortion by commercial or vested interests.” (Chan 2013) The submission of UKCTAS suggests that the adoption of a commitment within the WHO reform process to non-engagement with both the tobacco and alcohol industries would significantly enhance such protection.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J Collin', with a stylized flourish at the end.

Professor Jeff Collin (on behalf of UKCTAS)
Director, Global Public Health Unit

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