

THE ALCOHOL INDUSTRY AND ALCOHOL POLICY

1. BACKGROUND

There are significant commercial interests involved in promoting alcohol's manufacture, distribution, pricing and sale. The beverage alcohol industry consists of relatively large-scale producers and wholesalers who market alcoholic beverages to retailers who then distribute them through bars, restaurants, and off-premise establishments for sale to consumers. Over the last 25 years, there has been an enormous consolidation in the alcohol industry, such that in 2004, about half the market share of the global beer market is owned by the top five companies, and just under half the global spirits market is owned by the top five companies¹. Since the 1980s, the alcohol industry has become increasingly involved in the policy arena in order to protect its commercial interests. It is a common claim among public health professionals that alcohol industry representatives are influential in setting the policy agenda, shaping the perspectives of legislators on policy issues, and determining the outcome of policy debates. To promote their interests and influence on national level policy decisions, industry sources have funded a network of national, regional, and global 'social aspects' organizations which sponsor selected prevention initiatives or industry-friendly views on alcohol problems and policies through promoting the concept of corporate social responsibility. This background paper argues that caution should be made against the role of the private sector in trying to do the work of governments, which are the proper guardians of the public interest, accountable to all citizens to set goals for regulators, deal with externalities, mediate among different interests, attend to the demands of social justice and provide public goods and collect the taxes to pay for them².

2. WHAT IS KNOWN ABOUT THE EFFECTIVENESS OF ALCOHOL POLICY

There are a wide range of alcohol policies and prevention programmes aimed at minimizing the health and social harms from alcohol consumption, and there is an extensive evidence base which identifies those measures that are effective^{3,4}.

Regulating the alcohol market In general the number and density of alcohol outlets has a positive relationship on alcohol-related harm. The relationship is strongest when there has been a major change in the number or types of such outlets. Whilst extending times of sale can redistribute the times that many alcohol-related incidents occur, which may reduce some peak loading problems, such extensions do not reduce violent incidents and may lead to an overall increase in consumption and problems. The effectiveness of underage sales restrictions depends considerably on the degree to which restrictions are enforced. There is strong and consistent evidence that both young people and heavy drinkers are particularly sensitive to price. This is supported by a large amount of evidence which has shown an impact of

¹ Impact Databank (2005). The Global Drinks Market: Impact Databank Review and Forecast. New York, M. Shanken Communications, Inc.

² Economist (2005). The Good Company. 20 January 2005.

³ Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, Grube JW, Gruenewald PJ, Hill L, Holder HD, Homel R, Österberg E, Rehm J, Room R and Rossow I (2003). Alcohol: No Ordinary Commodity. Research and Public Policy. Oxford, Oxford Medical Publication, Oxford University Press.

⁴ Anderson, P. & Baumberg, B. (2006). Alcohol in Europe: a public health perspective. http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm.

prices on a wide variety of health and social harms caused by alcohol. Although there are a wide variety of strategies which seek to reduce the risk of harm from intoxication by affecting the context of drinking, in general their effectiveness is rather limited, particularly when not backed up by enforcement. Strong evidence has come from several recent longitudinal studies which have all found small but significant effects of exposure to advertising on both whether young people drink and whether there is binge drinking. There is the convincing evidence that both establishing a legal Blood Alcohol Concentration (BAC) for driving and lowering it are effective in reducing drinking-driving casualties. There is also convincing evidence that both intensive random breath testing, where police regularly stop drivers on a random basis to check their BAC, and checkpoints, where all cars are stopped and drivers suspected of drinking driving are breath-tested, reduce alcohol-related injuries and fatalities.

Education and persuasion A variety of educational approaches have been used with the intention of reducing alcohol-related harm, including education of younger people in classroom settings, information campaigns using mass media, the promotion of drinking guidelines, labelling of alcoholic beverage products with warning labels; school based activities carried out as part of school plus family initiatives and as part of community action projects, and community initiatives aimed to challenge norms around alcohol consumption and distribution. Whilst educational approaches might seem valid, unfortunately, a number of careful systematic reviews of evaluations of school based education which aimed to reduce alcohol related harm, concluded that the results have not provided support for classroom based education as an effective intervention to reduce alcohol related harm; although there is evidence of positive effects on increased knowledge about alcohol and in improved attitudes, there is no evidence for a sustained effect on behaviour. In general, public information campaigns also seem to be an ineffective antidote to the high quality, pro-drinking messages that appear far more frequently in the media. Also, there have been no evaluations that find an impact of these guidelines on alcohol related harm. On the other hand, there is some evidence for the impact of mass media campaigns to reduce drinking and driving. There is some evidence to support combining school and community interventions, in part because the community interventions may be successful in restricting access to alcohol by young people. An important component of community action programmes which has been shown to impact on alcohol related harm such as traffic crashes and violence is media advocacy, which can educate the public and key stakeholders within the community by increasing the status of alcohol on the political and public agenda and reframing the solution to alcohol related problems to include a co-ordinated approach by relevant sectors such as health, enforcement, non-governmental organizations, and municipal authorities.

There is extensive evidence that shows the effectiveness and cost-effectiveness of opportunistic screening and brief interventions for persons with hazardous and harmful alcohol use in the absence of severe dependence. For people with more severe alcohol dependence and related problems, a wide variety of specialized treatment approaches have been evaluated. The evidence shows that individuals given these treatments achieve better outcomes than those not receiving treatment.

3. HOW DOES THE ALCOHOL INDUSTRY DIFFER IN ITS VIEWS OF ALCOHOL POLICY, COMPARED WITH GOVERNMENTAL AND NON-GOVERNMENTAL ORGANIZATIONS?

A European questionnaire survey undertaken at the end of 2004 found that representatives of the alcohol industry (AIs) tended to hold different views on alcohol policy than representatives of governmental (GOs) and non-governmental

organizations (NGOs), who were more similar in their views, Figure 1⁵. The AIs viewed regulatory measures as of low impact and policy importance in strong contrast to both NGOs and GOs.

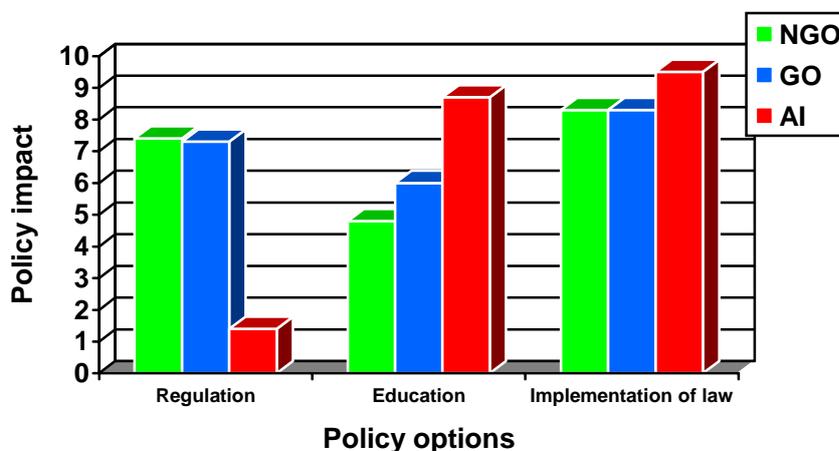


Figure 1 Results of the views of three groups of policy options (regulations, education and implementation of the law) in reducing the harm done by alcohol for NGOs, government organizations (GOs) and the alcohol industry (AI). Source: Anderson & Baumberg (2006)⁵.

AIs were more favourable to educational measures than either NGOs or GOs. All three groups were similar and positive in their views of the impact and importance of implementation measures and of interventions for hazardous and harmful alcohol consumption. In general, AIs were more positive in their views of successful implementation of both the WHO European Alcohol Action Plan⁶ and the European Council Recommendation on the drinking of alcohol by young people⁷ than GOs who were more favourable than NGOs, but this was largely due to the AIs giving very high implementation scores for items that were their responsibility. With regard to perceived advances and barriers to reducing the harm done by alcohol, again there were discordant views between the AIs and both the GOs and NGOs, who were more similar in their perceptions. The strongest theme among GOs and NGOs was the importance of coordination in implementing action plans and strategies at country and European levels. The strongest theme among AIs was stakeholder involvement, i.e. their own participation in the policy process. This was in contrast to the views of GOs and NGOs who both saw industry lobbying as a major barrier to effective policy to reduce alcohol-related harm.

4. SOCIAL ASPECTS ORGANIZATIONS OF THE ALCOHOL INDUSTRY

Since the 1980s, the beverage alcohol industry has set up and funded what are termed social aspects organizations to manage issues that may be detrimental to its

⁵ Anderson, P. & Baumberg, B. (2006). Stakeholders' views of alcohol policy. *Nordic Studies on Alcohol and Drugs* 2006 23 393-414.

⁶ World Health Organization (2000). *European Alcohol Action Plan 2000-2005*. Copenhagen: World Health Organization.

⁷ Council European Union (2001) Council Recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents. http://ec.europa.eu/eur-lex/pri/en/oj/dat/2001/l_161/l_16120010616en00380041.pdf .

business⁸. Social aspects organizations operate at the global level, the European level and at the country level, in high, middle and low income countries. They aim to manage issues by attempting to influence the alcohol policies of national and international governmental organizations; becoming members of relevant non-alcohol specific organizations and committees to broaden policy influence and respectability; recruiting scientists, hosting conferences and promoting high profile publications; creating social aspects organizations in emerging markets and low income countries; and preparing and promoting consensus statements and codes of practice.

Social aspects organizations hold five main viewpoints: 1) addressing patterns of drinking rather than volume of alcohol consumption is the best basis for alcohol policies; 2) responsible drinking can be learned and this should be the cornerstone of alcohol policy; 3) they have an equal place at the policy table; 4) the marketing of alcoholic beverages should be self-regulated; and 5) alcohol, despite its potential for “abuse”, confers a net benefit to society.

5. WHAT HAPPENS IN ALCOHOL POLICY WHEN PUBLIC HEALTH SITS AT THE SAME TABLE AS THE ALCOHOL INDUSTRY?

One example of sitting at the same table is the European Policy Centre’s (EPC, “an independent, not-for-profit think tank, committed to making European integration work”) report of a Roundtable on “Alcohol-related harm”⁹. The EPC hosted a series of four meetings to “identify areas of agreement between the stakeholders as to actions that can contribute effectively to the reduction of [alcohol-related] harm and indicate where and why there is disagreement, and in so doing help create confidence between stakeholders”. The meetings were attended by representatives of selected companies producing alcoholic beverages (beer, wine and spirits), consumers and public health non-governmental organisations (NGOs), the European Commission and Member States, together with academic experts.

Participants addressed 78 separate alcohol policy measures and recommendations, as they were proposed in an informal draft working paper prepared by the European Commission in its process of preparing its Communication on Alcohol into one of three categories:

1. green (indicating that the participants expressed broad consensus on that specific item but not necessarily detailed agreement);
2. amber (on which the participants expressed partial agreement and an explicit will to continue discussing); or
3. red (on which the participants expressed clear disagreement).

Of the 78 items, 68 were green. Seven were amber and 3 were red. The seven amber items were:

1. Member States should reduce the blood alcohol concentration (BAC) level from 80 to a maximum of 50 milligrams (in 100 millilitres of blood).
2. The alcohol industry should support effective drink-driving countermeasures and demonstrating responsible business activities, especially by not serving alcohol to drivers and ensuring alternative transport programmes for drivers who do consume alcohol.

⁸ Anderson P. (2005). Social aspects organizations of the beverage alcohol industry: a public health warning. www.eurocare.org.

⁹ Report of the EPC Roundtable on Alcohol-related harm: ways forward <http://www.theepc.be/pdf/alcohol.pdf> 2006.

3. The alcohol industry should contribute to a central and independently-managed fund for “Europe against Drink-driving” mobilisation.
4. If not already in place, establishing a lowest minimum selling/serving age of 18 years in all Member States, preserving existing higher minimum selling/serving ages.
5. The alcohol industry should refrain from producing and marketing products that are attractive to, or target children and adolescents.
6. The alcohol industry should endorse the monitoring and enforcement of its own codes of conduct through a body that is independent of the alcohol and advertising industries.
7. Non-governmental organizations should set targets for the regulation of commercial communications, monitoring and reporting on the marketing strategies of the alcohol industry and on the enforcement of regulatory and self-regulatory mechanisms.

The three red items were:

1. The alcohol industry should submit any educational type messages placed on alcoholic beverages to review by an independent government-appointed public health body before placing them on the labels.
2. The Commission should assess the possibility to have a special rate of excise duty on specific alcoholic beverages that are proved to cause harmful consumption.
3. Member States should establish effective pricing policies.

With regard to pricing policy, the alcohol industry stated that they “...Objected to the statement that there is ‘strong evidence’ that increasing the level of excise duties is an effective means of reducing alcohol-related harm. This assertion was based on a selective and tendentious reading of the available ‘evidence’ and a comprehensive and balanced reading does not support this conclusion”.

6. WHAT HAPPENS WHEN NGOS PARTNER WITH THE ALCOHOL INDUSTRY?

One example is Alcohol Education Australia Ltd¹⁰. In August 2002, the Alcohol and Drug Foundation of Queensland in Australia (ADFQ) announced the formation, in conjunction with the alcohol industry, of Alcohol Education Australia Ltd. (AEA), to “promote responsible drinking and moderation in the consumption of alcohol.” The Alcohol and Drug Foundation of Queensland was a non-government, not-for-profit body with a thirty-year history. It conducted treatment services in residential, custodial and community settings, a prevention program, an annual conference, and published a quarterly magazine.

According to the Alcohol Education Australia prospectus: “The Company is owned by the Alcohol and Drug Foundation of Queensland, and was set up as a separate legal entity for the purpose of being recognised as a national public health organisation.” A board of nine directors would govern AEA, three appointed by each of ADFQ, industry stakeholders, and community stakeholders. Within months of forming AEA, ADFQ intervened in a licensing case to support a manufacturer whose application to sell alcoholic milk (*Moo Joose*) was rejected by a state licensing authority. Two principals of ADFQ, the president, and the CEO submitted an eight-page statement in defence of *Moo Joose* and both appeared before the tribunal as witnesses for the manufacturer. In supporting *Moo Joose*, ADFQ reversed a previous policy; in 1997,

¹⁰ Munro, G. (2004) An addiction agency’s collaboration with the drinks industry: *Moo Joose* as a case study. *Addiction*, **99**, 1370–1374.

ADFQ declared *Candy Shots*, a vodka-based pre-mixed drink marketed in flavours of chocolate, banana, caramel, and marshmallow, “dangerous,” and called for proscription. The CEO said, “But everyone knows that underage drinking occurs and this is just the type of drink that will make it easier for kids to get started.”

Features of ADFQ’s defence of *Moo Joose* included: the narrow neck of the bottle and the screw top would militate against the risk of drink spiking; the four-pack was “a harm minimisation strategy” that would limit consumption; and the milk content would prevent excessive use and intoxication. Liquor Licensing Victoria rejected *Moo Joose* because it saw alcoholic milk as a corruption of a product known to be healthy and one that might easily be taken up by children.

7. HOW DOES THE ALCOHOL INDUSTRY ATTEMPT TO INFLUENCE AND USE SCIENCE?

Scientists are used by social aspects organizations to promote their standpoints, ideologies and viewpoints and to discredit scientific findings inconsistent with these standpoints. When *Alcohol Policy and the Public Good* was published, scientists were offered £2000 by the United Kingdom’s Portman Group to “rubbish” the report and to permit their criticisms to be published with or without their names¹¹.

Babor and Xuan compared the results of a survey undertaken by the International Centre of Alcohol Policies (ICAP) (a global social aspect organization of the alcohol industry of 48/114 (42%) countries, representing 22% of the world’s population, with the results of a survey undertaken by the World Health Organization (WHO) of 118/175 (67%) countries, representing 86% of the world’s population¹². Table 1 shows that, in general, the ICAP survey underestimated the prevalence of existing policies compared with the WHO survey.

Table 1 Prevalence of existing policies comparing ICAP and WHO surveys

Policy	Global %		Regions									
	ICAP	WHO	L. America %		Africa %		W. Europe %		E. Europe %		Asia Pacific %	
	ICAP	WHO	ICAP	WHO	ICAP	WHO	ICAP	WHO	ICAP	WHO	ICAP	WHO
Number of countries	(48)	(118)	(12)	(23)	(10)	(26)	(7)	(20)	(6)	(23)	(6)	(19)
Minimum purchase age	63%	82%	67%	100%	60%	64%	72%	100%	50%	87%	83%	74%
Licensing of sales	75%	73%	58%	88%	80%	82%	100%	65%	83%	52%	83%	80%
Drinking and driving	81%	93%	50%	96%	70%	84%	100%	100%	100%	96%	100%	89%
Regulations on advertising	52%	60%	42%	70%	20%	43%	72%	70%	83%	74%	50%	65%
Health warning labels	25%	33%	42%	56%	20%	27%	14%	10%	17%	30%	0%	33%

¹¹ Rows over drinks industry attempt to rubbish alcohol report, *Alcohol Alert*, April 1995, 20, 2-3.

¹² Babor, T.F. & Xuan, Z. Alcohol policy research and the grey literature. *Nordic Studies on Alcohol and Drugs*, Vol 21 (2004)125-37. English Supplement.

When asked about partnerships with the alcoholic beverage industry, 50% of the 48 respondents in the ICAP survey answered yes to the question: “Do you view the beverage alcohol industry as an effective partner in developing alcohol policies in your country?” Among the 24 answering yes, respondents were then asked to list the topic areas for potential partnerships. ICAP reported these results as the two right of each of the four columns in Figure 2, suggesting that a relatively high proportion of countries were in favour of partnerships. But, ICAP used the wrong denominator, 24, the respondents who answered yes to the question “Do you view the beverage alcohol industry as an effective partner in developing alcohol policies in your country?”, instead of the total sample of 48. When the correct denominator is used, then a much lower proportion of countries are in favour of partnerships with the alcohol industry, the two left of each of the four columns.

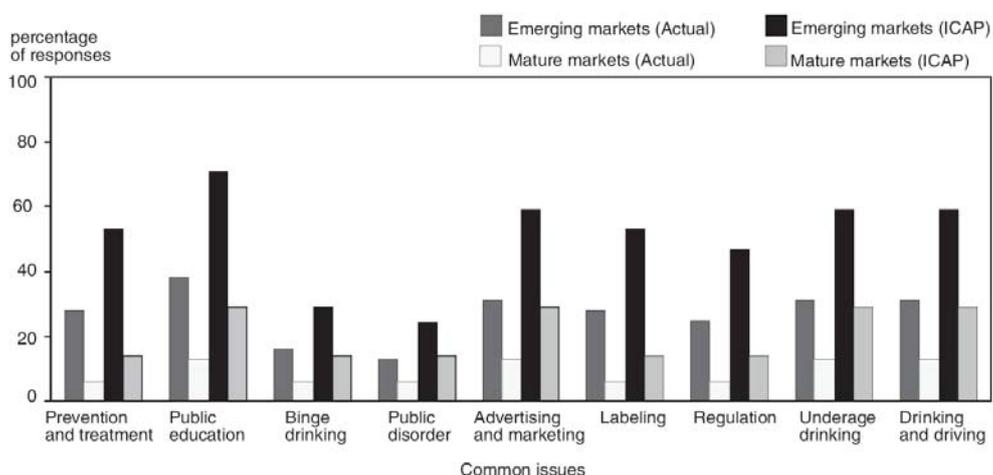


Figure 2 Respondents in ICAP who answered yes to the question, “Do you view the beverage alcohol industry as an effective partner in developing alcohol policies in your country?” For each block of four columns, the right two columns used the incorrect denominator; the left two columns use the correct denominator.

8. WHAT COULD BE THE ROLE OF THE ALCOHOL INDUSTRY IN ALCOHOL POLICY?

The alcohol industry has a particular role to play in the implementation of alcohol policies and programmes. This can include providing server training to all involved in the alcohol sales chain to ensure responsibility in adhering to the law, and in reducing the risk of subsequent harmful consequences of intoxication, harmful patterns of drinking and the risk of drinking and driving; and ensuring that the full marketing process does not promote an alcoholic product by any means that directly or indirectly appeals to minors¹³. Engagement with the alcohol industry should be limited to ‘harm reduction’ strategies that do not require any reduction in alcohol use for their effectiveness (for example, plastic glassware at high risk venues for violence) and to some ‘demand reduction’ strategies that seek to educate about lower-risk alcohol use (for example, no drinking whilst pregnant)¹⁴.

¹³ Anderson, P. & Baumberg, B. (2006). Stakeholders’ views of alcohol policy. *Nordic Studies on Alcohol and Drugs* 2006 23 393-414.

¹⁴ Stockwell, T. (2007). Working with the alcohol industry on alcohol policy: should we sometimes sit at the same table? *Addiction* 2007 102 1-2.

9. HOW SHOULD PUBLIC HEALTH RELATE TO THE ALCOHOL INDUSTRY?

In relating to the beverage alcohol industry, Eurocare has made the following recommendations¹⁵:

1. Governments need to implement evidence based policies to reduce the harm done by alcohol, with such policies formulated by public health interests, recognizing that the viewpoints of social aspects organizations are not impartial;
2. Governmental organizations should be concerned at spending public money on programmes put forward by the social aspects organizations, since such programmes lack evidence of effectiveness;
3. A proportion of alcohol taxes, hypothecated for the purpose, should be used to fund relevant independent non-governmental organizations to implement evidence based campaigns to reduce the harm done by alcohol;
4. Governments should support nongovernmental organizations that are independent of the beverage alcohol industry;
5. Independent non-governmental organizations that have a specific role with regard to safeguarding effective alcohol policy should inform and mobilize civil society with respect to alcohol-related problems, lobby for implementation of effective policy at government level, and expose any harmful actions of the beverage alcohol industry;
6. In discharging their role, non-governmental organizations mentioned in point 5 above should remain completely independent of social aspects organizations;
7. All independent scientists that are paid by or undertake work for social aspects organizations and the beverage alcohol industry should state their declarations of interest in their scientific publications;
8. Research scientists in high income countries should consider their ethical responsibility not to profit from or contribute to the beverage alcohol industry's actions in low income countries; and
9. Greater vigilance and monitoring of beverage alcohol industry behaviour is needed.

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¹⁵ Anderson P. (2005). Social aspects organizations of the beverage alcohol industry: a public health warning. www.eurocare.org.