

IAS response to consultation WHO Global NCD Action Plan 2013-20, Appendix 3
Comments sent via email to appendix3@who.int 31st August 2016

The Institute of Alcohol Studies welcomes the opportunity to comment on the evidence to support very cost-effective and affordable interventions for Member States to implement in order to prevent and control non-communicable diseases. This submission relates to the [WHO discussion paper \(version dated 25th July 2016\)](#), which represents a draft Updated Appendix 3 of the WHO Global NCD Action Plan 2013-2020ⁱ.

Summary recommendations:

- **There is strong evidence to support the continuation of the current ‘best buy’ policies relating to alcohol use as part of the WHO NCD Action Plan**
- **The term “harmful alcohol use” could be amended to “alcohol use” to better reflect the latest available evidence indicating there is no level of alcohol consumption that is without risk to health**
- **The list of fiscal measures under A1 that Member States can use to raise the price of alcohol should include minimum pricing policies, to account for the latest evidence indicating their effectiveness at tackling alcohol mortality, morbidity and health inequalities**
- **The wording for A2 should be amended to read: ‘Enforcement of bans or comprehensive restrictions on exposure to alcohol advertising, promotion and sponsorship (across multiple types of media)’ to better reflect the evidence indicating that *exposure* to a range of alcohol marketing practices is associated with harm**
- **The wording for A3 should be amended to include minimum legal purchase age laws**
- **IAS supports calls for enhanced policy coherence which would ensure that commitments in agriculture or trade are developed in ways that protect and promote health**
- **Guidelines should be developed for Member States to support them in preventing, identifying and managing conflicts of interest when implementing policies to tackle NCDs or exploring partnerships with the private sector**

Evidence of alcohol harm

Since the publication of the WHO Global NCD Action Plan in 2013ⁱⁱ, additional evidence has been published to reinforce the need for Member States to take action to reduce alcohol harm. The Global Status Report on Alcohol and Health published in 2014 indicated that each year 3.3 million deaths are attributable to alcohol, representing 5.9% of all deaths, and that alcohol is responsible for 5.1% of the global burden of disease and injuryⁱⁱⁱ.

With regards alcohol’s impact on non-communicable diseases, evidence has been published that corroborates the WHO’s International Agency for Research on Cancer classification of alcohol as a group one carcinogen^{iv}. A 2016 report published by the World Cancer Research Fund International found stronger links between alcohol use and stomach cancer^v, and a comprehensive evidence review published in 2016 found strong evidence that alcohol causes cancer in seven sites of the body and probably others^{vi}.

With regards to any health benefits accrued from low level alcohol consumption, a major evidence review published in 2016 concluded that regular moderate drinking had no net health benefits compared to abstinence or occasional drinking^{vii}. The latest available evidence supports the statement that there is no level of alcohol consumption that is without risk to health. **The terminology used in the NCD Action Plan, ‘harmful alcohol use’ could therefore be updated to ‘alcohol use’ to better reflect the latest available evidence.**

Evidence to support ‘best buy’ policy options to reduce alcohol harm

Price (relating to A1: Increase in excise taxes on alcoholic beverages)

The research consensus that raising the price of alcohol is among the most effective means of reducing alcohol-related illness and injury has only grown stronger in recent years, bolstered by an ever-growing evidence base across a range of countries. For example, in 2015 the Organisation for Economic Co-operation and Development (OECD) endorsed the raising of taxes on alcohol, including it among a suite of cost-effective measures that it estimated would cost US\$1,000/DALY in Germany and \$3,000 in Canada.^{viii}

Both health economic models, based on consumers’ observed price sensitivity and harm curves, and evaluations of existing pricing interventions have continued to find that higher alcohol prices bring about less consumption and less harm. Analysis of the effects of **minimum pricing** in Canadian provinces has shown that a 10% increase in the floor price for alcohol was associated with a 3% reduction in consumption in British Columbia^{ix} and an 8% reduction in consumption in Saskatchewan^x, with the greatest declines in high strength beer and wine. This, in turn, led to a 9% decrease in alcohol attributable hospital admissions^{xi} and a 32% reduction in alcohol attributable deaths in British Columbia.^{xii} In the UK, a number of modelling studies have suggested that a minimum unit price for alcohol would reduce hospitalisations and deaths significantly, resulting in substantial healthcare cost savings.^{xiii} The most recent of these showed that a 50p per unit minimum unit price in Scotland would cut both by 7%.^{xvi} Minimum unit pricing is estimated to have the biggest impact in terms of avoidable premature mortality amongst lower income groups, a sign the policy would contribute to reducing health inequalities. Research indicates that 80% of the lives potentially saved by introducing minimum pricing in England would be from those with low socioeconomic status^{xvii}.

Given the emerging evidence to support minimum pricing as a policy tool to tackle the affordability of alcohol, alongside increased alcohol taxes, **IAS recommends that ‘minimum pricing policies’ are added to the list of fiscal measures under intervention A1 designed to raise the price of alcohol.** This policy is already listed in the WHO Global Strategy to reduce harmful use of alcohol^{xviii} and the WHO European action plan to reduce the harmful use of alcohol^{xix}.

Marketing (relating to A2: Enforcement of bans or comprehensive restrictions on alcohol advertising)

As with price, the position of marketing as a best buy has been reinforced by international institutions and academic researchers. Advertising regulations were included in the OECD’s list of effective alcohol policies.^{xx} Across a range of countries, a number of measures of exposure to alcohol advertising have been associated with higher consumption and thus harm. Most straightforwardly, in the US^{xxix}, Germany, Italy, Netherlands, Poland^{xxiii} and Scotland^{xxiv}, among other countries, it has been shown that adolescents and young adults that recall seeing or liking alcohol advertisements drink more frequently and in higher quantities, even controlling for confounders such as previous drinking levels. More sophisticated studies have isolated the impact of alcohol product placement in movies, demonstrating that young people who watch films depicting alcohol use are more likely to binge drink,

but finding no such effect for those who watch films depicting smoking.^{xxv} Alcohol sponsorship has been identified as an influential marketing activity, with a systematic review published in 2016 finding a positive association between exposure to alcohol sports sponsorship and increased drinking amongst schoolchildren and adult sportspeople.^{xxvi}

Given that the majority of evidence linking alcohol advertising and harm relates to *exposure* to alcohol marketing practices, IAS recommends that the wording for A2 be amended to read: **Enforcement of bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media).**

Availability (relating to A3: Enforcement of restrictions on the physical availability of retailed alcohol)

Evidence supporting the efficacy of restrictions on the availability of alcohol for curbing NCDs has also built over the past few years. As with pricing and marketing, in 2015 the OECD included reduced opening hours among its recommended policies for tackling alcohol-related harm.^{xxvii} A number of studies have found a persistent link between shorter opening times and reduced illness and injuries. Among the most notable is a 2011 paper showing that restricting pub closing times in Newcastle, Australia was associated with a 37% reduction in assaults.^{xxviii} A follow up study, 3½ years later, found that this effect had been sustained, and assaults remained well below their pre-intervention levels.^{xxix} Research in the USA^{xxx}, Netherlands^{xxxi} and Norway^{xxxii} echoes these findings, linking longer opening hours to increased violent crimes and ambulance callouts.

Academics have also investigated the impact of the number and density of outlets on alcohol consumption and harm. Though a 2015 systematic review noted the methodological difficulties of demonstrating a causal link between the two, it concluded that “Outlet densities are likely to be positively related to alcohol use and harm”.^{xxxiii} This conclusion is supported by evidence from Canada showing that a 10% increase in private liquor stores is associated with a 2% increase in alcohol attributable mortality.^{xxxiv} Similarly, it has been shown that English local authorities that adopted more restrictive licensing policies, for example limiting the number of outlets in specific areas or rejecting greater proportions of licensing applications, enjoyed larger reductions in alcohol-related hospital admissions – 5% greater than would otherwise be expected.^{xxxv}

In addition, there is strong and consistent evidence supporting the use of minimum purchase age laws for alcohol: A review of 132 studies published between 1960 and 1999 found very strong evidence that changes in minimum drinking-age laws can have substantial effects on drinking among young people and alcohol-related harm, particularly in relation to road traffic accidents. These effects can often be seen years after young people reach the legal drinking age^{xxxvi}. The WHO Global Strategy to reduce harmful use of alcohol acknowledges that ‘implementation of laws that set a minimum age for the purchase of alcohol show clear reductions in drinking-driving casualties and other alcohol-related harm^{xxxvii} and recommends, alongside the WHO European action plan to reduce the harmful use of alcohol, that Member States adopt minimum legal purchase age laws of 18 years for on-trade and off-trade establishments^{xxxviii}. **IAS recommends that the wording for intervention A3 is amended to include this: ‘Enforcement of restrictions on the physical availability of retailed alcohol (via reduced density of retail outlets, reduced hours of sale and minimum legal purchase age laws)’.**

Additional comments

Under Objective 1, to raise the priority awarded to the prevention and control of NCDs, IAS wishes to draw attention to the recently agreed UN Sustainable Development Goals (SDGs), which include a target under Goal 3 to ‘strengthen the prevention and treatment of substance abuse... including harmful use of alcohol’^{xxxix}. The inclusion of this prevention goal within the SDGs highlights the impact alcohol harm has on development in terms of costs to health services, social costs and economic

output. This reaffirms the importance of tackling alcohol harm via public policies that have strong evidence of effectiveness.

However, under Objective 2, which includes ‘strengthening multisectoral action and partnerships’, IAS highlights that competing interests exist within the SDGs and other public policy areas which threaten to undermine progress in reducing alcohol harm. These include further trade liberalisation and emphasis on partnerships with the private sector^{xi}. **With reference to trade liberalisation, IAS supports calls for enhanced policy coherence which would ensure that commitments in agriculture or trade are developed in ways that protect and promote health^{xli}.**

With reference to partnerships with the private sector, IAS joins calls from civil society organisations for the WHO to ensure that health policy is protected from vested interests, in particular producers of unhealthy commodities such as alcohol, soft drinks, infant formula and processed foods high in fat, salt and sugar^{xlii}. **Guidelines should be developed for Member States to support them in preventing, identifying and managing conflicts of interest when implementing policies to tackle NCDs.**

Regarding the **overarching/enabling actions for reducing harmful use of alcohol**, IAS recommends that, as is the case with the Tobacco Use and Unhealthy Diet act enabling actions, this section should refer to **“Strengthening the effective implementation of the global strategy to reduce harmful use of alcohol”**. The specific recommended policy options and interventions outlined in the WHO Global Alcohol Strategy could then be listed in two tables below: the existing “Specific interventions with WHO-CHOICE analysis” table, plus an “Other interventions from WHO Guidance (without WHO-CHOICE analysis)” table. This would put stronger emphasis on the hierarchy of effectiveness of the interventions and would bring the format of the list of policy actions related to alcohol harm in line with other NCD risk factors. **IAS recommends that WHO includes interventions with strong or emerging evidence of effectiveness, such as minimum purchase age laws or minimum pricing policies, in future CHOICE analyses.**

Finally, IAS would like to draw attention to the relationship between **alcohol consumption and unhealthy diet**. Alcoholic beverages make a considerable contribution to calorie intake in many countries. For example, the US Centre for Disease Control estimates that in 2010, the US adult population consumed on average almost 100 calories per day from alcoholic beverages^{xliii}. The UK Royal Society of Public Health has called for mandatory calorie labelling on alcoholic drinks in order to help tackle obesity^{xliiv}. **IAS recommends that WHO explore options for formally linking policy recommendations for these two interacting NCD risk factors.**

For further information please contact Nils Garnes at ngarnes@ias.org.uk

Institute of Alcohol Studies
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ⁱ World Health Organization (2016), Draft Updated Appendix 3 of the WHO Global NCD Action Plan 2012 -2020. Available from: <<http://www.who.int/ncds/governance/discussion-paper-updating-appendix3-25july2016-EN.pdf?ua=1>> [Accessed 16 August 2016].

ⁱⁱ World Health Organization (2013), Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. Available from: <http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf> [Accessed 16 August 2016].

ⁱⁱⁱ World Health Organization (2016), Global status report on alcohol and health 2014. Available from: <http://www.who.int/substance_abuse/publications/global_alcohol_report/en/> [Accessed 16 August 2016].

^{iv} World Health Organization International Agency for Research on Cancer (2012), Consumption of Alcoholic Beverages, *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans Volume 100E*. Available from: <<http://monographs.iarc.fr/ENG/Monographs/vol100E/mono100E-11.pdf>> [Accessed 16 August 2016].

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- ^v World Cancer Research Fund International (2016), Diet, nutrition, physical activity and stomach cancer. Available from: <http://wcrf.org/sites/default/files/Stomach-Cancer-2016-Report.pdf?utm_source=wcrfuk&utm_medium=alcohol%26cancer&utm_campaign=CUPStomach> [Accessed 16 August 2016].
- ^{vi} Connor, J. (2016), Alcohol consumption as a cause of cancer, *Addiction*. doi: 10.1111/add.13477
- ^{vii} Stockwell, T. et al (2016), Do “moderate” drinkers have reduced mortality risk? A systematic review and meta-analysis of alcohol consumption and all-cause mortality, *Journal of Studies on Alcohol and Drugs* 77:2, pp186-98.
- ^{viii} OECD (2015), Tackling Harmful Alcohol Use. Available from: <<http://www.oecd.org/health/tackling-harmful-alcohol-use-9789264181069-en.htm>>. [Accessed 16 August 2016].
- ^{ix} Stockwell, T. et al (2012), Does minimum pricing reduce alcohol consumption? The experience of a Canadian province, *Addiction* 107:5, pp912-20.
- ^x Stockwell, Y. et al (2012), The Raising of Minimum Alcohol Prices in Saskatchewan, Canada: impacts on consumption and implications for public health, *American Journal of Public Health* 102:12, ppe103-110.
- ^{xi} Stockwell, T. et al (2013), Minimum alcohol prices and outlet densities in British Columbia, Canada: Estimated impacts on alcohol-attributable hospital admissions, *American journal of Public Health* 103:11, pp2014-20.
- ^{xii} Zhao, J. et al (2013), The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002-09, *Addiction* 108:6, 1059-69.
- ^{xiii} Holmes, J. et al (2014), Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study, *Lancet* 383, pp1655-64.
- ^{xiv} Meier, P. et al (2016), Estimated effects of different alcohol taxation and price policies on health inequalities: a mathematical modelling study, *PLOS Medicine* 13:2, doi: 0.1371/journal.pmed.1001963.
- ^{xv} Angus, C. et al (2016), Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland. Sheffield: SchARR, University of Sheffield.
- ^{xvi} Ibid.
- ^{xvii} Meier, P. et al (2016), Estimated effects of different alcohol taxation and price policies on health inequalities: a mathematical modelling study, *PLOS Medicine* 13:2, doi: 0.1371/journal.pmed.1001963.
- ^{xviii} WHO (2010) Global strategy to reduce harmful use of alcohol. Available from http://www.who.int/substance_abuse/alcstratenglishfinal.pdf?ua=1 [Accessed 16 August 2016].
- ^{xix} WHO (2011) European action plan to reduce the harmful use of alcohol 2012-2020. Available from http://www.euro.who.int/_data/assets/pdf_file/0008/178163/E96726.pdf?ua=1 [Accessed 16 August 2016].
- ^{xx} OECD (2015), op. cit.
- ^{xxi} Tucker, J. et al (2013), Cross-lagged associations between substance use-related media exposure and alcohol use during middle school, *Journal of Adolescent Health* 53, pp460-4.
- ^{xxii} Tanski, S. et al (2015), Cued recall of alcohol advertising on television and underage drinking behaviour, *JAMA Pediatrics* 169:3, pp264-71.
- ^{xxiii} de Bruijn, A. (2016), European longitudinal study on the relationship between adolescents’ alcohol marketing exposure and alcohol use, *Addiction* doi: 10.1111/add.13455
- ^{xxiv} Morgernstern, M. et al (2014), Favourite alcohol advertisements and binge drinking among adolescents: a cross-cultural cohort study, *Addiction* 109:12, pp2005-15.
- ^{xxv} Hanewinkel, R. et al (2012), Alcohol Consumption in Movies and Adolescent Binge Drinking in 6 European Countries, *Pediatrics* 129:4, doi:10.1542/peds.2011-2809
- ^{xxvi} Brown, K. (2016) Association Between Alcohol Sports Sponsorship and Consumption: A Systematic Review, *Alcohol and Alcoholism*, 1-9 doi: 10.1093/alcal/agw006
- ^{xxvii} OECD (2015), op. cit.
- ^{xxviii} Kypri, K. et al (2011), Effects of restricting pub closing times on night-time assaults in an Australian city, *Addiction* 106:2, pp303-10.
- ^{xxix} Kypri, K. et al (2014), Restrictions in pub closing times and lockouts in Newcastle, Australia five years on, *Drug & Alcohol Review* 33:3, pp323-6.
- ^{xxx} Schofield, T. & Denson, T. (2013), *Alcohol & Alcoholism* 48:2, pp363-9
- ^{xxxi} de Goeij, M.C. et al (2015), The impact of extended closing times of alcohol outlets on alcohol-related injuries in the nightlife areas of Amsterdam: a controlled before-and-after evaluation, *Addiction* 110:6, pp955-64.
- ^{xxxii} Rossow, I. & Norstrom, T. (2012), The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities, *Addiction* 107:3, pp530-7.
- ^{xxxiii} Gmel, G., Holmes, J. & Studer, J. (2015), Are alcohol outlet densities strongly associated with alcohol-related outcomes? A critical review of recent evidence, *Drug & Alcohol Review* 35, pp40-54.
- ^{xxxiv} Zhao et al (2013), op. cit.

^{xxxv} de Vocht, F. et al (2016), Measurable effects of local alcohol licensing policies on population health in England, *Journal of Epidemiology & Community Health* 70, pp231-7.

^{xxxvi} Wagenaar AC, Toomey TL. (2000), 'Alcohol policy: gaps between legislative action and current research', *Contemporary Drug Problems*, 27, pp. 681–733

^{xxxvii} WHO (2010) Global strategy to reduce harmful use of alcohol. Available from http://www.who.int/substance_abuse/alcstratenglishfinal.pdf?ua=1 [Accessed 16 August 2016].

^{xxxviii} WHO (2011) European action plan to reduce the harmful use of alcohol 2012-2020. Available from http://www.euro.who.int/_data/assets/pdf_file/0008/178163/E96726.pdf?ua=1 [Accessed 16 August 2016].

^{xxxix} United Nations, Sustainable Development Goals, <https://sustainabledevelopment.un.org/?menu=1300> accessed 17 August 2016

^{xl} Collin, J, Casswell, S, 'Alcohol and the Sustainable Development Goals', *The Lancet*, vol 387 June 25, 2016

^{xli} *ibid*

^{xlii} Conflict of Interest Coalition Statement of Concern, http://info.babymilkaction.org/sites/info.babymilkaction.org/files/COIC150_0.pdf [accessed 17 August 2016].

^{xliii} Centre for Disease Control, Calories Consumed from Alcoholic Beverages by U.S. Adults 2007-2010 <http://www.cdc.gov/nchs/data/databriefs/db110.pdf>. [Accessed 17 August 2016]

^{xliv} Royal Society of Public Health, Alcohol Calorie Labelling <https://www.rsph.org.uk/our-work/campaigns/alcohol-calorie-labelling-.html> [Accessed 17 August 2016].