"Framework to strengthen implementation of the WHO European Action Plan to Reduce the Harmful Use of Alcohol (EAPA), 2022 – 2025" Public Consultation

March 2022

Comments on the overall document

The Institute of Alcohol Studies (IAS) is generally pleased with and welcomes the focus and recommendations of the draft framework.

We do believe that there should be more of a focus throughout the document on socioeconomic inequalities, and the rights of individuals and communities – not just children – to be protected from alcohol industry activities and have both physical and virtual alcohol-free social spaces.

The 'Vision and values' section should also further emphasise the alcohol-related harm to others and the need to reduce this. Additionally, preventing and reducing alcohol harms in children should be included in either the 'Vision and values' section or elsewhere as a target.

IAS would also encourage the WHO to adopt bolder language in relation to the alcohol industry as well as to avoid using terms such as 'risky' and 'hazardous' drinking and 'severe forms of alcohol use disorder'.

Focus area 1 – Alcohol Pricing

We welcome the actions and tone of Focus area 1. The emphasis on transnational and international collaborations, the sharing of best practice as well as capacity building are very aptly placed and home in on the importance of alcohol pricing.

There are three key proposals that we would like to suggest for Focus area 1 for recommendations for Member States.

Firstly, we suggest that all alcohol pricing policies, not just taxation levels, should be regularly reviewed and linked to inflation adjustment measures. For example, in Scotland, which introduced MUP in 2018 at 50 pence per unit, it is widely recognised that the impact of MUP has been reduced by inflation, with the equivalent MUP in 2021 being 61 pence (1).

Secondly, the suggestion to consider bans on below-cost selling should be removed as there is little evidence for such bans having a significant impact on alcohol harm reduction. Brennan et al. (2014) estimated that below cost selling in England reduced harmful drinkers' mean annual consumption by just 0.08%, around 3 units per year (2).

Thirdly, the focus area should include a recommendation calling for Member States to consider public health objectives in all taxation policies. Furthermore, Member States should also be called to advance health taxes across all unhealthy commodities, especially as they are complementary towards reducing the burden of noncommunicable diseases.

Additionally, we would also recommend an additional action for the WHO Regional Office for Europe. The Regional Office should convene all the major international organisations in the Region – including, World Trade Organisation, OECD, International Monetary Fund and so on – to discuss better taxation and interregional collaboration on this.

(1) Alcohol Focus Scotland (2021) AFS calls for 65p minimum unit price for alcohol: https://www.alcohol-focus-scotland.org.uk/news/afs-calls-for-65p-minimum-unit-price-for-alcohol/.
(2) Brennan, A. et al. (2014) Potential benefits of minimum unit pricing for alcohol versus a ban on below cost selling in England 2014: modelling study. *The BMJ*, 349.

Focus area 2 – Alcohol Availability

We welcome this section as controlling the temporal and physical availability of alcohol is one of the 'Best Buys' but one which is often particularly challenging for Member States to address. As is recognised, there are diverse approaches within the European region including of state-owned monopolies and licensing systems. We strongly support WHO Europe taking on a more proactive role in sharing experiences and learning across Member States and helping to identify best practice in controlling availability. We consider it would be helpful for WHO Europe to develop tools for Members States to help them utilise the evidence base and consider the questions they should consider in developing or improving national systems to control availability.

We would like to see stronger recognition in this section of the links between deprivation, alcohol outlet density and alcohol harms. Research by Alcohol Focus Scotland and the Centre for Research on Environment, Society and Health (CRESH) found that neighbourhoods in Scotland with the highest alcohol outlet availability had significantly higher rates of alcohol-related health harm and crime. (1) Alcohol-related death rates and hospitalisation rates in neighbourhoods with the most alcohol outlets were double those in neighbourhoods with the least. Crime rates were more than four times higher in neighbourhoods with the most alcohol outlets as compared to the least. In addition, there were 40% more alcohol outlets in the most deprived neighbourhoods than in the least deprived neighbourhoods.

We would like to see the recommendation on licensing systems expanded to recognise that not only should there be "the ability to refuse to grant licences where it can reasonably be assessed that their provision will impact negatively on public health and social functioning", but that the any licensing system should include an active requirement to assess the impact of licensing polices and decisions on public health. In Scotland, there are five licensing objectives, one of which is "protecting and improving public health". This requires local licensing boards to consider the impact on public health in each decision they make. In addition, a requirement on the boards to assess overprovision in their area provides an opportunity to establish a presumption against granting any additional licences of a particular type in a particular locality.

Local licensing decisions can have profound impacts on local communities. We would like to see inclusion of a recommendation to Member States that communities should be actively involved in shaping these decisions and they should develop robust mechanisms and processes to enable this to happen.

We would also suggest the inclusion of a recommendation to Members States that they consider requiring licence-holders to provide data on their alcohol sales to the national public health agency and to their local licensing body. Requiring licence-holders to provide this information to their licensing board as a condition of their licence would significantly enhance local licensing policy development and decision-making. It would provide licensing boards with a much clearer and more accurate picture of the availability of alcohol in their area and the impact of different types of premises. The data would also be invaluable at national level to enable the government to review and improve the effectiveness of the current licensing system. Most licensees already routinely collect data on their alcohol sales through their tills, for their own stock control purposes so this would require limited additional work.

We welcome the recommendation that WHO Europe facilitates consideration of how to deal with the emerging issues of online sales which challenges existing geographically-based licensing systems and on-demand deliveries which raise particular risks around supply of alcohol to those under-age or in an intoxicated state. Both of these issues can usefully be considered across the European region.

(1) Alcohol Focus Scotland and Centre for Research on Environment, Society and Health (CRESH) at the Universities of Glasgow and Edinburgh (2018), Alcohol Outlet Availability and Harm in Scotland: https://www.alcohol-focus-scotland.org.uk/media/310762/alcohol-outlet-availability-and-harm-in-scotland.pdf.

Focus area 3 – Alcohol Marketing

The section on alcohol marketing is very much welcomed. It would be helpful to explicitly reiterate the WHO recommendation for a complete ban on alcohol marketing and the reasons why such an approach is proposed, i.e.:

- to protect young people from exposure;
- to protect those with (or at risk of) an alcohol problem from exposure; and
- to prevent industry influence on social norms around alcohol consumption.

Framing alcohol marketing as a human right issue is important, not just in relation to children and young people but also for those with (or at risk of) an alcohol problem, and for the general population. We believe this should be stated upfront.

The alcohol industry and their marketers are highly sophisticated and innovative in utilising a range of channels and activities to reach their audience and in identifying and exploiting new opportunities to market their products. Digital marketing has clearly become a growth area and poses new challenges. It enables the targeting of the most vulnerable, including those with existing alcohol problems who are a significant source of revenue for the alcohol

industry. In England, 78% of alcohol is consumed by the heaviest drinking 4% of the population accounting for almost a quarter of all revenues. (1) WHO Europe has done excellent work in increasing understanding of digital marketing and the challenges it poses. While Member States may be able to take action on digital marketing, a transnational approach is likely to be most effective.

However, it is also important for Member States to act on other forms of marketing, including in physical spaces. Children we have worked with have spoken about shops being one of the places they see alcohol the most. This is in keeping with research from New Zealand which identified that nine in ten 11-13 year olds making trips to supermarkets were exposed to alcohol marketing, with 87% of all trips resulting in exposure. (2) Similarly, people in recovery from alcohol problems tell us that the way alcohol is sold makes them feel excluded from everyday life; some of them have felt the need to adopt strategies to avoid certain places or shops to reduce the chances of being triggered to buy alcohol.

Other innovative marketing approaches which the industry has adopted to circumvent marketing regulation in some European countries are the use of brand sharing where non-alcoholic products and services are used to promote a brand, and alibi marketing where a brand's name or logo is replaced with key, identifiable components of the brand identity. Brand sharing may be for a completely unrelated product, even an airline, but increasingly frequently we are seeing low or no alcohol versions of alcohol products being heavily marketed. In doing so they are inevitably also marketing the alcohol product, which represents most of the brand's sales. Alibi marketing has been seen in regulated markets, for example the use of catchphrases and brand colours/fonts in sponsorship of international sporting events in France and Ireland. Given the clear association of the brand and its elements with alcohol products, it is important that any statutory regulation covers brand sharing and alibi marketing. We would suggest this is made explicit in the recommendations.

There is clear evidence from Scotland that self-regulation is ineffective in protecting children and young people from exposure to alcohol marketing. Primary school children in Scotland described alcohol as being highly visible, including in the home, in the community, on the streets, in shops, on public transport, at sports games and at festivals. (3) Experience from the UK and from other European countries also shows that the alcohol industry often seeks to oppose statutory regulation. One of the most recent examples of this has being the extensive industry lobbying in Ireland against aspects of the Public Health (Alcohol) Act 2019). Industry also continues seek to undermine and circumvent legislation where it is put in place, for example, seeking amendments to loosen the restrictions under the loi Evin in France. It would be helpful to explicitly recognise the conflict of interest in the industry playing any part in designing or enforcing alcohol marketing controls and therefore the need to exclude them from playing a role in policymaking or enforcement.

We would also recommend putting bullet 4 of the Recommendations for Member States upfront.

(1) Bhattacharya, A. et al (2018). How dependent is the alcohol industry on heavy drinking in England?. *Addiction*, *113*(12), 2225-2232.

(2) Chambers, T. et al. (2017). Children's exposure to alcohol marketing within supermarkets: an objective analysis using GPS technology and wearable cameras. *Health & Place*, *46*, 274-280.
(3) Children's Parliament (2019). *"It's all around you, all the time." Children's Parliament investigates: an alcohol-free childhood*. Glasgow: Alcohol Focus Scotland.

Focus area 4 — Health Information

We welcome the general focus of this section: It is hugely important for statutory labelling requirements to set out alcohol label content and design, and this is reflected very well in this document. There are, however, four key changes we would suggest to the framework document.

Firstly, the recommendation for Member States to 'self-regulate if easier in their context' should be removed (Bullet 3, page 18). The WHO's recommendations should be evidence-based and guided by best practice: yet there is wide evidence that including the industry — alcohol, tobacco or any other — in developing public health policies leads to watered down measures (1). The WHO's own *Health Evidence Network Synthesis Report 68* reports that "[…] practices have been hindered by slow procedures in some parts of the Region, opposition from international institutions and the alcohol industry, and the lack of set labelling specifications and monitoring activities." (2) While we understand that the WHO wants to leave room for Member States to fit alcohol labelling policies to their own contexts, it is unhelpful for the WHO to endorse this approach. This is particularly so as there is a danger that including a recommendation on potential self-regulation could give cause for Member States to hold back from moving away from self-regulation systems and advancing towards statutory labelling requirements – and provide a basis for industry to lobby them to this effect. At the very least, the suggestion for public health agencies to engage with the alcohol industry should be removed, as this can lead to watered down measurements beyond alcohol labelling.

Secondly, the language throughout Focus area 4 is very strongly based on the principle of individual consumer choice. While consumer rights and informing consumers is definitely an advantageous framing for getting alcohol labelling on the political agenda, we believe that the framework should still be mindful how such a framing also advances the narrative of individual responsibility, and how damaging this can be for advancing alcohol harm reduction measures, particularly whole-population interventions (3). Thus, we believe that the tone of language should be replaced from "enable them to make informed choices" to "enable them to understand the risks of alcohol consumption", throughout the document. We do however support the recommendation for Member States to consider advancing the core principle of a 'Right to Know'.

Thirdly, we believe it is important for the framework to cement that health warnings should be a standard component on labelling, not a separate add-on. As the draft document mentions, the provision of this information is complementary to an overall policy approach to reduce alcohol-attributable harms. However, it is also important to note that labelling

and health warnings are complementary to each other. We thus suggest strengthening the language within the text and the recommendations to reflect that labelling and health warnings should be introduced together and not separated.

Lastly, we would suggest that the background and recommendations should also highlight the importance of delivering mass media campaigns as a means of raising awareness on alcohol-related harms. There is extensive evidence on this, with Young et al. (2018) finding that mass media campaigns on alcohol have "achieved changes in knowledge, attitudes and beliefs". (4)

(1) Moodie, R. et al. (2013) Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *The Lancet, 381 (9867), 670-679.*
(2) WHO (2020) WHO Health Evidence Network Synthesis Report 68: What is the current alcohol labelling practice in the WHO European Region and what are barriers and facilitators to development and implementation of alcohol labelling policy?.
(3) Hawkins, B. and Holden, C. (2013) Framing the alcohol policy debate: industry actors and the regulation of the UK beverage alcohol market. Critical Policy Studies, 7 (1), 53-71.
(4) Young, B. et al. (2018) Effectiveness of Mass Media Campaigns to Reduce Alcohol Consumption and Harm: A Systematic Review. *Alcohol and Alcoholism,* 53(3), 301-316.

Focus area 5 – Health Service response

We are overall pleased with Focus area 5. We especially welcome the recognition of the need for a holistic approach and placing those with lived experiences at the heart of this. We would urge this focus to be strengthened by including a recommendation that individuals with lived experience be included in the development and implementation of health service frameworks and programmes, as well as within alcohol-related policy making.

We also welcome the recognition of the value of screening as a preventative measure in primary care settings, as well as the acknowledgement of the value of brief intervention programmes in primary care. However, we believe that Alcohol Brief Interventions should be listed as the first and main recommendation for Member States, and that other treatment alternatives should be listed after this. We would also recommend considering including specific examples in the recommendation on ABIs, instead of simply stating 'expansion into other contexts'. Examples of other contexts, such as emergency and antenatal services should also be listed.

We additionally welcome the inclusion of the fact that alcohol problems are often intersecting, and the acknowledgement that people with alcohol-related problems also commonly experience other health-related issues such as mental health issues. We often see that individuals with co-occurring alcohol and mental health issues fall between the gaps of services and would urge the inclusion of a recommendation for a more joined up approach between services, including through communication and referrals.

Furthermore, there are four additional recommendations we believe should be introduced.

Firstly, stigma as a barrier to service access must be reflected in the framework and recommendations. The framework should make clear in the background section on Focus area 5 that stigma – from both service providers and users – is a major factor preventing many individuals from accessing alcohol treatment services, specifically minority groups such as ethnic minorities and the LGBTQ+ community. Recommendations should reflect the acknowledgement of this barrier to treatment through the inclusion of a recommendation to reduce stigma through adequate training of service providers and signposting that alcohol services are inclusive. We strongly recommend the inclusion of both background information and recommendations on the fact that there is a lack of knowledge about the health risks from alcohol consumption among healthcare professionals, and that training can help to address this.

Secondly, while the framework discusses financial pressures caused by alcohol-related harm, it does not reference the fact that alcohol-related interventions are often under-funded and funded on a short-term basis, which makes forward-planning and long-term goals impossible. The Recommendation for Member States should highlight this and suggest the use of levies, taxes and duties as a way to combat this.

Thirdly, it is important for the framework to recognise the influential role that national medical associations and medical schools have, particularly regarding how opportunities to raise awareness of alcohol-related health harms and reduce stigma can be found within these organisations.

Lastly, we would strongly believe that the framework should recognise the needs of children who come from households experiencing alcohol-related harms and reference the role of the health service response in addressing these needs.

Focus area 6 – Community action

We welcome the contents of Focus area 6, especially the recognition of the individual, family and wider community level harms that alcohol consumption can cause. We also welcome the recognition that stigma is a significant barrier for some individuals in seeking help, and that working within communities to reduce alcohol harms can help to reduce stigma as well.

There are five changes that would benefit this section, however.

Firstly, we believe that this Focus area needs to be more strongly concentrated on prevention and preventative strategies towards alcohol harms, as opposed to treatment and services. We would encourage the framework to include the benefits of preventative measures in its background section – including examples in a community setting – and also reflection of this in the recommendations.

Secondly, while we are pleased to see the recognition of the value of lived experiences in informing strategies to tackle the harm caused by alcohol problems, then similarly to Focus area 5, we believe this should be reflected in the recommendations to Member States, through calling for individuals with lived experience to be included in the development and implementation of any legislation/frameworks/strategies which affect communities.

Thirdly, it would be beneficial to the framework and its implementation to acknowledge that community action is an opportunity to address the whole continuum of alcohol harm, and that communities are relevant to all focus areas.

Furthermore, the framework should emphasise that solutions to tackle alcohol-related harm can exist outside or alongside the healthcare system, and that community action for recovery must be funded to reflect this. The framework should include this in its recommendations, alongside the encouragement of communities having decision making power over how funding should be distributed in a way that benefits their specific community best. All communities are different and will benefit from funding in different ways. It is vital that individual communities are given a voice in this in order to see the biggest benefits.

Lastly, we believe that the background section of this focus area should include evidence of the existence and effectiveness of school-based community interventions. We also recommend that it is explicitly stated in the recommendations that industry should not be involved in school or community projects to avoid a conflict of interest.