

**MRC/CSO Social and Public Health Sciences Unit Consultation Response**

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| **Title of consultation** |
| Web-based consultation on the implementation of the WHO global strategy to reduce the harmful use of alcohol since its endorsement, and the way forward |
| **Name of the consulting body** |
| World Health Organization (WHO) |
| **Link to consultation** |
| <https://www.who.int/health-topics/alcohol/online-consultation> |
| **Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this** **consultation?** |
| The MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow conducts world-leading research to understand the determinants of population health and health inequalities, and to develop and test interventions to improve health and reduce inequalities. The Unit is currently working on a Minimum Unit Pricing of Alcohol in Scotland study. |
| **Our consultation response** |
| **1) What, in your organization’s view, have been the most important achievements, challenges and setbacks in implementation of the WHO global strategy to reduce the harmful use of alcohol since 2010?** \*  **Achievements**  Section three of the report essentially tells us that the global alcohol strategy developed by WHO in 2010 has been implemented by informing the development of regional strategies and action plans.  Although it is to be welcomed that binge drinking is reducing in all WHO regions and alcohol- related mortality and morbidity are reducing in some, evaluation is warranted to establish the contribution of WHO policies to these trends.  It is good news that more countries have implemented evidence-based alcohol policies, with some countries reporting progress in reducing the availability and restricting the marketing of alcohol, and increasing alcohol duty. It is also encouraging that more countries have drink-driving policies,1 and that more than half of responding countries have expanded access to alcohol screening and brief intervention (albeit mostly higher income countries).  Less positively, the three WHO best buy interventions (tax increases, marketing restriction and restricting availability) show the least progress. This is doubly unfortunate as these are the policies most likely to reduce health inequalities since they do not rely on individual agency (i.e. do not require people to take up an intervention).2 3 Reducing health inequalities is particularly salient for alcohol given the systematically elevated levels of harm among individuals in lower  socioeconomic groups.4 |

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| **Challenges**  While an important step in the implementation process, the development of more localised strategies and plans alone will not bring about the magnitude of reduction in alcohol-related harms needed. In addition, such development has been the case only in some countries. True implementation must mean delivering evidence-based intervention that connects with the problem on the ground in an attempt to improve health outcomes. An essential feature of good implementation is the gathering of data to monitor the effectiveness of the implementation as well as the efficacy of the intervention itself. For interventions whose effectiveness is still uncertain, whether universally or locally, there is a need to attempt to determine effectiveness through studying outcomes, ideally in comparison with a control group, for example using a natural experiment design where possible.5-7 Withdrawal of policies and other interventions may also provide an opportunity to learn more about the effectiveness of different potential solutions. Once effectiveness is established, implementation monitoring can focus on either outcomes or ensuring the implementation process is correct and complete.  There is the further challenge of maintaining the effectiveness of policies. For example, there is a need for inflation linking alcohol taxes and tailoring them to improve public health rather than to raise revenue, ensuring marketing policies are not unduly influenced by industry interests, and ceasing investment in ineffective interventions such as those simply providing information.  The alcohol problem is complex, with a wide variety of interest groups, and manifold harms managed by multiple agencies. The global dimension adds to that complexity, which is a challenge for the development of consensus policies.  Alcohol consumption is influenced by social norms and cultural traditions, which may downplay the importance of alcohol’s harmful effects. This is a vulnerability, which can be exploited by the globalised alcohol production and sales industry, adept at legal and marketing challenges to local alcohol controls.  **Setbacks**  Unfortunately, there has been a lack of progress in reducing the per capita alcohol consumption globally, but there has been progress on this front in Europe. That suggests that alcohol strategies and action plans may be having an effect in Europe although other factors may be at play e.g. the 2007-08 recession. It also suggests the policies are not being equally well implemented worldwide, a situation likely to further exacerbate global health inequalities, and so running counter to the declared aims of the WHO.  **2) What, in your organization’s view, should be priority areas for future actions to reduce the harmful use of alcohol and strengthen implementation of the global strategy to reduce the harmful use of alcohol? \***  **Reducing harmful use**  A fundamental barrier to addressing alcohol-related harms has been the lobbying and related activities of alcohol-related industries. There is a large body of evidence demonstrating the adverse influence of alcohol-related industries on public health policy, with industry collaborations generally resulting in the implementation of ineffective interventions, while their diminished involvement has been found to facilitate the adoption of more effective policy.8-11 There should therefore be urgent consideration given to restricting or preferably entirely precluding their involvement in public health policymaking.12-15 The precedent of Article 5.3 of the Framework Convention on Tobacco Control illustrates how impactful this can be. WHO is uniquely positioned to take a leadership role in how best to implement a similar measure for alcohol control policy.  We support the proposal for a global impost (tax) on alcohol. There is no reason why taxation and |

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| Minimum Unit Pricing (MUP) should not work together. The prevention of tax avoidance and evasion by the global alcohol industry would be a priority.  **Strengthening the implementation of the global strategy to reduce harmful use**  If lack of resources is an issue preventing true implementation (as defined above), WHO could helpfully develop tools to aid resource access for strategy implementation at local level. That could include fund raising measures such as alcohol taxation. The funds raised could be hypothecated for further action in controlling alcohol marketing and influence on alcohol policy by the global alcohol industry and for controlling access to alcohol locally. We suggest linking taxation levels to the reported levels of alcohol-related harm on an ongoing basis as an incentive to the alcohol industry to reduce harm.  Convincing economic and political analysis showing whether there are economic and political benefits of increasing alcohol taxation in addition to MUP could be developed and made available to public health and related professionals in all countries.  The WHO strategy promotes MUP, and there is clear evidence of the relationship between the consumption of alcohol and its price, but MUP has not yet been fully evaluated in the real world. Scotland is in the process of doing an evaluation16-19 but it will be some years before a final picture is revealed. Some formative lessons from carrying out the Scottish evaluation in this area include the crucial importance of adequate preparation so that the evaluation, especially the gathering of baseline data, is not rushed. To facilitate evaluation it is important to embed it in policy delivery. Data improvements would greatly facilitate agile evaluation by making relevant time series data routinely available. For these reasons, we support the data improvements WHO specifies, such as the inclusion of alcohol modules in data collection tools used in population- based surveillance activities. That would ensure the availability of time series of data on alcohol consumption in populations and vulnerable population groups such as adolescents, women of childbearing age and people suffering from different health conditions. We think these alcohol modules should be as standardised as possible to facilitate international comparisons. Given the persistent decline in participation levels in national surveys, robust statistical correction procedures, which improve comparability over time and place, should be applied.20-22  **3) Any additional comments?**  typo: p14 line 3 of text  'Effective monitoring of total per capital alcohol consumption' should this read 'per capita'?  **Additional information**  **1) Attachment**  Please attach any files that would complement your submission None.  **References**   1. Haghpanahan H, Lewsey J, Mackay DF, et al. An evaluation of the effects of lowering blood alcohol concentration limits for drivers on the rates of road traffic accidents and alcohol consumption: a natural experiment. *The* *Lancet* 2019;393(10169):321-29. doi: 10.1016/S0140-6736(18)32850-2 2. Katikireddi SV, Higgins M, Smith KE, et al. Health inequalities: the need to move beyond bad behaviours. *Journal of* *Epidemiology and Community Health* 2013;67(9):715-16. doi: 10.1136/jech-2012-202064 3. Macintyre S. Inequalities in health in Scotland: what are they and what can we do about them? MRC Social and Public Health Sciences Unit Occasional Papers. Glasgow: MRC Social and Public Health Sciences Unit, 2007. 4. Katikireddi SV, Whitley E, Lewsey J, et al. Socioeconomic status as an effect modifier of alcohol consumption and harm: analysis of linked cohort data. *The Lancet Public Health* 2017;2(6):e267-e76. doi: 10.1016/S2468- 2667(17)30078-6 5. Craig P, Cooper C, Gunnell D, et al. Using natural experiments to evaluate population health interventions: new Medical Research Council guidance. *JECH* 2012;66:1182-6. doi: 10.1136/jech-2011-200375 |

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| 1. Craig P, Gibson M, Campbell M, et al. Making the most of natural experiments: What can studies of the withdrawal of public health interventions offer? *Preventive Medicine* 2018;108:17-22. doi: <https://doi.org/10.1016/j.ypmed.2017.12.025> 2. Craig P, Katikireddi SV, Leyland AH, et al. Natural experiments: An overview of methods, approaches and contribution to public health intervention research. *Annual Review of Public Health* 2017;38(1):39-56. 3. Moodie R, Stuckler D, Monteiro C, et al. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. *The Lancet* 2013;381(9867):670-79. doi: 10.1016/S0140- 6736(12)62089-3 4. Petticrew M, Katikireddi SV, Knai C, et al. ‘Nothing can be done until everything is done’: the use of complexity arguments by food, beverage, alcohol and gambling industries. *Journal of Epidemiology and Community Health* 2017;71(11):1078-83. doi: 10.1136/jech-2017-209710 5. Stuckler D, McKee M, Ebrahim S, et al. Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco. *PLOS Medicine* 2012;9(6):e1001235. doi: 10.1371/journal.pmed.1001235 6. Katikireddi SV, Bond L, Hilton S. Changing Policy Framing as a Deliberate Strategy for Public Health Advocacy: A Qualitative Policy Case Study of Minimum Unit Pricing of Alcohol. *Milbank Quarterly* 2014;92(2):250-83. 7. Bryden A, Petticrew M, Mays N, et al. Voluntary agreements between government and business - a scoping review of the literature with specific reference to the Public Health Responsibility Deal. *Health policy (Amsterdam, Netherlands)* 2013;110(2-3):186-97. doi: 10.1016/j.healthpol.2013.02.009 [published Online First: 2013/03/20] 8. Knai C, Petticrew M, Durand MA, et al. The Public Health Responsibility deal: has a public-private partnership brought about action on alcohol reduction? *Addiction* 2015;110(8):1217-25. doi: 10.1111/add.12892 [published Online First: 2015/03/27] 9. McCambridge J, Hawkins B, Holden C. Industry Use of Evidence to Influence Alcohol Policy: A Case Study of Submissions to the 2008 Scottish Government Consultation. *PLoS Medicine* 2013;10(4):e1001431. doi: 10.1371/journal.pmed.1001431 10. McCambridge J, Mialon M, Hawkins B. Alcohol industry involvement in policymaking: a systematic review. *Addiction*   2018 doi: 10.1111/add.14216 [published Online First: 2018/03/16]   1. Beeston C, Robinson M, Craig N, et al. Monitoring and Evaluating Scotland’s Alcohol Strategy. Setting the Scene: Theory of change and baseline picture. Edinburgh: NHS health Scotland, 2011. 2. NHS Health Scotland. Monitoring and Evaluating Scotland’s Alcohol Strategy (MESAS): Briefing paper. December 2009 Glasgow, 2009. 3. NHS Health Scotland. Evaluation of minimum unit pricing Edinburgh2017 [Available from: [http://www.healthscotland.scot/health-topics/alcohol/evaluation-of-minimum-unit-pricing/mup-evaluation- overview](http://www.healthscotland.scot/health-topics/alcohol/evaluation-of-minimum-unit-pricing/mup-evaluation-overview) accessed 15/11/2018. 4. O’Donnell A, Anderson P, Jané-Llopis E, et al. Immediate impact of minimum unit pricing on alcohol purchases in Scotland: controlled interrupted time series analysis for 2015-18. *BMJ* 2019;366:l5274. doi: 10.1136/bmj.l5274 5. Gorman E, Leyland AH, McCartney G, et al. Adjustment for survey non-representativeness using record-linkage: refined estimates of alcohol consumption by deprivation in Scotland. *Addiction* 2017;112(7):1270-80. doi: 10.1111/add.13797 [published Online First: 2017/03/10] 6. Gray L. The importance of post hoc approaches for overcoming non-response and attrition bias in population- sampled studies. *Social Psychiatry and Psychiatric Epidemiology* 2016;51(1):155-57. doi: 10.1007/s00127- 015-1153-8 7. Gray L, Gorman E, White IR, et al. Correcting for non-participation bias in health surveys using record-linkage, synthetic observations and pattern mixture modelling. *Statistical Methods in Medical Research* 2019;0(0):15. doi: 10.1177/0962280219854482 |
| **When was the response submitted?** |
| 4th November 2019 |
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