Alcohol and Global Health 3

Reducing harm from alcohol: call to action

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Despite clear evidence of the major contribution alcohol makes to the global burden of disease and to substantial economic costs, focus on alcohol control is inadequate internationally and in most countries. Expansion of industrial production and marketing of alcohol is driving alcohol use to rise, both in emerging markets and in young people in mature alcohol markets. Cost-effective and affordable interventions to restrict harm exist, and are in urgent need of scaling up. Most countries do not have adequate policies in place. Factors impeding progress include a failure of political will, unhelpful participation of the alcohol industry in the policy process, and increasing difficulty in free-trade environments to respond adequately at a national level. An effective national and international response will need not only governments, but also non-governmental organisations to support and hold government agencies to account. International health policy, in the form of a Framework Convention on Alcohol Control, is needed to counterbalance the global conditions promoting alcohol-related harm and to support and encourage national action.

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This is the third in a **Series** of three papers about alcohol and global health

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Alcohol: a global priority for action

The first report in this Series showed that consumption of alcohol contributes greatly to the burden of disease. Alcohol has an important effect on mental health and injury, overall accounting for 4·6% of the global burden of disease and injury in 2004.[1]

Present estimates of health effects probably underestimate the harm caused by alcohol, because the full range of social costs are under-researched.[2] Estimates of economic costs associated with alcohol, which include measures of lost productivity and criminal justice costs, show that more than 1% of gross domestic product (GDP) purchasing power parity in high-income and middle-income countries is attributable to alcohol consumption. A further gap, in which more research is needed, is measurement of externalities—eg, the effect of alcohol on the drinker's associates and family, and on victims of violence and traffic injury. Similar to passive smoking, these effects are relevant in debates about the public and political acceptability of effective alcohol policy.[3]

Alcohol is a determinant of health that contributes to health inequalities. Prevalence of drinking increases as income rises from very low amounts;[1] however, heavy consumption and harm is associated with lower socioeconomic status and marginalisation.[4–6] Furthermore, heavy alcohol consumption contributes to lowered human capital; emerging economic research suggests a negative effect of drinking on achievement in school and subsequent earnings.[7,8] Household expenditure on alcohol exacerbates poverty, and resources directed to respond to social and health effects of alcohol impair community development.[9,10] Strengthened regulatory controls on health-damaging commodities, such as alcohol, are necessary for achievement of health equity.[11]

Although alcohol has been used for millennia in some parts of the world, the past few decades have seen striking changes in production and use of alcohol. Traditional and indigenous beverages, though still important in some countries, are increasingly commercialised and replaced by industrially produced, branded beverages. Ethanol, the active agent, is delivered in an expanding range of beverage types—branded and unbranded—designed to meet the needs of all parts of the market.

Alcohol producers have been consolidated and globalised, such that the international market is now dominated by a few large corporations with enormous financial resources and sophisticated marketing

Key messages

- Alcohol is a major risk factor for burden of disease, and countries are estimated to spend more than 1% of their gross domestic product (adjusted by purchasing power parity) on economic costs attributable to alcohol.
- Relative to these harms, alcohol is not high on the global health agenda and, unlike tobacco and illicit drugs, no international policy is in place.
- The role of vested interests in subverting development of an effective public health response to alcohol-related harm is similar to that of tobacco.
- Cost-effective interventions exist and are focused on total populations; these interventions control availability, affordability, marketing of alcohol, and driving while under the influence of alcohol.
- Some national governments have implemented effective policy, but in most governments a strengthened response is urgently needed. Implementation needs multisectoral activity driven by national governments, but also including local governments and community-level responses.
- WHO, other international agencies, and the non-governmental organisation sector are showing raised concern and engagement with alcohol harm and alcohol-control policy.
- An international health response to reduce harm from alcohol—a Framework Convention for Alcohol Control—is needed to spur national action and enable collaboration and negotiation on international and regional issues.

techniques. Rationalisation and consolidation of production and distribution has resulted in yearly surpluses (10% or more), providing ample resources to spend on investment in emerging markets.[12] International companies are expanding their investment behind brands[13–16]—increasing advertising, sponsorship, and other forms of marketing that ensure recruitment of a continuing supply of drinkers.[17,18] The industry is a sophisticated user of marketing, and makes good use of new electronic technologies that are of great relevance to young people.[19]

In countries with growing economies and largely unregulated trade environments, increased penetration of alcohol leads to a rise in alcohol-related harm. Brazil, Russia, India, and China are populous countries that have been targeted by global alcohol corporations as emerging alcohol markets.[20,21] The extent to which markets expand will depend on the economic situation and its effect on disposable income. If these economies continue to expand, a change in social and cultural conditions and amplified marketing efforts are likely to lead to a rise in consumption, increasing alcohol-related harm worldwide (panel 1).

Effective regulatory controls exist, as outlined in this Series.[29] The challenge is to identify the core cost-effective steps needed to reduce alcohol-related harm, and to identify national and international efforts that will ensure their implementation. This last report in the Series identifies the key players in the policy arena, and calls for a sustained effort internationally, nationally, and locally to prevent and control alcohol-related harm.

Panel 1: Alcohol market expansion in low-income and middle-income countries

Thailand is an example of a country with a rapid rise in alcohol consumption and alcohol-related harm. Historically, alcohol use by Thai people, many of them practising Buddhists, was low. However, increasing gross domestic product, in the context of an unregulated alcohol-policy environment, contributed to a substantial growth in per head consumption—from 0·26 L in 1961 to 8·47 L in 2001.[22]

In the past two decades, government action has smoothed the way for a free market in alcohol. Controls on production were removed, and the government stated that the taxation system should not obstruct growth of the alcohol market.[23] A liberal licensing system (and lack of enforcement of hours-of-sale regulation) ensures easy access to alcohol—the average Thai drinker takes 7·5 min to obtain their beverages.[22] Between 1989 and 2003, alcohol promotion in the broadcast media grew seven-fold,[24] and regulations, introduced in 2003, are circumvented by the alcohol industry.[25]

Estimates from surveys show that a third of the population are now drinkers, and a rise in rates of drinking in young women is especially pronounced.[21,22] Prevalence of alcohol-use disorder in Thai drinkers, screened by AUDIT (alcohol use disorders identification test), was 22·7% in 2007.[26] Furthermore, risk of psychological disorders in children of alcohol-dependent parents is heightened, and risk of family violence is 3·84 times higher in families with one or more drinkers.[27]

Estimates of burden of disease in Thailand, with use of the WHO method, show that alcohol is the second most significant health risk, with 8·1% of overall disability-adjusted life-years attributed to alcohol consumption in 2004.[28] Increases in mortality from liver disease and from traffic accident morbidity and mortality correspond with the heightened consumption.[22]

A global marketplace

Global, regional, and national policies to accelerate free trade in goods, services, and financial investments are enabling the expansion of alcohol corporations in emerging markets, contributing to increased availability, affordability, and marketing of alcohol.[13] Trade agreements, structural adjustment programmes, and World Trade Organization (WTO) dispute settlements have often failed to recognise alcohol as a health-damaging commodity. The effects of trade agreements are felt nationally and locally, because alcohol policy has to meet conditions of the treaties by allowing equal access to foreign imports. Potentially, advertising and distribution restrictions on imports could also be affected, should they be regarded as non-tariff barriers to trade and competition.[21, 30–32] Negotiations have occurred outside the formal policy process; in Thailand, a newspaper reported that a group of foreign operators had threatened that the Thai Government would be taken to the WTO if a proposed ban on alcohol advertising were to come into force.[33]

Alcohol policy has been safeguarded from the effect of trade agreements in other situations. France's alcohol policy law, *Loi Evin*, which restricts alcohol advertising, was challenged by the European Commission and the UK. However, the European Court decided that the law was justified on the grounds that it protected health and was an effective strategy.[32] Similarly, after a challenge to Sweden's regulations on alcohol advertising, Sweden was able to retain most of its restrictions by rewriting the legislation to state clearly that the policy was necessary to achieve public health goals.[34] Some trade agreements have excluded alcohol (and tobacco) from their scope of concern, at least temporarily, which is the best response from a public health perspective.[35]

Attention to trade treaties is an important part of policy development for alcohol control,[36,37] because membership of the WTO, and involvement with regional, multilateral, and bilateral trade agreements, directly and indirectly affects the success of alcohol policies.[32] However, little effective participation from the health sector has occurred. A trade study, initiated in 1983 by WHO, was brought to an unscheduled end.[38] Despite a joint study by

WHO and WTO in 2002 into public health and WTO agreements,[39] no formal mechanisms exist by which public health interests are represented in the development of trade agreements.[32]

Alcohol producers

Alcohol producers are well organised and effective lobbyists for industry-friendly policies both internationally and nationally. Representatives of the global alcohol industry, especially the distilled spirits sector, were strong supporters of trade treaties that expanded their access to rapidly emerging markets.[40] The World Spirits Alliance lobbied for the General Agreement on Trade in Services (GATS), seeking liberalisation or elimination of barriers to tariffs and non-tariffs, including all restrictions on distribution and advertising.[34] Industry also lobbies directly at the national level; in 2007, alcohol interests in California, USA, spent US$3 million on lobbying, and $3·5 million on political donations.[41] The tobacco experience in the USA suggests that this amount of funding would buy much support.[42]

A major focus of industry lobbying is to campaign against effective strategies and for ineffective strategies—examples in which this lobbying has been successful are documented. For example, in Brazil, at a time when the government was reviewing the law on advertisement of alcohol products, the largest brewer (AmBev) initiated a publicity campaign against driving while under the influence of alcohol, a partnership with taxi drivers, and an educational programme against drinking by minors—none of which has evidence for effectiveness.[43] Both Diageo[44] and SABMiller[45] fund responsible drinking campaigns aimed at teenagers, and have established partnerships on drink-driving with government and non-government agencies in emerging markets. Research suggests that responsible drinking messages are strategically ambiguous. Although these messages seem to be prohealth, they serve to advance both industry sales and public-relations interests.[46]

Public-relations interests are also met by an increased focus on corporate activities, such as disaster relief and support for global governance activity. At the 2005 G8 summit on international trade, world poverty, and climate change, Diageo paid £125 000 to be an official sponsor. The summit was held at a Diageo-owned hotel in Scotland, and Diageo donated the profits from the bar and a corporate donation to water projects in Uganda.[47] Analysis of internal company documents have shown how the philanthropy undertaken by Phillip Morris to improve its image in the 21st century included payment of dividends and influence on public officials.[48]

An indication of the organisation of the industry is their network of more than 30 social aspects organisations (SAOs)—industry-funded groups that were established to manage issues detrimental to the industry's interests.[49,50] One of the earliest of these organisations to be established was the Portman Group in the UK, who have been an active player in the alcohol policy arena. For example, after meetings with the Portman Group, the UK Government reneged on a proposal to lower the limit of alcohol concentration in the blood for driving to 0·05%, which would have brought the limit in line with Europe.[51]

SAOs have also been established in countries with emerging alcohol markets, and have taken an active role in shaping alcohol policy, with results that are regarded as industry-friendly and unsupportive of public health.[52] A draft alcohol policy presented to government agencies in some African countries in 2007 and 2008, did not adequately cover effective policy and advocated self-regulation of alcohol marketing.[53] Country visits promoting this draft alcohol policy were funded by SABMiller and facilitated by a senior consultant from the global SAO—the International Council on Alcohol Policy (ICAP)—operating from Washington, DC, and funded by the ten largest alcohol corporations.

ICAP was established in 1995, and has promoted industry interests in a relative absence of international public health activity. ICAP's activities are similar to those of organisations representing other globalised industries[54]—including participation in scientific and policy agendas; and support for research, publications, and conferences. A major ICAP focus is on the development of working partnerships with alcohol research and public health.[49] ICAP's position is that the industry has a part to play in developing alcohol policies in emerging markets.[55] In 2006 and 2007, three regional meetings promoting voluntary codes in advertising were held in key emerging alcohol markets—Asia Pacific (China, Vietnam, Laos, India, and Thailand), Africa, and Latin America. Promotion of voluntary codes and strong arguments against regulation of marketing has been a major focus for ICAP and for the industry in general.[56,57] A clear distinction can be made between the policies promoted in ICAP publications and those that are assessed as effective in non-industry funded reviews.[58,59]

Another industry tactic that has been adopted is to attempt to instil doubt about non-industry research, including WHO's Global Burden of Disease project, by misrepresentation and critique of data and methods[60,61]—a tactic made familiar by the tobacco industry.[62]

Global alcohol corporations have lobbied strongly to be included in the process of development of international health policy; the Global Alcohol Producers Group paid $240 000 to lobbyists to promote their interests at WHO before the 2007 World Health Assembly (WHA).[63] The relation between industry and WHO in recent years has been a matter of much debate,[64,65] but the Expert Committee on Problems Related to Alcohol Consumption, reporting in 2007, recommended that: "WHO continue its practice of no collaboration with the various sectors of the alcohol industry. Any interaction should be confined to discussion of the contribution the alcohol industry can make to the reduction of alcohol-related harm only in the

context of their roles as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion".[66] Subsequently, the successful amendment of a draft resolution,[67] at the 2008 WHA, to downgrade the role of industry to one of consultation rather than collaboration indicated the determination of member states to ensure an appropriate health response to alcohol-related harm.

The organisation and outreach activity of the global alcohol industry suggests they might occupy an unchallenged position, compared with that of the tobacco industry in the years before the Framework Convention Alliance for Tobacco Control (FCTC). However, the scarcity of public health critique is now being addressed.[20,68] There are no signs as yet that alcohol corporations recognise the need to support international and national regulation to protect their own (and societies') interest as is now emerging in response to the need for sustainable development.[69] Therefore, at this stage, argument for participation of commercial interests in the development of alcohol-control policy seems unjustified.

Non-governmental organisation response

A major scaling up of activity both nationally and internationally will need increased resources to enable advocacy from well informed voices that are independent of commercial interests. The tobacco experience shows that investment in the non-governmental organisation (NGO) sector can catalyse and support national action.[70] Development of the FCTC was supported by, and also supportive of, the development of a global network incorporating more than 200 NGOs.[71,72] However, in the alcohol policy arena, NGO engagement is severely constrained by a lack of resources. The $500 million contribution, made in 2008 by Bloomberg Philanthropies and the Bill & Melinda Gates Foundation to address the tobacco epidemic, has not been matched for alcohol—an equally urgent and challenging issue.[73] Nor has alcohol advocacy had the benefit of funding from charitable foundations, such as cancer societies and heart foundations, which have been supportive of antitobacco activity.

A useful national model is a hypothecated tax or levy on alcohol sales, which is used to fund NGO activity. For example, the StopDrink Network in Thailand provides a model of active linkage with all elements of civil society, and has had a proactive role supporting alcohol policy. It has been supported by the Thai Health Promotion Foundation, which is funded by an earmarked tax of 2% on alcohol and tobacco.[74]

Within the past decade, regional and international NGO networks have been established in response to the perceived need for an international response to the active promotion of alcohol. The Global Alcohol Policy Alliance has kindred organisations in regions targeted by the global industry (eg, India and the Asia Pacific region). Their aim is to support development of evidence-based alcohol policy that is free from commercial interests. Other international associations, including the World Medical Association and the American Public Health Association, have called specifically for binding international treaties modelled on the FCTC.[75–78]

WHO

WHO is the policy holder for alcohol within the UN system. However, neither WHO nor other UN agencies with potential interests have paid much attention to alcohol.[65] The financial and human resources allocated to international alcohol-related activities remain very small. For some years, WHO has received funding earmarked for alcohol (and other drug activities) from only two countries—Norway and New Zealand.

However, awareness of the role of alcohol in the global burden of disease has improved through measurement and comparison of alcohol with other risk factors.[79] This comparison, plus raised concern of member states, has facilitated heightened emphasis within WHO. At the WHA 2005, the first specific focus on alcohol since 1983 occurred when a resolution calling for a report on policy effectiveness and assessment of alcohol-related problems (WHA 58.26) was passed. However, the highly contestable nature of the alcohol issue was shown by failure of a 2007 resolution, promoted by 40 member states, to gain endorsement from the Assembly. In 2008, a resolution was adopted,[67] which requested the secretariat to work towards development of a global alcohol strategy.

Regional activity has also strengthened and might have an increasingly important role in the years ahead. The earliest example was in Europe, where, during the 1990s, WHO's regional office led 53 European nations in adoption of strong goals for reduction of alcohol use and associated problems, and many countries in that region subsequently strengthened their alcohol policies. Since then, however, a void in the WHO European office[65] led to the European Commission taking on the role of alcohol-policy holder.

The European Commission, which has its roots in trade, placed priority on a collaborative relationship with alcohol-industry interests, leading to activity that has been judged as largely ineffectual.[68] In other regions that have heavily targeted emerging markets, recent developments have shown a more robust response than has been observed in Europe. In 2006, the western Pacific region and the southeast Asian region, which include the populous and strongly targeted countries of China and India, respectively, adopted evidence-based regional strategies (panel 2).[36,80]

However, within the UN system, alcohol, in striking contrast with both tobacco and illicit drugs, lacks a coherent framework for global control of alcohol-related harm, despite the obvious need and importance relative to these substances.[65,81]

Readiness for action

This Series has shown that the preconditions that facilitated development of a strong global and national response to the tobacco epidemic are also present for alcohol. These preconditions include: evidence for the extent of alcohol-related harm, evidence of cost-effective interventions and countries' experience in implementation; understanding of strategies and tactics used by the industry; and pressure for change from NGOs.[70]

Furthermore, this Series has provided data for the costs associated with implementation of effective interventions;[29] these data show the feasibility of scaling up activity globally. In three culturally and geographically distinct regions of the world, chosen because of their present and potential contribution to the international burden of alcohol-related harm, costs were reported to be within the range of yearly investments regarded as acceptable and comparable with interventions for other disorders.[82] This analysis drew attention to the cost-effectiveness of total population approaches focused on regulation of affordability, availability, marketing, and drink-driving legislation. It showed that the costs involved of less than $1·00 per person per year, and many well below that, are less than the figure of $1·50 per person cited by Beaglehole and colleagues.[82] Even the less cost-effective, individual-focused approach of brief intervention approximated the figure considered acceptable.

The preconditions for action on alcohol, including availability of cost-effective and affordable interventions, are in place. Therefore, taking action on alcohol remains a matter of political will—both nationally and internationally.

Strengthening of national action

Countries vary in the extent to which they implement cost-effective strategies. A WHO global survey of alcohol policy, done in 2002, showed that some of the effective policies—eg, restrictions on place and time of alcohol sale, and age—are in place in most countries that responded.[83] However, in many countries not all key effective policies are in place, and policies with reduced effectiveness (such as classroom education and mass-media campaigns) are more popular than are those policies shown to work.[18] Furthermore, in many countries, failure of implementation happens even when legislation is in place.

National (and local) governments have the task of deciding policy direction in the face of conflicting interests. Their decisions show the dominant ideology and effects of globalisation,[42] but can also be influenced by the availability and dissemination of local data, engagement of all relevant sectors of government in development and implementation of policy, and direction by an authoritative agency or person. The role of NGOs and the media is crucial in placement of alcohol on the public and political agenda and promotion of effective policy responses.[16,84]

Panel 2: Western Pacific regional strategy to reduce alcohol-related harm

In September, 2006, 37 countries of the western Pacific region endorsed a regional strategy to reduce alcohol-related harm. The strategy provides a framework for national action, and, although the health and welfare sector are envisaged to lead it, the key roles of the sectors for education, finance, transportation and traffic, public order, and law enforcement are acknowledged.

Four core areas were laid out in the strategy:

- Reduce risk of harmful alcohol use through measures such as raised awareness and advocacy about alcohol-related harm and regulation of alcohol marketing, including during sponsorship of cultural and sports events
- Keep effects of harmful alcohol use to a minimum through support of the responses of civil society, and enhancement of the capacity of the health and welfare workforce; establish blood-alcohol limits for driving and random breath testing; encourage law-enforcement sector responses to alcohol-related crime and antisocial behaviour
- Regulate accessibility and availability by regulation of production and sales (establish licensing procedures and restrictions by place, time, and age); use taxation to reduce harmful use; take alcohol harm reduction into account when negotiating international trade and economic agreements
- Establish mechanisms to facilitate and sustain implementation of the strategy with data collection and analysis; develop nationally appropriate alcohol policies and establish regional mechanisms to support individual countries

By endorsing the strategy, member states urged countries to use it as a guide to develop and strengthen policies and regulations, and to improve capacity for action. They requested WHO to provide technical support for member states and also to collaborate with member states, international agencies, academics, and civil society to promote evidence-based, multisectoral approaches.

This regional development provides an evidence-based strategy that is a useful basis for the development of a global response.

A stepwise approach to choice of interventions, advocated by WHO for prevention and control of non-communicable diseases, is relevant for alcohol. This approach calls for implementation of effective interventions—core, expanded, and optimum—on the basis of availability of resources, political and community support, and configuration of national health systems.[82] For alcohol, prevalence and pattern of use are also relevant because cost-effectiveness of interventions varies, depending on the penetration of alcohol use in the population.[85]

As reported in this Series, the evidence for mechanisms that affect affordability and availability of alcohol ranks raised alcohol taxes, and restrictions on easy access to alcohol, at the top of a core national policy list, along with drink-driving legislation and regulation of marketing. However, the extent to which these mechanisms are implemented will show the level of political support achievable. Panel 3 lists suggested allocation of evidence-based interventions to core, expanded, and optimum categories, with feasibility of interventions based on resource availability and likely extent of support. Feasibility will, however, vary between countries.

Panel 3: Stepwise approach to the choice of alcohol-control policies

Core

Affordability
- Excise tax graded by volume of ethanol
- Inflation-adjusted taxes

Availability
- Regulation of all production and sale
- Licensing of places for sale and consumption
- Licensing of days and hours of sale
- Minimum purchase age

Regulation of marketing
- Regulation of all marketing, including sponsorship
- Content restricted with no lifestyle advertisements
- Bans on sponsorship
- Placement restricted by volume and media (eg, no electronic media)

Drink-driving
- Blood limit of alcohol concentration established in law
- Sobriety check points

Treatment
- Brief intervention

Expanded

Availability
- Bans on sales and drinking in public places
- Enforced laws on service (to intoxication and to minors)
- Different availability based on volume of alcohol

Regulation of marketing
- No pricing promotions or discounts
- No promotions using competitions or gifts

Drink-driving
- Random breath testing
- Administrative licence suspension

Optimum

Affordability
- Minimum price

Availability
- Mass media campaigns supporting availability policy

Regulation of marketing
- Restrictions on packaging and product design
- Ban advertising of corporate philanthropy
- Ban on all forms of product marketing

Drink-driving
- Mass media campaigns supporting policy—eg, drink-driving
- Mandatory treatment for repeat drinking drivers

Treatment
- Detoxification
- Cognitive-behavioural therapies
- Pharmacological treatments

A taxation policy scaled according to the alcohol content of beverages, and adjusted regularly in line with inflation, will reduce a country's consumption and related harm, provided that affordability is affected. Evidence shows that such a policy will slow recruitment of young drinkers, thus achieving long-term health gains.[29] Taxation has the added advantage of providing government revenue. Therefore, taxation is a key strategy in all countries. For countries in which the link between taxation and affordability of alcohol is affected by a ready supply of non-taxed alcohol (smuggled, illegal, or informal), bringing the non-taxed alcohol market under regulatory control is an essential part of policy. When affordability is affected by income growth or pricing promotions by retailers, taxation needs to be set appropriately to affect affordability—particularly of the least expensive beverages.

Availability controls will vary in their detail country by country, but, at a minimum, some form of control over all production and conditions of sale is needed. These controls will affect where alcohol is available (the nature of the venue, the density and clustering of outlets), when it is available (days and hours of sale), and who can purchase it (age and state of intoxication).

In view of the extent to which traffic-crash injury contributes to alcohol-related harm and the cost-effectiveness of strategies, a package of well enforced drink-driving legislation—such as establishment of a legal blood alcohol concentration, random breath testing, and sobriety checkpoints—is another core intervention. The effectiveness of both checkpoint programmes and random breath testing depends on their being highly visible, rigorously enforced, sustained and consistent, and accompanied by widespread publicity.[86]

Marketing contributes to the uptake and spread of alcohol use, and the consequent spread of harm. Regulation and restriction of all marketing should be a core national response, rather than leaving industries to make voluntary agreements, which tend to be underinterpreted, underenforced, and unstable.[16] Legislation can be written to ensure that all forms of marketing are not allowed unless specified, such as with present French law. This legislation needs to cover sponsorship and all branding of events, which are powerful forms of marketing.[87] The nature of marketing, which increasingly uses global technologies and strongly interacts with a global youth culture,[88] means that an international response, covering the internet and

satellite broadcast, is needed in addition to the national response.

Other policies that might be relevant, and for which evidence of effectiveness exists,[18] include: ensuring sellers do not serve to intoxication (ie, effectiveness depends on law enforcement); placing restrictions on drinking in some public places; different availability of beverages depending on potency; bans on price promotions and discounts; mass-media campaigns enhancing and supporting effective policies; administrative driving-licence suspension; zero blood alcohol concentration and graduated licensing for young or novice drivers, or both; mandatory treatment for repeat drinking drivers; and detoxification and intensive treatment options.

Strengthening of global action

An international refocus is urgently needed, particularly within WHO.[81] Positive signs exist, both in the 2008 call from WHO member states for the development of a global alcohol strategy and in the regional activities. Signs of change in other international agencies are also present. The World Bank—which once facilitated the establishment of breweries as part of economic development—now takes public health issues and social policy concerns into account when considering investments in production of alcohol beverages.[89] Furthermore, World Bank statements have called for countries to strengthen their alcohol policies, especially for tax, availability control, and advertising bans.[90,91] Additionally, development agencies have provided some small-scale assistance to address alcohol issues in low-income and middle-income countries.[92]

For an adequate response, WHO will need to substantially scale up its efforts, which will need funding. An appropriate response would be the establishment of a WHO cabinet project similar to the Tobacco Free Initiative, which was able to focus international and regional attention, resources, and action on the tobacco epidemic. The establishment of a WHO cabinet project was one factor that facilitated development of the FCTC.[70]

A Framework Convention for Alcohol Control: a matter of time

In view of the comparability between tobacco and alcohol, plus the precedent established by the FCTC, calls for a Framework Convention on Alcohol Control (FCAC) are not surprising. These calls come from a range of sectors, including professional,[77,78] academic,[65,93,94] and NGO sectors.[95] Furthermore, this call appears in WHO publications, with a recommendation by the 2006 Expert Committee on Problems Related to Alcohol Consumption that WHO should analyse the feasibility of "international mechanisms, including legally binding agreements",[66] and a WHO Commission on the Social Determinants of Health stating that alcohol is a prime candidate for stronger global, regional, and national regulatory controls.[11] Member states first discussed the possibility of an FCAC at an Executive Board meeting in 2005, with mixed viewpoints expressed.[64]

These calls recognise the similarities between alcohol and tobacco, but acknowledgment of the differences is also important. Alcohol use is more widely and deeply embedded in many parts of the world than is tobacco use. Saturated alcohol markets in high-income countries have drinking rates of 80–90%, and histories of use much longer than the 100 years or so that tobacco use has been embedded in high-income countries. A goal of abstinence for alcohol will probably not be adopted by many of the countries that have adopted this goal for tobacco (but have stopped short of prohibition of use).

The objectives of high-income countries with a high rate of use will probably focus on controlling rather than eradicating endemic alcohol use through policies that raise the age of onset of drinking, and reduce the frequency of intoxication and overall volume consumed.[96] Other countries with low rates of use might choose to protect their rate of abstinence, or at least slow the rate of change by discouraging young people from drinking.[97] Despite these likely differences in objectives, the broader goal of reduction of harm related to consumption is identical for alcohol and tobacco, and the only cost-effective approach—which includes affordability, availability, and marketing—is also very similar.

Many of the key elements needed or encouraged by the FCTC are comparable with the effective measures for

***Panel 4:* Transferability of evidence-based interventions: FCTC to FCAC**

Transferable
- Price measures
- Advertising, promotion, sponsorship (national and international)
- Communication, scientific information
- Regulating product content
- Protection from passive smoking effects of alcohol use on others
- Cessation and treatment
- Elimination of illicit trade (national and international)

Comparable
- Packaging and labelling
- Liability of producers and sellers
- Controls on sale (hours of sale, density and location of places of sale and use)

Alcohol specific
- Drink-driving legislation
- Protection of alcohol-control policies in negotiation of trade and economic agreements

FCTC=Framework Convention for Tobacco Control. FCAC=Framework Convention for Alcohol Control.

alcohol, as outlined in this Series (panel 4). These measures include: price measures; restrictions on advertising, promotion, and sponsorship; and communication and dissemination of scientific information. Packaging and labelling restrictions have not been addressed for alcohol in the same way that they have for tobacco, but changes to labelling—at least for alcohol strength and ingredients—will probably be introduced. Within the area of control of sale, a similar emphasis has been placed on age at which alcohol can be purchased. However, in alcohol control the regulation of place and conditions of sale and consumption is used more than for tobacco, implying the intoxicating effects of alcohol—in this area, an FCAC would cover more interventions than does the FCTC.

The FCTC includes measures to protect the public from exposure to tobacco smoke by restriction of places of use. Harm to people other than the drinker, especially from the intoxicated drinker, is a major public health problem, and is responded to by measures such as drink-driving legislation, controls on hours of sale (which reduce the likelihood of intoxication), and restrictions on drinking in public spaces (which reduce the effect on other people). Although these interventions necessarily differ from those of the FCTC, the main goal to protect others from the effect of the substance is similar.

Panel 5: Call to action—steps needed to reduce alcohol-related harm

- National and local governments to formulate and implement alcohol-control policies on the basis of evidence of cost-effectiveness
- Non-governmental organisations and civil society to enhance the position of alcohol on national and local policy agendas, and improve understanding of and support for effective policies
- Academics to work independently of commercial interests, researching and assessing control policies, particularly those relevant to low-income and middle-income countries
- Member states to request WHO to begin a process of development of international health policy in the form of a Framework Convention for Alcohol Control
- WHO and other international agencies, including development agencies and philanthropic foundations, to provide technical support and aid capacity building—particularly in low-income and middle-income countries—to develop, implement, and assess alcohol-control policies
- Global and regional non-governmental organisation networks to support the Framework Convention for Alcohol Control process
- Alcohol industry to withdraw subversive efforts to influence effective policy development, health promotion efforts, and research agendas

Although individual-focused approaches, such as treatment, tend to be less cost-effective than are some measures, assistance for users who want to cut back or cease use are essential for a complete policy portfolio—for both alcohol and tobacco.[18]

Internationally, legislation against illicit trade is needed within the FCTC and is also relevant for alcohol, as is the option to restrict duty-free sales and imports. Elimination of cross-border advertising, promotion, and sponsorship, which might be banned and penalised within the FCTC, is of great importance for support of national efforts to restrict alcohol promotion.

The FCTC does not deal explicitly with the coverage of tobacco in economic agreements, although the possibility has been discussed.[98] However, even without explicit coverage, a negotiated international health law covering alcohol control makes nations more likely to respect other nations' laws and policies in this area.[64] To bring these issues onto the agenda in international forums might also reduce the so-called chilling effect, in which national governments self-censor policy believing that economic agreements require this to a greater extent than is the case.[99] Furthermore, to have international policy for alcohol control on the agenda when free-trade ideology is being challenged by economic circumstances might be more successful than it would have been previously. The process of negotiation also provides opportunity for government officials from outside the health sector to become acquainted with the health issues associated with alcohol use.[98]

The framework convention approach is the least prescriptive of the legally binding international instruments available.[100] However, the strength of this approach is that it uses international law to establish an institutionalised forum for cooperation and negotiation. Countries undertake (upon ratification) to apply the principles of the convention in national law, and also engage in multilateral information exchange. Some issues are the subject of later development—eg, the present work to establish a protocol on illicit tobacco trade. The framework and protocol approach is a dynamic and incremental process of international law making.[101] Participation of the NGO movement in the continuing implementation of the FCTC has also evolved: the Framework Convention Alliance is a legal entity with more than 350 organisations from 100 countries. This alliance has a watchdog and support function for the FCTC, with a particular focus on low-income countries.[102] Effects of international agreements, such as the FCTC, are as much about domestic policy as about control across borders. Even before a consensus on the FCTC was reached, national policy was affected (the same occurred with climate change and ozone protection).[98] The FCTC process triggered development of national tobacco control by expansion of numbers of stakeholders participating in tobacco control.[72] A framework enhances rapid implementation of national policies in low-income

and middle-income countries, because development aid, including technical advice, is more likely to be provided.[98] In view of the general decrease in implementation of effective alcohol-control policies in recent decades,[18] and the threats posed by globalisation, the need for such assistance and impetus at the national level is urgent.[103]

The process undertaken to reach the FCTC was lengthy and rigorous—the WHA resolution calling for a feasibility study was in 1995; the member states, in 1999, paved the way for multilateral negotiations to begin; and the convention was adopted in 2003, and came into force in 2005. Vigorous negotiations are needed to achieve a carefully balanced legal instrument that takes into account scientific, economic, social, and political considerations.[70] One aspect of the tobacco process that might be relevant for future alcohol negotiations was the establishment of a member states' group open to all.[98] A key reason for the success of this group was the strong support of WHO's Director General. A similar commitment and willingness to test WHO's organisational and political capacity[98] will be needed if an FCAC is to be achieved in an appropriate timeframe (panel 5).

Conclusion

Strong evidence exists for the need for an effective response to prevent alcohol-related harm. Rates of alcohol-related harm and potential increases in use (particularly in low-income and middle-income countries), the availability but little uptake of cost-effective, affordable interventions, and the dangers posed from aspects of globalisation all show the need for a strengthened response both nationally and globally. To enable this response we need: an active process of negotiation in which the international focus on alcohol is expanded; national governments to be supported and strong in their response; and non-governmental advocacy to increase both internationally and nationally. Use of international law to achieve a forum for cooperation and negotiation—an FCAC—is essential, and the initial steps that have been undertaken urgently need to be scaled up.

Contributors

SC drafted the report and coordinated input from the Series' co-authors. TT participated in co-authoring and in the review and design of the report. Both authors have seen and approved the final version of the reoprt.

Conflicts of interest

We declare that we have no conflicts of interest.

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