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# THE GLOBE

Issue 1 2016

A portrait of Professor Sally Casswell, an older woman with short, wavy white hair, wearing a light-colored striped blazer over a teal top. She is looking slightly to the right of the camera with a neutral expression. The background is a blurred outdoor scene with greenery and a building.

## Transnational Alcohol Corporations are a Global Health Risk

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# Transnational Alcohol Corporations are a Global Health Risk

**Professor Sally Casswell**  
**GAPA Chair**

**The very successful GAPC15 in Edinburgh last October, covered in this GLOBE, provided a clear picture of the strengths of the networks from NGO and government agencies around the world who are working to reduce alcohol related harm in their home countries and worldwide.**

The stories told in the papers and posters presented at GAPC15 reflect a common concern – alcohol is causing harm in all our countries; levels are unacceptably high and are growing fast in the emerging alcohol markets. Presenters told stories of action at the community level to reduce harm, advocacy for national policy, and efforts to look for regional and global solutions by making alcohol more visible in the intergovernmental global agenda. But they also painted a clear picture of the barriers we face in reducing levels of harm: lack of adequate legislation and taxation, minimal if any enforcement where legislation exists, and largely unregulated marketing of commercial alcohol. Marketing was a conference theme and presenters told of the extent of exposure to marketing, its effects, violation of both voluntary codes

and legislation, and the increasing importance of digital marketing and social media.

To make policy change first we need evidence that change will make a difference, which we have, second; that it can be implemented, which we have; but finally it needs to be politically feasible and here is where the problem lies because politicians in many countries lack the political will to introduce effective policy... and why is this?

In each country there will be a mix of different reasons but in many countries where alcohol policy is weak and contested, local people tell stories of the involvement of the alcohol industry in policy development and close relationships between industry and politicians such that less effective policies are favoured. This influence and lobbying extends beyond the national and provincial level to the regional and global and Big Alcohol funds a number of organisations internationally to promote their agenda. Two global organisations active over the past two decades, ICAP and the GAPG, have recently amalgamated to form the International

Alliance for Responsible Drinking (IARD) with offices in Washington and Geneva. Many of the big global beer and spirits producers are also active in the political arena nationally and globally. The recent amalgamation of two beer giants, Anheuser Busch and AB InBev, has resulted in a new active player which recently launched a new initiative promising a one billion dollar investment to achieve 'Smart Drinking Goals'.

The alcohol industry frames itself as a partner in reducing alcohol related harm. It then promulgates ways of understanding the issue which lead directly to industry friendly solutions. A focus on the individual heavy drinker, rather than marketing, availability and affordability of alcohol, the drivers of heavy consumption, is found in all industry communications. A recent example is the statement by IARD's new Vice President (like the IARD President a recruit from the NCD NGO sector) when announcing the opening of their Geneva office: 'Alcohol is a normal part of an enjoyable life for millions of people but for a minority, alcohol is associated with harm'.

From this, the argument goes, there should be no policies which might affect moderate drinkers and we find this echoed by political leaders around the world when deciding against implementation of effective policies.

It is important we use our evidence and advocacy skills to challenge and reframe the industry arguments. It is clear from all our epidemiological work that there is a skewed distribution of alcohol use a minority drink more heavily than the majority (although they don't account for all the harm). But let's turn this frame around and look at it from the perspective of the producers and retailers of alcohol. To what extent do they depend on these 'super-consumers' for their profits?

Data from the collaborative international alcohol research project, the International Alcohol Control (IAC) study, show how much of the combined alcohol market from these participating countries is consumed in heavier drinking occasions. In one of these analyses we set the level of heavy drinking at eight plus drinks for male drinkers and six drinks plus for women, as drunk on a typical drinking occasion (this is higher than the WHO 'Heavy Episodic Drinking' category). Looking at the data from this perspective makes the industry's reliance on heavier drinking occasions obvious and makes the conflict of interest very apparent. Fifty percent of the alcohol market in two high income countries was drunk in these heavy drinking occasions and in three middle income countries it was even more – sixty percent.

These data show that effective action to reduce over consumption would cut into industry sales and profits. This conflict of interest is at the heart of the issue we face and why GAPA is important. GAPA's mission 'to reduce alcohol-related harm worldwide by promoting science-based policies independent of commercial interests' is a recognition of this inherent conflict of interest.

GAPA aims to support national and regional capacity building primarily by co-hosting biannual conferences and ensuring, by sponsorship, sizeable participation from low and middle income countries where both consumers and policy makers in the emerging alcohol markets are being targeted by the alcohol industry. GAPC provides an opportunity to bring together the government sector, civil society and academia in a shared endeavour and we have particularly appreciated the co-sponsorship of WHO in GAPC meetings. We need this opportunity to meet together, learn from each other, transfer

successes from very different settings, identify and make visible the workings of a common enemy, build regional and global networks and, very importantly, decide on priorities for our strategic direction. Our next GAPC, in 2017, will be in Australia, co-hosted by FARE and the Australian Public Health Association. GAPA's primary role is to provide a global voice to advocate for the development of alcohol policy free from commercial interest. To achieve this we support the World Health Organization work allied with the Global Strategy to Reduce Alcohol Related Harm, the UN's NCD goals and the Sustainable Development Goals (SDGs) 2015 – 2030. Goal 3 of the new SDGs includes targets to "strengthen the prevention and treatment of substance abuse, including ... the harmful use of alcohol". There is a growing focus on alcohol as a significant risk factor in NCDs (non communicable diseases) and the inclusion of an alcohol target in the SDGs is a major step forward in the global governance arena. However, the world is also faced with a developing focus on partnerships between the private sector, governmental agencies and NGOs, as illustrated in current negotiations at WHO over the Framework for Engagement of Non State Actors and, unlike tobacco, alcohol is not currently excluded from potential engagement. Alcohol policy is also threatened by the

**Professor Obott**  
Vice Chairman of GAPA



new generation of economic agreements which protect the interests of the global corporations and have the potential to chill national government attempts to regulate their activities. At the same time there is a rapid expansion by the transnational alcohol corporations into countries with high abstention rates, youthful populations and growing economies.

It is imperative, therefore, we ensure Big Alcohol's conflict of interest is understood to be as compelling as that of Big Tobacco and they should be excluded from these global governance arenas as is tobacco.

Goal 3 of the SDGs also states the need to: 'Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks'. Big Alcohol is, in its effects on people's daily lives and their subversion of efforts to regulate their marketing activity, a 'global health risk' and rather than being represented as partners their conflict of interest needs to be recognised. Their accountability is to shareholders' profits and not to the public good. GAPA, with its civil society partners around the world, will continue to speak this truth to power at every opportunity.

**David Jernigan**  
Chair of the Scientific  
Advisory Committee



# Nicola Sturgeon: Scotlands First Minister Opens GAPC15

**The Fourth Global Alcohol Policy Conference was held in Edinburgh in October 2015 by invitation of Alcohol Focus Scotland. It attracted 412 delegates from 60 countries. Nicola Sturgeon, First Minister Scottish Government delivered the Opening Speech to the Conference:**



"I want to thank the Global Alcohol Policy Alliance and Alcohol Focus Scotland for all the work they've done to organise this conference. And I know that Derek Rutherford is retiring later this month – after more than four decades of work on alcohol policy. So I want to thank him for his contribution to a hugely important area, and to wish him all the best for a long and happy retirement.

I'd also like to acknowledge the award of the fellowship to the late Dr Evelyn Gillan. Evelyn brought passion and enthusiasm to every cause she cared about. She was an exceptional Chief Executive of Alcohol Focus Scotland, and was especially inspirational as an advocate of minimum unit pricing. She is missed enormously by many people in Scotland and far beyond. The Scottish Government is delighted

that Scotland has been chosen to host this conference. Scotland has a distinctive approach to tackling the harms caused by alcohol – but it's one which has always been based on international evidence.

For example in our work on minimum pricing we have looked at Canada's example. The Framework for Action which we published in 2009 is closely aligned with the ten priorities set out by the World Health Organization. And now, as we look to refresh and revise that framework in the coming year, we're especially keen – not just to share our knowledge and experience – but to learn lessons from others. So this is an ideal time for Scotland to host a conference which is attended by delegates from more than 60 countries around the world. I warmly welcome all of you.



**Nicola Sturgeon with Dr Mac Armstrong, Chair of Alcohol Focus Scotland - Conference Host**

I want to spend my time this morning giving you a summary of the Scottish Government's priorities in relation to alcohol policy. I'll explain why it's important to us, and I'll set out some of the key approaches we're adopting. And in doing that, as you might expect, I'll spend some time setting out our current position on minimum unit pricing - since I know that it's an issue which has attracted international attention.

But I'll begin by setting the context for

our policies. Scotland certainly isn't unique in having a problem in terms of our relationship with alcohol. But unfortunately we are unusual - certainly among other western European countries - in the severity and extent of that problem.

Alcohol consumption in Scotland is almost 1/5 higher than in England and Wales. Our rates of liver disease and cirrhosis are the highest in western Europe.

During the three days of this conference, it is likely that approximately 300 people in Scotland will be admitted to hospital as a result of alcohol misuse. It is also likely that approximately 10 people will die.

Those consequences affect some sections of our population far more severely than others. People in the most deprived parts of Scotland are six times more likely to die from alcohol misuse, than those in the most affluent areas.

The evidence is very clear. The extent and nature of alcohol consumption in Scotland damages individuals, families, businesses and communities across the country. It harms the poorest families and communities most of all. No responsible government can ignore an issue which has such devastating consequences.

That was the motivation behind the Framework for Action which the Scottish Government published in 2009. It set out more than 40 proposals to reduce consumption, promote a healthier attitude towards alcohol, and improve treatment and support for people who need it.

For example we introduced a ban on bulk discounts in shops, which had previously encouraged people to buy alcohol in greater volume. We estimate

that it has reduced alcohol sales by 2.6%.

We've also increased investment in alcohol treatment and care services. We now deliver around 100,000 alcohol brief interventions every year. Those are short structured conversations - based on evidence that they might be desirable - which encourage people to think about and change their pattern of alcohol consumption. They're a low-cost intervention which can have a big impact.

We're now looking at refreshing our Framework for Action. As we do that, we're increasing the ability of health boards to deliver interventions in a wider range of settings. For example we want to have more alcohol brief interventions in places such as prisons and custody suites. By doing that, we can potentially make further progress in tackling health inequalities - we'll reach more of the people who need help the most.

There are two other areas where we are keen to see progress as soon as possible.

The first of those is advertising - particularly in relation to children. I know that's an important part of tomorrow's conference proceedings.

Broadcast advertising is reserved to the UK Government - it's not something that the Scottish Government has responsibility for. So we are arguing that the UK Government should protect children from alcohol advertising on television, in the cinema and online. We believe that one way of achieving that would be to prevent alcohol from being advertised before the 9pm watershed. There is mounting evidence that alcohol advertising has an impact on children and young people - and so we believe that their exposure to it should be reduced. It's a case the UK

Government has not heeded so far; but it is one which we will make as persistently and persuasively as possible.

The second area - where we have legislated, but are now awaiting the outcome of legal proceedings - is minimum unit pricing. We see this as an essential part of how we address alcohol harm in Scotland.

There's some good evidence that the other approaches we've adopted in the framework for action are having some effect.

Scotland has seen a 9% fall in alcohol consumption since 2009. Rates of alcohol-related deaths, which doubled between 1981 and 2003, have fallen by more than a third since then.

It is possible, just possible, that we are starting to shift individual behaviour and public attitudes. Scotland may be starting to develop a healthier relationship with alcohol. However, we also know that much more needs to be done.

In particular, alcohol-related deaths may be significantly lower than in 2003 - but they have risen in each of the last two years.

That provides strong evidence that many of the changes we have seen in people's behaviour are heavily influenced by affordability. Our framework has helped to reduce consumption, but so too did the economic downturn.

As economic recovery continues - as unemployment falls and living standards rise - the improved affordability of alcohol seems to be causing an increase in consumption. There's a danger that much of the good work of recent years will be undone.

That's why reducing the affordability of alcohol is the best way of reducing the harm it causes. And in our view,

minimum unit pricing is more effective than general taxation for doing that. It allows us to respond to changes in affordability – for example when they are a consequence of rising household incomes. And it allows us to target the strong-alcohol and low-cost products which are especially associated with damaging drinking patterns. That’s why a Sheffield University study - which looked at the impact of a 50p minimum unit price - indicated that it would save 300 lives a year after 10 years, and reduce hospital admissions by more than 6,000.

The case for minimum unit pricing initially met with widespread opposition in Scotland. But steadily, hearts and minds have shifted. They have been swayed by the overwhelming fact that Scotland has a major problem; and the very clear evidence, such as the Sheffield study, that minimum unit pricing is an important part of the solution. As a result, in 2012 - when the legislation providing for minimum unit pricing was passed - it received support from four of the five parties in the Scottish Parliament.

Scotland’s position is now attracting international endorsement and recognition. A supportive study was published recently by the Organisation for Economic Co-operation and Development. Their Policy Brief on Tackling Harmful Alcohol Use, argues that raising prices will lower consumption. It also acknowledges that raising prices where they are cheapest can be the most effective way of reducing harmful drinking. It was also heartening to see that when the European Union took evidence on the court proceedings relating to minimum unit pricing, Scotland’s stance received support from five member states, and also the European Free Trade Association.

I’m just going to touch on those court proceedings very briefly. I’m not going to pre-empt the outcome, but I do want to make two points clear.

The first is that I welcome the opinion last month from the EU’s Advocate General. He confirmed that minimum unit pricing is not precluded by EU law, and stated that it is for domestic courts to take a final decision. He also found that the policy can be implemented, if it is shown to be the most effective public health measure available.

And the second point, as you would expect, is that I can confirm that the Scottish Government continues to be absolutely committed to minimum unit pricing. We believe that it is the best way to reduce the harm caused to our communities by low-cost and high-strength alcohol. We are convinced that it will reduce damaging alcohol consumption, improve health and save lives – and that it will do so more effectively than any alternative measures available to us.

What Scotland is trying to do - through minimum unit pricing and through more than 40 other measures in our framework - is to create a cultural transformation. We want to change Scotland’s relationship with alcohol for good, and for the better. That’s not simply about government action. Industry and the media have an important role - and individuals also need to consider their own alcohol consumption, and their position as parents, role models and friends. But the Scottish Government is determined to take a lead. Because we know that by doing so, we will reduce inequality, increase prosperity, and improve the wellbeing of individuals and communities across the country.

And as we work towards that aim, we will always look to learn from the example

and experiences of countries around the world. That’s why I’m delighted to welcome you here this morning. I wish you all the best, for a constructive and enjoyable conference.

**Latest News:** MUP Returns to Scotland’s Court of Sessions.

In December, the European Court of Justice stated that it is up to the Scottish court to decide if minimum unit pricing is more appropriate and proportionate than other measures i.e. taxation, to protect health. The Court of Session in Edinburgh held a procedural hearing on 28 January and agreed to hear further evidence, with a final hearing provisionally scheduled for June.

Alison Douglas, Chief Executive of Alcohol Focus Scotland, and Eric Carlin, Director of Scottish Health Action on Alcohol Problems said:

“Today the Scotch Whisky Association (SWA) continued its efforts to prevent the implementation of minimum unit pricing in Scotland. This comes the day

after the SWA launched a campaign to reduce alcohol duty on spirits. SWA’s action suggests that they put profit above health. “They are seeking to obstruct both the mechanisms that would reduce harm by increasing the price of alcohol: minimum unit price and taxation. This despite the Scottish Parliament and the courts in both Scotland and Europe accepting the clear link between price, consumption and harm. “We are pleased the Court of Session is seeking further evidence. We remain confident that the case for minimum unit pricing will be conclusive and look forward to this much-needed policy finally being implemented.”



**Derek Rutherford, Maureen Watt Minister of Public Health and Barbara O’Donell, organiser of conference.**

# Reducing the Harmful Use of Alcohol: A Global Public Health Perspective

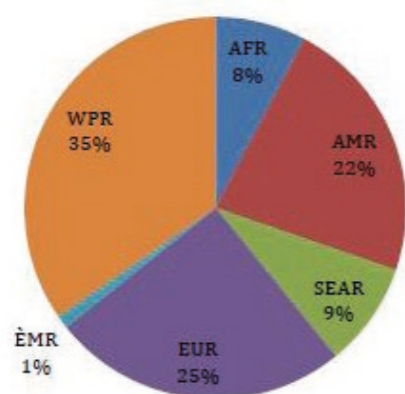
Vladimir Poznyak, Dag Rekve  
 Management of Substance Abuse, World Health Organization  
 Globe Summary of the Presentation

## A summary of their presentation

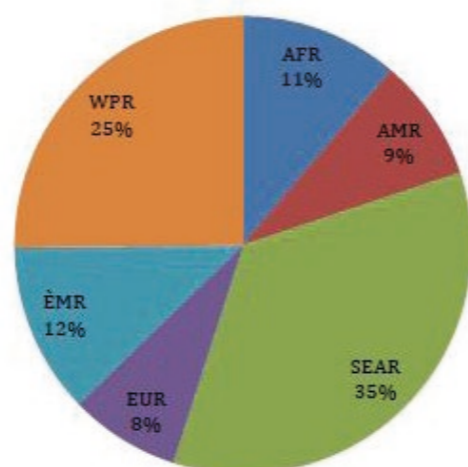
Alcohol is consumed by 38.3% of the world population aged 15-64 (1.9 billion people). Of that number 7.2% of men and 1.3% of women have alcohol use disorders. The number of abstainers is 61.7%. The distribution of drinkers and abstainers in the world by WHO region is as follows:

In 2012 the global burden of disease attributable to alcohol consumption was 3.3 million deaths and 139 million DALYs (disability adjusted life years). The distribution of alcohol attributable to the burden of disease is outlined in **Figures 1&2**

**Drinkers (38.3%)**



**Abstainers (61.7%)**



## Distribution of Alcohol – Attributable Burden of Disease

Figure 1

Net total = 3.3 million deaths

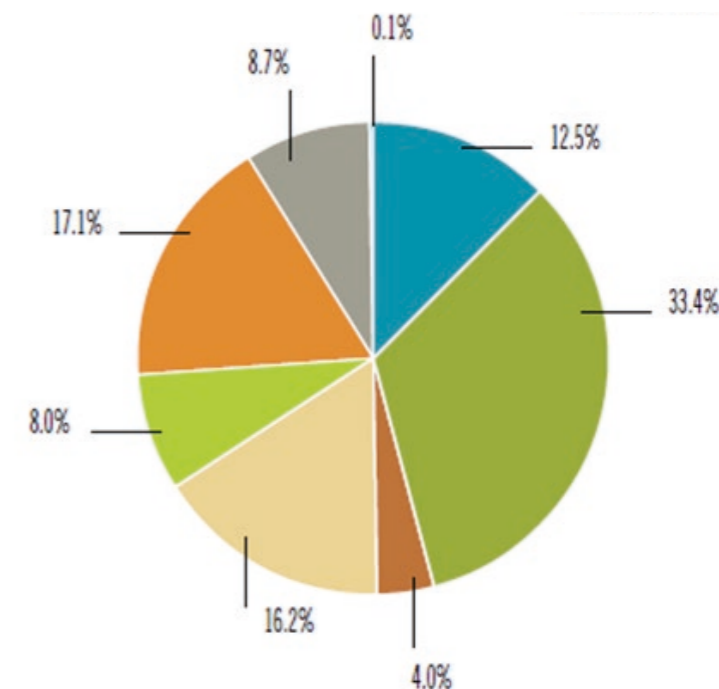
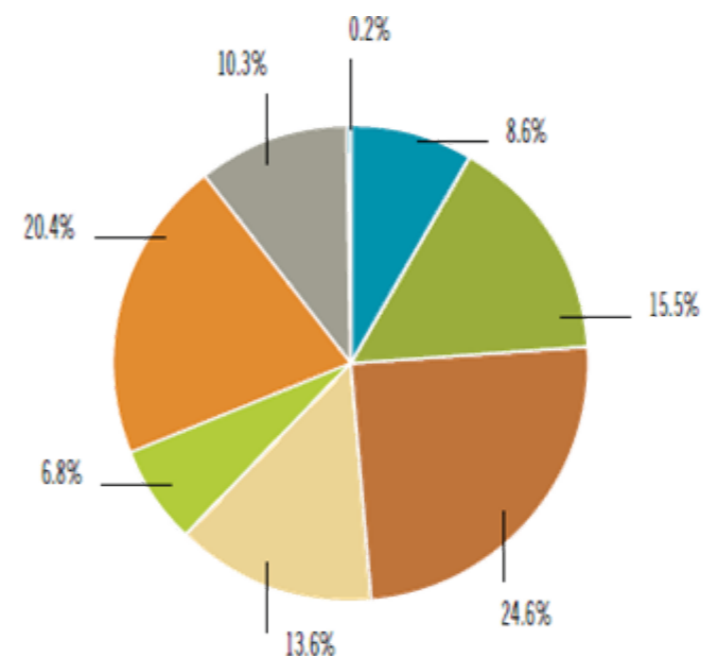


Figure 2

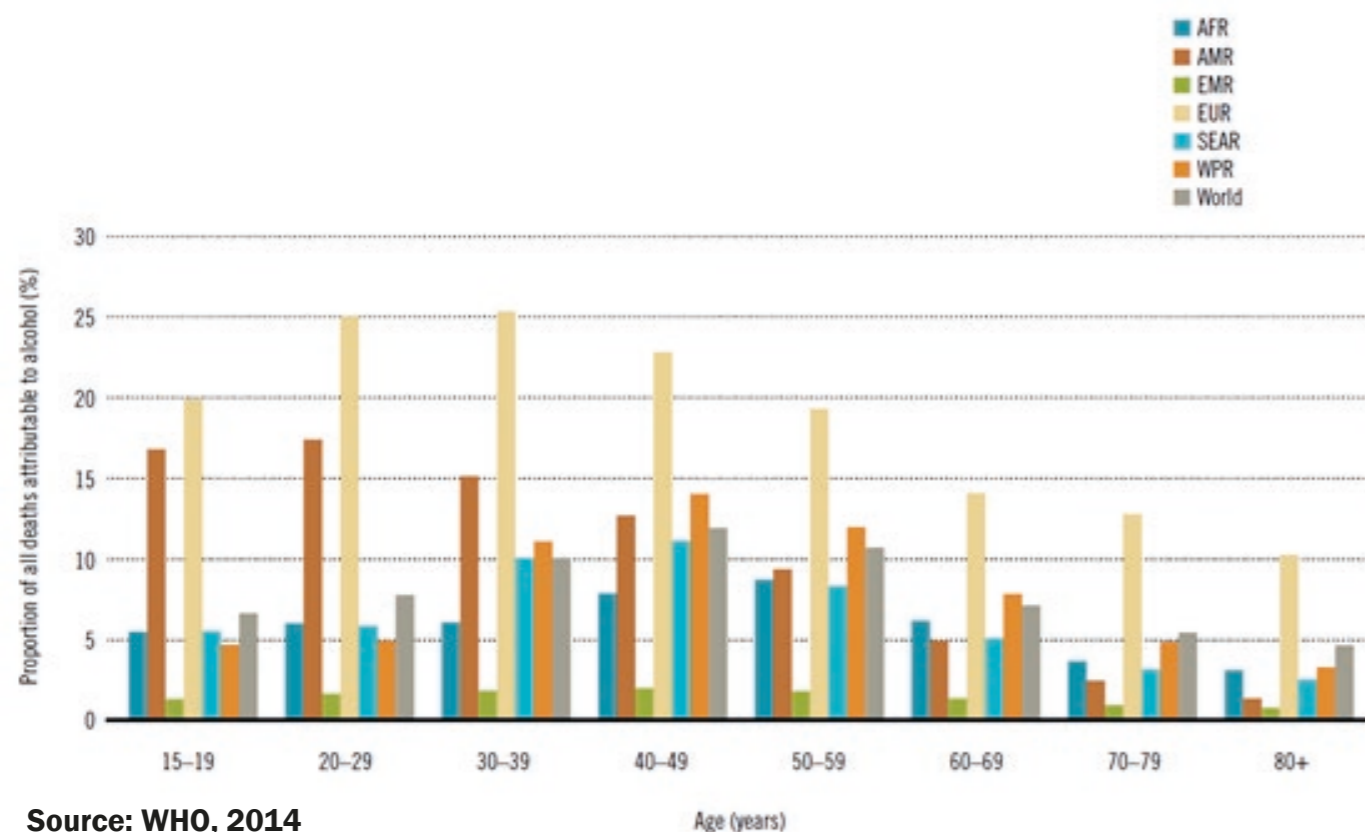
Net total = 13.9 million DALYs



- Cancers
- Cardiovascular diseases and diabetes\*
- Neuropsychiatric disorders
- Gastrointestinal diseases
- Infectious diseases
- Unintentional injuries
- Intentional injuries
- Neonatal conditions

\* Including beneficial effects of low-risk drinking patterns on some diseases. Note: Percentages may not add up to 100% due to rounding.

### Proportion of alcohol-attributable deaths (%) of total deaths by age group 2012 (WHO 2014)



Source: WHO, 2014

The European region has the highest number of alcohol-attributable deaths in all age groups; among adolescents 1 in 4 and among young adults 20-29 years old 1 in 4.

The concept of the harmful use of alcohol is broad and encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes.

#### Actions needed to reduce the harmful use of alcohol?

Global, regional and national actions are required on levels, patterns and contexts of alcohol consumption and the wider

social determinants of health. Special attention needs to be given to reducing harm to people other than the drinker and to populations that are at particular risk from harmful use of alcohol.

The harmful use of alcohol is one of the key risk factors in the WHO Global NCD Action Plan.

One of a number of targets of the NCD global monitoring framework is a 10% relative reduction in the harmful use of alcohol.

Best buys to reduce the harmful use of alcohol are to regulate commercial and public availability of alcohol; restrict or ban alcohol advertising and promotions; and to use pricing policies such as excise tax increases on alcoholic beverages

## Key messages

Vladimir Poznak and Dag Rekve concluded their presentation with the following Key messages:

- Harmful use of alcohol is among the top five risk factors for the global burden of disease
- Global policy frameworks for alcohol control include the Global strategy to reduce the harmful use of alcohol (WHO, 2010), WHO Global NCD Action Plan 2013-2020 and UN High Level Political Declaration on NCDs
- Harmful use of alcohol included in the health target of the UN Sustainable Development Goals 2015 - 2030
- Effective and cost-effective strategies to reduce the harmful use of alcohol include: pricing policies; restricting availability of alcohol; comprehensive restrictions or bans on alcohol advertisements; drink-driving policies; brief interventions for hazardous and harmful drinking.

*The burden from harmful use of alcohol can be effectively reduced and governments have an obligation to intervene as appropriate for protecting the health of populations.*



# Mega Trade Treaties as Obstacles to Control Policies

Professor Jane Kelsey



## Alcohol Control Policies and Trade and Investment Agreements

Public health policies on alcohol aim to protect people from harm. Trade and investment agreements aim to maximise commercial opportunities for firms that supply goods and services to, and invest in, other countries. Increasingly the two objectives collide<sup>1</sup>. Sometimes a compromise can be identified. But as governments seek more effective alcohol control policies, on one hand, and commercial agreements expand in scale and scope on the other, conflicts seem set to intensify. International commercial treaties are enforceable by other states, and sometimes by foreign

investors, through economic penalties, whereas internationally mandated health policies are not. As a result, the autonomy of governments to determine their preferred public health policies, including a number of those promoted in the World Health Organization (WHO) Global Strategy to Reduce the Harmful Use of Alcohol<sup>2</sup>, is jeopardised.

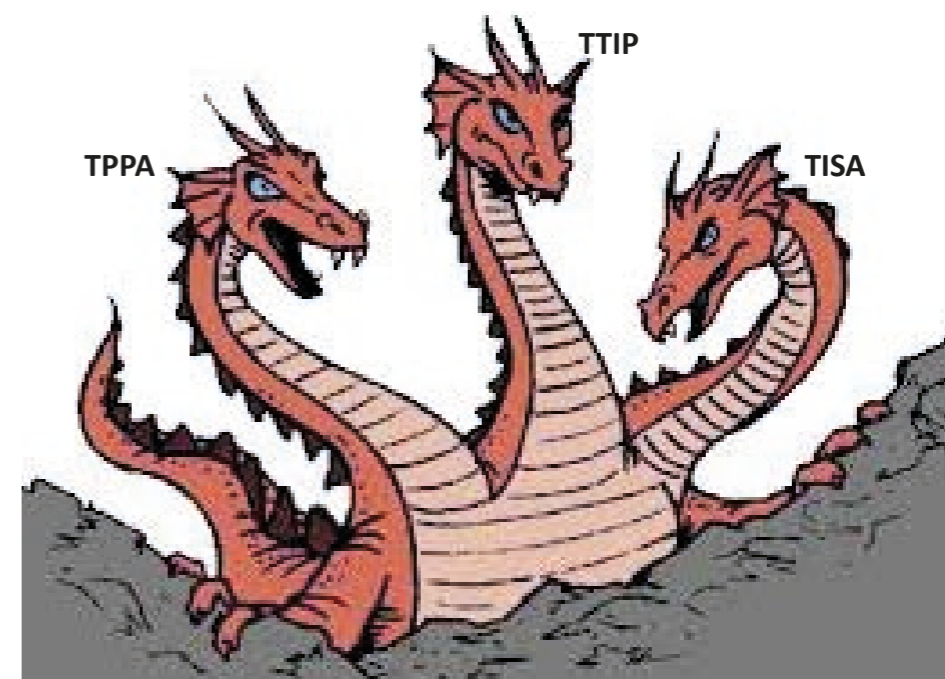
### What are 'trade' agreements and how do they vary?

The number and scope of 'trade' agreements has expanded rapidly beyond what is traditionally seen as trade. The General Agreement on Tariffs and Trade (1947) was limited to restrictions on imported goods, such as discriminatory treatment, and reducing border taxes (tariffs) and import licensing, including on alcohol.

1 For earlier commentaries on this tension see Grieshaber-Otto, Jim and David Jernihan, 'Trade treaties, alcohol and public health', *The Globe*, Issue 2, 2001; Kelsey, Jane, 'The implications of new generation free trade agreements for alcohol policies' paper to the Global Alcohol Policy Conference, Bangkok, February 2012

2 WHO, Global Strategy to Reduce the Harmful Use of Alcohol, adopted May 2010

## Three headed hydra



Over time the GATT expanded to include rules that targeted behind-the-border laws and policies when they were deemed to pose barriers to trade, such as quarantine and food safety rules, product labelling requirements or technical standards about product content.

In 1995 the World Trade Organization (WTO) expanded the scope of global rules so as to facilitate global services transactions, such as wholesale and retail distribution, health and social services, environment services, and communications, through the General Agreement on Trade in Services (GATS). Governments were also bound to a new intellectual property rights regime under the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) that guarantees minimum monopolies over medicines, technological innovations, copyright, brand names and other trade marks, and trade secrets.

As moves to expand the WTO stalled in the late 1990s, a new wave of bilateral and regional free trade agreements (FTAs) emerged that covered similar issues and, more notably, rules to liberalise foreign investment and protect such investments<sup>3</sup>. These agreements vary depending on the countries involved, creating a complex and sometimes inconsistent web that can impose onerous obligations on countries with limited bargaining power. A separate category of bilateral investment treaties (BITs) between states creates rights and protections for foreign investors, which are increasingly integrated into new generation FTAs. Some countries have a large number of BITs as well as FTAs<sup>4</sup>.

3 The WTO has an incomplete data base of FTAs: <http://rtais.wto.org/UI/PublicMaintainRTAHome.aspx>. A good source of multilingual information and commentary about FTAs under negotiation is <http://www.bilaterals.org/>

4 The UNCTAD has a good database of BITs: <http://investmentpolicyhub.unctad.org/IIA>

Most recently, a number of mainly developed countries have been negotiating three new mega-regional agreements: the 12-country Trans-Pacific Partnership Agreement (TPPA)<sup>5</sup>, the Transatlantic Trade and Investment Partnership (TTIP) between the US and EU<sup>6</sup>, and the Trade in Services Agreement (TISA)<sup>7</sup>. Collectively, they aim to impose far more extensive substantive constraints on participating governments' laws and policies than any previous agreements, including new chapters in areas like e-commerce and state-owned enterprises. In addition, chapters on transparency, regulatory coherence or regulatory cooperation and domestic regulation of services provide more opportunities for foreign states and corporations to influence a nation's policy and regulatory decisions.

### What do these commercial agreements have to do with public health?

Many chapters of contemporary FTAs have implications for health policy and services, ranging across intellectual property (affordability of medicines and medical devices); financial services and investment (health and accident insurance); government procurement (public-private partnership (PPP) hospitals, blood services); cross-

border services<sup>8</sup> (advertising, Internet, telemedicine, radiography, e-retail, water supply and sanitation); investment (alcohol or tobacco production, mines, coal fired power plants, wholesale and retail chains, aged care franchises, trademarks); international movement of persons (health professionals, consultants, brand ambassadors); and environment (international environment agreements, climate change), among many others.

### How specifically might these agreements restrict alcohol control policy?

A number of chapters dictate the substantive rules that governments must follow; these rules are becoming progressively more restrictive of regulatory autonomy in the new generation FTAs. There is almost always provision for state-state enforcement, supported by commercial penalties, and increasingly investor-state dispute settlement that allows foreign investors to enforce rules against states.

**Goods:** The traditional area of trade in goods, including alcohol products, seeks to eliminate quantitative restrictions and reduce border taxes or tariffs. What level of tariffs a country can impose depends on its tariff schedule in a particular agreement. Internal taxes on alcohol products must also be non-discriminatory, and not act as disguised barriers to imported products. Like products must be treated the same, irrespective of which country they come from.

**Technical barriers to trade (TBT):** Exporters, including of alcohol, increasingly use global brands, marketing strategies and distribution networks that assume they can export

<sup>8</sup> Cross-border includes foreign establishments inside the host country.

the same products to different countries. Domestic regulations are seen as trade barriers even when they appear non-discriminatory. Because of that country specific rules on alcohol products, including restrictions on the chemical composition or the permitted alcohol content, or large and graphic health labelling<sup>9</sup>, have been challenged as technical barriers to trade<sup>10</sup>.

**Services:** The global supply chain for alcohol relies on a sophisticated strategy for marketing and distribution, across borders, through the local presence of foreign firms and by electronic delivery. The FTAs impose three main rules for regulation of services at central and local government levels.

First, any government measure (meaning a law, regulation, policy, decision, action, or anything else) must not close off the size and growth of the market in that service by imposing a ban (eg internet sales), operate monopolies, or limit the quantity of suppliers (eg liquor outlets) or service operations (eg advertising) nationally or in specific locations.

Second, local services and suppliers must not get any better treatment than 'like' foreign services and suppliers; 'like' may mean the service they provide (selling or advertising alcohol) even if the suppliers are very different (small local shops and mega-retailers).

<sup>9</sup> Thailand's proposals for alcohol labelling and restrictions on messaging have been the subject of ongoing challenges in the WTO; see, for example, the discussion in the WTO Committee on Technical Barriers to Trade meeting on 17-18 June 2014, G/TBT/M/66 pp.37-39; 'Thailand's new alcohol labelling and message requirements', Bangkok Post, 18 September 2015

<sup>10</sup> The US Trade Representative's 2015 National Trade Estimate Report on Foreign Trade Barriers provides a useful indication of the kinds of TBT issues that arise in relation to alcohol policy: <https://ustr.gov/sites/default/files/2015%20NTE%20Combined.pdf>

Third, domestic regulation that involves licensing (eg. liquor outlets) or technical standards (eg. zoning, advertising standards or limits on retail displays) are required to be based on 'objective criteria, such as competence to supply the service, and not more burdensome than necessary to achieve 'quality' of the service. Quality is undefined, but implies a consumer, rather than public policy, focus. Licensing procedures cannot in themselves restrict the supply of the service. Administration of these regulations must be 'reasonable, objective and impartial'; decisions that respond to local community objections, for example, may be challenged as subjective, unreasonable or biased.

While governments can usually protect various measures, including alcohol policies, from these rules, agreements increasingly require them to list what will be protected rather than what will be covered. That 'negative list' approach is especially problematic where the alcohol industry is using rapidly developing technologies and new opportunities that were not foreseeable when these lists were created. There are also moves to lock in any new liberalisation, making it difficult or impossible to re-regulate such services or activities<sup>11</sup>.

### Mutual recognition agreement:

Exporters want the same rules to apply to their products in different countries. Rather than harmonisation, which is politically difficult to achieve, mutual recognition means a product that can lawfully be sold in one country must be allowed to be sold in the importing country. That restricts the ability of the importing country to take a different approach on public health grounds, for example the amount of alcohol permitted in a ready-to-drink product or

<sup>11</sup> See the discussion of the draft core text and chapter on domestic regulation in the TISA negotiations, <https://www.wikileaks.org/tisa/>

<sup>5</sup> Australia, Brunei Darussalam, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, USA, Vietnam. The final text is available at <http://tpp.mfat.govt.nz/text>

<sup>6</sup> For EU's commentary on negotiating texts see <http://trade.ec.europa.eu/doclib/press/index.cfm?id=1230>

<sup>7</sup> Australia, Canada, Chile, Chinese Taipei (Taiwan), Colombia, Costa Rica, Hong Kong, Iceland, Israel, Japan, Liechtenstein, Mexico, New Zealand, Norway, Pakistan, Panama, Paraguay, Peru, South Korea, Switzerland, Turkey, the United States, and the European Union. Singapore, and recently Uruguay and Paraguay, have withdrawn. Many draft texts and analyses are available at <https://wikileaks.org/tisa/>

the kind of labelling required<sup>12</sup>.

**Intellectual property (IP):** Names, logos, images, colours, words are all important to branding, marketing and sales of products, including alcohol. The intellectual property chapters of new generation FTAs confer more extensive and longer monopolies on those who register them. Moves by a country to limit promotion of alcoholic products through labelling and marketing may be said to breach the intellectual property chapter<sup>13</sup>, as well as expropriation of unfair treatment of an investment, being the intellectual property right itself<sup>14</sup>.

**Investment:** An investment is very broadly defined in BITS and the investment chapters of FTAs. It might, for example, be a factory, shop or sports promotion business, or shares in such a business, a franchise, a contract held by a foreign advertising company or a trade mark. In addition to being treated no less favourably than domestic counterparts, investors secure special rights and protections not available to nationals. These include a 'minimum standard of treatment', which investors commonly interpret as a stable regulatory environment from the time of investment – for example, tighter regulations related to alcohol

12 The Australian industry challenged proposals from New Zealand to limit the alcohol level of RTDs as in breach of the Australia-New Zealand Trans-Tasman Mutual Recognition Agreement, see 'Liquor law changes could breach CER, committee told', National Business Review, 11 March 2011: <http://www.nbr.co.nz/article/liquor-law-changes-could-breach-cer-committee-told-nn-88142>

13 This is one of the grounds for the challenge in the WTO to Australia's tobacco plain packaging legislation: Australia – Certain Measures Concerning Trademarks and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging, DS435

14 Tim Lince, 'The international implications of the Philip Morris branding battle in Uruguay', World Trademark Review, 19 September 2014

that affect a foreign investment's value or future profits. New regulations that have a significant impact can also be challenged as a direct or indirect expropriation.

Investment chapters empower states and investors to allege a breach through ad hoc offshore tribunals rather than the domestic courts. Investor-state dispute settlement (ISDS) is especially controversial, as is involves ad hoc tribunals with arbitrators drawn mainly from a small group of investment litigators and academics, without any effective conflict of interest rules, no consistent system of precedents, no cap on the level of monetary awards and no appeal<sup>15</sup>.

Challenges to tobacco control policies show how public health policies can be undermined by foreign investors<sup>16</sup>. The state or investor that threatens or brings a dispute may have little interest in the country it is challenging, but is primarily concerned to prevent precedent setting innovative policies. Even where the investor's legal arguments are weak, threats of disputes may be intended to have a 'chilling effect' so governments drop proposed measures.

The need to reform the ISDS mechanism has been vigorously debated, with some governments withdrawing from investment agreements or arbitral facilities, others proposing new legal forums for pursuing such disputes, and yet others proposing new substantive

15 The United Nations Conference for Trade and Development (UNCTAD) has been playing a leading role in this debate; see <http://investmentpolicyhub.unctad.org/IIA/KeyIssueDetails/42>

16 Investment disputes brought by Philip Morris against Uruguay and Australia are prominent examples; Matthew Porterfield and Christopher Byrnes, 'Philip Morris v Uruguay: will investor-State arbitration end restrictions on tobacco marketing up in smoke?', Investment Treaty News, 12 July 2011;

and procedural safeguards<sup>17</sup>.

**Process rules:** In more recent agreements, chapters on transparency and regulatory coherence/cooperation set out the required decision making processes and criteria, obligations on governments to provide information, and rights of other governments and 'interests' to participate in developing new policy or regulation and to challenge decisions.

The same policy or law is likely to be affected by a number of chapters across a number of agreements. The cumulative effect across public health policy is to pose multiple barriers to an integrated and coherent strategy to address non-communicable diseases.

**Exceptions:** Agreements will provide some general exceptions and some that are specific to individual chapters. In most cases these must be argued as defences to a dispute. The general exception in Article XX of the GATT and Article XIV of the GATS appears to provide protection for public health measures, but is overlaid by numerous requirements that are so difficult to satisfy that the exception has fully succeeded only once in the 44 times it has been pleaded in the WTO<sup>18</sup>. Measures that are innovative or precautionary may find it especially difficult to satisfy requirements that they are evidence based and there is no

17 See 'Official Government Statements and Actions against Investor-State Dispute Settlement (ISDS)', Public Citizen, Washington DC, December 2014 <http://www.citizen.org/documents/isds-quote-sheet.pdf>

18 'Only one of 44 attempts to Use the GATT Article XX/GATS Article XIV "General Exception" has Ever Succeeded: Replicating the WTO Exception Construct will not Provide for an Effective TPP General Exception', Public Citizen, Washington DC, August 2015, <https://www.citizen.org/documents/general-exception.pdf>

equally effective, but less burdensome, policy option available.

The general exception does not necessarily apply to the investment chapter, where specific provisions provide possible protections for public policies. The inclusion of a specific option to deny the use of ISDS for tobacco control policies in the TPPA implies that other public health policies, including for alcohol, are at risk<sup>19</sup>.

### How might the Global Strategy to Reduce the Harmful Use of Alcohol be most affected?

The strategy identified 10 target areas, which should be treated as supportive and complementary. It is clear from the rules outlined above that policies and interventions that target the availability of alcohol, marketing of alcoholic beverages, and pricing policies are most at risk from these agreements. In addition, they constrain general preventive public health measures and affect access to affordable medicines, especially the new biologics drugs to treat cancer.

### Are health officials involved in trade agreements and what can they do to have a voice?

Trade ministries run trade negotiations. The presumptions that drive negotiations are economic and commercial, and preclude an approach that treats health objectives as paramount. Those seeking to defend health policies carry the burden of proving they are justifiable exceptions. Trade negotiators work from existing templates that reinforce that bias. Even if health officials are consulted or invited to negotiations, the dynamics and technical language makes it very hard for them to engage, let alone to intervene effectively. The

19 Article 29.5

secrecy of many negotiations means that health policy advocates outside government have no access to the text or tabled documents and are unable to provide independent and critical advice. Calls from UN special rapporteurs<sup>20</sup> and international health leaders<sup>21</sup> for human rights impact assessments of agreements before they are concluded have been ignored.

### How do these agreements empower the alcohol industry?

Because these agreements are designed to meet the needs of commercial interests, corporate lobbyists have a lot of influence in shaping a government's position. Frequently they operate through broad groupings, such as the Global Services Coalition, or bilaterally, for example, the Transatlantic Business Council. Sometimes industry representatives play a formalised role at a national level<sup>22</sup>.

Agreements increasingly require governments to provide opportunities for affected interests to have prior notice of proposed regulations, the opportunity to comment and submit evidence, to provide explanations for government decisions, and sometimes to review. Various chapters (domestic regulation of services, technical barriers

20 'UN experts voice concern over adverse impact of free trade and investment agreements on human rights', 2 June 2015, <http://www.ohchr.org/FR/NewsEvents/Pages/DisplayNews.aspx?NewsID=16031&LangID=E>

21 Joshua Freeman and others 'Call for Transparency in New Generation Trade Deals', *The Lancet*, 385, 9968, 604-605, 14 February 2015, [http://dx.doi.org/10.1016/S0140-6736\(15\)60233-1](http://dx.doi.org/10.1016/S0140-6736(15)60233-1)

22 The US, for example, maintains a system of industry trade advisory committees, including on distribution services and intellectual property, and cleared advisers who have the opportunity to comment on negotiating proposals; <http://ita.doc.gov/itac/>

to trade, regulatory coherence) privilege light-handed, least-burdensome regulation, with a preference for no, self or co-regulation ahead of directive regulation<sup>23</sup>.

### Lessons from tobacco

There are some important lessons and points of reflection from the experience with tobacco control policies, which have gained much more traction than alcohol policies in the critique of trade agreements.

First, a lot of research has been conducted on the trade-tobacco nexus that can be transposed to the context of alcohol control policies and adapted to provide educational and advocacy resources<sup>24</sup>.

Second, the Framework Convention on Tobacco Control (FCTC)<sup>25</sup> provides a more concrete reference for governments' competing obligations than general international human rights and health obligations or strategies

23 Jane Kelsey, 'The Trans-Pacific Partnership Agreement: A Gold-Plated Gift to the Global Tobacco Industry?', *American Journal of Law and Medicine*, 39,(2-3) p237-264, 2013, although this was written before the final TPPA text became available; see also the analysis of the draft TISA Transparency chapter, <https://wikileaks.org/tisa/transparency/04-2015/#a>.

24 eg. Jane Kelsey, *International Trade Law and Tobacco Control: Trade and investment law issues relating to proposed tobacco control policies to achieve an essentially smokefree Aotearoa New Zealand by 2025*, Tobacco Control Research Turanga, Auckland NZ, 2012, <http://www.turanga.org.nz/sites/turanga.org.nz/files/Kelsey%20Trade%20Law%20Tobacco%20Control%20Report.pdf>; Andrew Mitchell and Tanya Voon, *Legal Issues in Tobacco Control*, *Transnational Dispute Management*, 5, 2012; Benn McGrady, *Trade and Public Health: The WTO, Tobacco, Alcohol and Diet*, Cambridge University Press, New York, 2012

25 [http://who.int/fctc/treaty\\_instruments/adopted/en/](http://who.int/fctc/treaty_instruments/adopted/en/)

for alcohol control. The FCTC gives legitimacy to a raft of measures, including plain packaging of tobacco products<sup>26</sup>, and to the need to quarantine the industry from influencing national policy debates and decisions under Article 5.3<sup>27</sup>. Even if an equivalent instrument was possible for alcohol, that would come too late given the pace at which new FTAs are being signed and the far-reaching mega-agreements that are being negotiated. This reality check makes unequivocal statements from international health agencies and leaders that alcohol causes as much harm as tobacco and calls for the industry to be excluded from the policy and regulatory arena all the more important.

Third, the ambivalence towards restricting alcohol consumption is rarely evident today for tobacco. As a result, it is easier for the industry to push for soft policies like education and voluntary industry codes rather than graphic labeling or bans, even though the evidence shows they are largely ineffective. The robustness of research is crucial because it will be strongly contested throughout the domestic policy process, as the industry is likely to counter with its own 'expert evidence', and when governments rely on it to defend policies against challenges brought under the trade and investment rules. That will be especially hard when innovative or precautionary

26 Article 11.1(b) mandates large and graphic health warnings and messages. Para 46 of the Guidelines for Implementation of Article 11 of the WHO Framework Convention on Tobacco Control (packaging and labelling of tobacco products) encourages parties to consider the adoption of plain packaging.

27 Guidelines for Implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control on the protection of public health policies from commercial and other vested interests in the tobacco industry.

measures are, of necessity, not supported by empirical evidence – a problem encountered with innovations such as plain packaging of tobacco products. It is also important to recognise the potential for official documents that promote compromise, balance, and less directive measures in the hope of greater acceptance by governments and industry to be cited as evidence that there are less burdensome alternatives that could achieve the health policy objectives. Again, such opinions have been used to challenge tobacco control policies, including internal disagreements within governments disclosed through freedom of information laws<sup>28</sup>.

Fourth, governments have stronger commercial interests in alcohol production and sale than for tobacco, including as exporters. The World Wine Trade Group, for instance, is described as an informal group of government and industry representatives from various wine-producing countries. It was founded in 1998 with the aim to 'facilitate international trade in wine through information sharing, discussion of regulatory issues in wine markets, and joint actions for the removal of trade barriers'<sup>29</sup>. The industry section's 'vision' is 'a successful, competitive and growing global wine industry, characterised by social responsibility, sustainability and focus on consumer interests, operating in a climate free of trade-distorting factors'<sup>30</sup>. Given that governments and their industry partners deem many of the most effective alcohol control policies to be 'trade-distorting' there are intrinsic

28 Jane Kelsey, 'The Trans-Pacific Partnership Agreement: A Gold-Plated Gift to the Global Tobacco Industry?', *American Journal of Law and Medicine*, 39,(2-3) p237-264, 2013, pp.257-258

29 World Wine Trade Group: <http://ita.doc.gov/td/ocg/wwtg.htm>

30 World Wine Trade Group Industry Section: <http://www.wwtg-gmco.org/>

barriers that do not exist for tobacco. A number of governments and industry lobbyists have opposed strong tobacco control exceptions out of concern for a 'slippery slope' that this may extend to alcohol and beyond.

### Is it possible to protect alcohol policies from trade agreements?

The only way to fully protect public health policies is through a total carveout from an agreement. The clearest example is the reported proposal from Malaysia to exclude tobacco control policies, aside from tariffs, from the Trans-Pacific Partnership Agreement<sup>31</sup>. Malaysia was apparently supported by only one or two other countries. The compromise, promoted by the US, was an option to exclude tobacco control measures from investor-state dispute settlement<sup>32</sup>. That does not protect policies from state-state disputes in the investment or other chapters, and exposes governments to pressure from the tobacco industry not to exercise that option. Even that compromise is under pressure from members of US Congress from tobacco producing states<sup>33</sup>. It is easy to imagine a much more intense debate over an equivalent exception for alcohol.

Yet the main alternative is the general exception provision that governments often cite, misleadingly, as providing protection for legitimate public health policy. As noted above, the exception is weak and has failed almost every time it has been invoked. The investment chapter in some FTAs and many BITs

do not have even that level of putative protection. Another partial protection is through annexes that preserve the right to maintain measures that do not conform to certain rules on cross-border services or investment. But these only apply to some rules, and are very hard to add to in the future. Increasingly these annexes do not list what the rules cover, but what they do not, either by freezing the existing state of policy and regulation, or only preserving future policy space where a government has the foresight and negotiating ability to do so. Given shifts in thinking about alcohol policy that 'negative list' approach is very problematic. Even more problematic are moves in the TISA to automatically lock in every new liberalisation.

### Can free trade and investment agreements be reversed?

It is much easier to stop these agreements being concluded because the political price is too high, and there are numerous examples where that has occurred. Once an agreement is signed it is difficult to withdraw, and once it is ratified and the agreement comes into force it is binding on the state. Withdrawal is usually technically possible but carries with it reputational and economic harm. That said, a growing number of countries are withdrawing from their international investment agreements, replacing them with more balanced agreements<sup>34</sup> or offering remedies in the host country's domestic courts<sup>35</sup>, or proposing alternative

31 'Will Malaysia's tobacco carveout be adopted in Pacific trade deal?', <http://www.fctc.org/media-and-publications/fact-sheets/industry-interference/1096-will-malaysia-s-tobacco-carve-out-carry-in-pacific-trade-deal>

32 Article 29.5

33 'Reichart says about 15 Republicans will oppose TPP over tobacco', Inside US Trade Daily News, 3 December 2015

34 Luke Eric Peterson, 'India invites comments on draft model investment treaty; text offers radical departure, and calls to mind Norway's past efforts at revision', International Arbitration Reporter, 24 March 2015

35 Promotion and Protection of Investment Bill, following a Cabinet decision of the South African government in July 2010 to withdraw from South Africa's bilateral investment treaties.

dispute forums in future agreements<sup>36</sup>.

### What NGOs can do?

Alcohol industry messaging use of advertising, sponsorship, brand association with popular sporting events both attracts enthusiastic supporters and engenders skepticism about the sales pitch. Health professionals also have intrinsic credibility. It seems more important for alcohol than tobacco that research and stronger advocacy builds on this reputational advantage. Academics, local public health groups, community organisations, and churches among others, need to develop a basic level of literacy about these agreements and organize to stop their expansion and/or demand an effective alcohol carevout.

36 European Union, 'Commission proposes new investment court system for TTIP and other trade and investment negotiations', 16 September 2015, [http://europa.eu/rapid/press-release\\_IP-15-5651\\_en.htm](http://europa.eu/rapid/press-release_IP-15-5651_en.htm)

### Glossary of terms

BIT	Bilateral Investment Treaty
FCTC	Framework Convention on Tobacco Control
FTA	Free Trade Agreement
GATS	General Agreement on Trade in Services (in WTO)
GATT	General Agreement on Tariffs and Trade
SPS	Sanitary and Phytosanitary Measures
TBT	Technical Barriers to Trade
TISA	Trade in Services Agreement
TPPA	Trans Pacific Partnership Agreement
TRIPS	Agreement on Trade-related Aspects of Intellectual Property Rights
WHO	World Health Organization
WTO	World Trade Organization

### References available.

# Protecting Children's Right To Grow Up Free From Alcohol Marketing

**Melvyn Freeman**  
Chief Director Non-Communicable Disease  
National Department of Health, South Africa



**A rights based approach is somewhat different from both a scientific evidence based approach or a moral/ethical approach and may indeed assist in moving the marketing issue forward globally – if combined with the former two approaches.**

In 1989, governments worldwide promised all children the same rights by adopting the UN Convention on the Rights of the Child. The Convention changed the way children are viewed and treated – in other words as human beings with a distinct set of rights. These rights describe what a child needs to survive, grow and live up to their potential in the world. They apply equally to every child, no matter who they are or where they come from.

Article 33 states that:- “Parties shall take all appropriate measures, including

legislative, administrative, social and educational measures, to protect children from illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties. States parties shall encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her wellbeing. The child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.

This convention has been ratified by 195 countries and signed by another two and is binding on countries that have ratified it. Whether or not these clauses oblige us as countries to protect children from alcohol marketing is debatable and if indeed it does, it is not quite clear (to me) what exactly this means.

For example do these rights mean that marketing should not be aimed at children or that children should never be exposed to alcohol marketing? There is quite a difference between these.

## A few important points on alcohol related harm and children/youth

Child or adolescent alcohol consumption is very closely linked to adult alcohol related harm. There is substantial overlap between marketing that specifically targets children and alcohol advertising more generally. Alcohol consumption affects children without them ever touching any alcohol themselves, for example through Foetal Alcohol Syndrome or through being innocent victims of alcohol related traffic crashes or alcohol related violence – so marketing to adults may infringe on the right of the child to protection against harm.

From a health point of view and from the point of view of what is right for children, there is more than a strong case to be made for protecting children from all alcohol marketing through a total or near total marketing ban. Less than this will mean that children will grow up being exposed.

It is definitely “right” to protect children from marketing even if may be still in question whether it is or is not an internationally binding legal right.

## Why do we need to protect children from alcohol consumption?

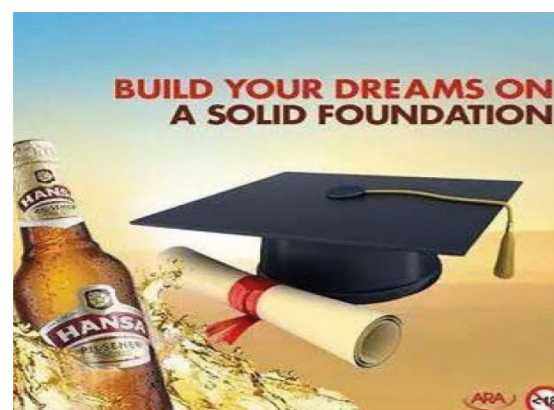
Why should we protect adolescents and children from alcohol marketing? Does advertising that is directed at adults (or ostensibly directed at adults) also impact on adolescents and children? What strategies on marketing would best prevent the harmful impacts of alcohol on children? What has been happening

in South Africa in this regard? Early drinking is associated with increases in motor vehicle crashes and other unintentional injuries. Young people tend to drink to high risk levels when they do drink and tend to be less risk averse.

The 2014 WHO Global Status report on Alcohol and Health explains that children and adolescents are more vulnerable to alcohol related harm from a given volume of alcohol than are adults. The report states that early initiation of alcohol use (before 14 years of age) is a predictor of impaired health status. Early drinking is associated with increases in motor vehicle crashes and other unintentional injuries. Young people tend to drink to high risk levels when they do drink and tend to be less risk averse and engage in reckless behaviour while drunk.

The status report does not go into the damage caused by alcohol to the developing brain but this is well documented elsewhere. The damage is probably worst in the developing uterus where as we all know Foetal Alcohol Syndrome may result, but the impacts can also be quite severe at other stages on the developing brain in children and adolescents. Research now suggests that the brain is still developing into the twenties.

A number of studies, mainly from higher income countries, show that harmful drinking generally begins during adolescence and persists into adulthood. It is estimated that the odds of future alcohol abuse or dependence are 7% greater for each year of age below age 21 that alcohol consumption begins. The risk of adult alcohol dependence is two to three fold greater for individuals who begin drinking by age 12 compared to those who begin at age 19.



Most countries understand that drinking in children is harmful and even the alcohol industry tends not to challenge restrictions on having an age limit for alcohol sales and consumption. In fact a lot of their responsible alcohol use interventions and campaigns are targeted at protecting against underage drinking. Obviously no “good guy” would want to target a child. The industry does though have views on what this age should be!

A review of seven cohort studies that followed up more than 13 000 young people aged 10-26 concluded that there is an association between exposure to alcohol advertising or promotional activity and subsequent alcohol consumption in young people. The effect was consistent across studies and a dose response between the amount of exposure and frequency of drinking was demonstrated. Every additional alcohol advertisement seen by youngsters increases the alcohol consumption with 1%. Youngsters who are highly exposed to alcohol commercial will drink more alcohol when they are in their twenties. However, alcohol consumption stabilises for youngsters who have been lightly exposed to alcohol commercials. Non-drinking 12 year olds who possess a promotional item from an alcohol producer, or would like to have one, have a 77% higher chance of drinking one year later compared to children who are not sensitive to alcohol marketing who

do not possess a promotional item and do not have a favourite alcohol brand.

**Does it really matter whether marketing is specifically aimed at children?**

**The Cochrane Review**

The absence of available evidence cannot be interpreted as evidence that alcohol advertising restrictions do not work. There simply has not been enough high quality research undertaken in the field to draw conclusions in one direction or another (and this is the case as regards restrictions on tobacco advertising as well). Notwithstanding there is a growing evidence base from observational data to show an association between advertising and early initiation of drinking and drinking greater amounts in young people.

A study conducted in Zambia examined the associations between alcohol marketing strategies, alcohol education including knowledge about dangers of alcohol and refusal of alcohol, and drinking prevalence, problem drinking, and drunkenness. It was found that alcohol marketing, specifically through providing free alcohol through a company representative, was associated with drunkenness and problem drinking among youth after controlling for demographic characteristics, risky behaviours, and alcohol education.

# “Momentum for Change: Research and Advocacy Reducing Alcohol Harm”

**David Jernigan**  
**Conference Statement**  
**Edinburgh, Scotland, 7-9 October, 2015**

**DECLARATION**

We, the participants of the fourth Global Alcohol Policy Conference "Momentum for Change: Research and Advocacy Reducing Alcohol Harm", gathered in Edinburgh, Scotland on 7-9 October 2015, to reaffirm our commitment to evidence-based actions to reduce alcohol-related harm worldwide. We recognise that alcohol consumption causes 3.3 million deaths per year, is the fifth leading cause of death and disability worldwide, and is the leading cause of death and disability for young people ages 15 to 24 in much of the world. We also recognise the harms alcohol use causes to non-drinkers, including violence and injury, alcohol-related birth defects, and impact on family budgets. Given the adverse consequences of these and other alcohol-related harms for development,

we note the importance of a specific indicator of alcohol consumption or harm in monitoring progress towards achieving the Sustainable Development Goals.

In light of the close relationship between alcohol consumption and alcohol-related harm, rising alcohol consumption and alcohol industry marketing activity in populous and rapidly growing economies, and the clear evidence of effectiveness of population-wide measures to curb alcohol consumption in reducing harm, we call on all parties to support global action to implement those measures.

We recognise the rights of children to grow up safe from alcohol-related harm, and call upon national governments to implement their commitments in the United Nations Convention on the Rights

of the Child and other human rights agreements, to ensure that children are protected from alcohol-related harm and that alcohol control policies and legislation reflect those commitments.

Specifically, we call on governments and civil society around the world to support and implement WHO's global strategies on alcohol and on non-communicable diseases, focusing on the most effective and cost-effective actions, including the three "best buys" – increasing the price of alcohol, reducing its physical availability, and restricting its marketing – as well as effective implementation and enforcement of proven strategies for reducing drink-driving.

We note with concern the ramifications of global and regional trade agreements for evidence-based public health policies regarding alcohol, and call on all parties to explore mechanisms for protecting the ability of governments at all levels to implement these policies, through the strengthening of existing instruments or the negotiation of a public health-oriented global agreement to address alcohol-related harm, independent of commercial interests in alcohol, that could be binding on its signatories, and be effective in preventing and reducing the global toll of alcohol use on human

health, safety and quality of life.

We call attention in particular to the urgent need to restrict alcohol marketing in all its forms. The evidence is clear that exposure to alcohol marketing increases the likelihood and quantity of young people's drinking. It normalises alcohol consumption and encourages the loss of abstinence in growing economies and populations where drinking prevalence has historically been low.

We also strongly recommend the implementation and evaluation of minimum pricing for alcohol where appropriate. We call on Member States, in setting and implementing their public health policies with respect to alcohol control, to act to protect their alcohol policies from commercial and other vested interests of the alcohol industry.

We call on the global philanthropic community to recognise alcohol's significant role in injuries, in infectious diseases such as HIV and tuberculosis, in cancer and a wide range of non-communicable diseases, and in mental health and social harms, and to provide funding to national and international NGOs and research organisations commensurate with alcohol's burden on health worldwide.

Maureen Watt welcomes delegates to the Scottish Governments reception at Edinburgh Castle



# Tribute to Derek Rutherford Retiring Chair of GAPA

Professor Dr Stephen Orchard  
Chairman Alliance House Foundation Former  
Principal Westminster College Cambridge



Sally Casswell speaking at the dinner to honour Derek Rutherford's retirement at The Royal College of Physicians Edinburgh hosted by Alliance House Foundation

**Derek Rutherford and I first met as young men in the 1960s as student leaders at the National Temperance Summer School. The schools were held annually at Eastwood Grange, Ashover, Derbyshire, sponsored by the British National Temperance League under the leadership of Herbert Jones. It provided a sophisticated approach to Temperance education - a country house holiday for young people from urban terraces, in which they were expected to take responsibility for running much of the programme themselves.**

Herbert Jones gave bursaries to young people he wished to cultivate as potential leaders of the movement. The residential experience was as

much about winning commitment to a cause as sharing information, though information was available, from authoritative and attractive sources.

The Summer School did not make Derek Rutherford a Temperance advocate – he was already committed through his association with the International Organization of Good Templars. It did confirm him in his views and strengthen his contacts with the then national leaders in the field and future allies. Although trained as a teacher, Derek had political ambitions and was on short lists for the Labour candidacy in at least two constituencies. Parliament's loss was public health's gain. Indeed, Derek's professional life has been spent in a period when those who chose to work in



non-governmental agencies have often achieved more in shaping national life than a backbencher can ever do.

The young teacher was not called to the House of Commons but to set up a new organization, TACADE, the Teachers' Advisory Council on Alcohol and Drug Education in 1969. This provided an outlet for Derek's varied interests. The extension of the school leaving age, first to fifteen and then sixteen had created an opportunity for religious education syllabuses to move beyond the scriptural curriculum of earlier years to engage with issues affecting young people, often characterised as "sex, drugs and rock'n'roll." There were also new opportunities in health education and the extension of the science curriculum. The provision of material and training for teachers in these new areas was a new opportunity for a campaigner like Derek.

TACADE, with backing from the United Kingdom Temperance Alliance, was launched and grew. In 1973, having demonstrated his commitment and competence, Derek was recruited as the Director of the National Council on Alcoholism. He travelled widely, establishing a network of alcohol

information centres at a local level in England and Wales, commissioned by the Department of Health. The Rutherford style was being formed. Challenge people with new information, infect them with your enthusiasm and trust them to carry forward the project. By the time he left the National Council, in 1982, there were 40 such centres to testify to its effectiveness.

He became a confidant of the Chairman of the Council, the late Sir Bernard Braine MP, and briefed him extensively when relevant legislation was before Parliament, both during this time and subsequently. In his time at the National Council the training of voluntary alcohol counsellors had been established, together with alcohol and workplace programmes for trade unions, industry and commerce. He was also a member of the Government's Advisory Committee on Alcoholism from 1975-1979.

This solid professional development prepared Derek for the remainder of his life's work. The United Kingdom Alliance was the old political vehicle for the Temperance movement. In the period after the Second World War the Alliance took the tactical decision to vest much

of its property in a new educational charity, the United Kingdom Temperance Alliance, with an educational and advocacy programme, rather than a political agenda. The UKTA became the owners of the Alliance's freehold offices in Caxton Street, Westminster. By 1982 it was evident to some members of the board of the UKTA that all was not well in the organisation. They then invited Derek Rutherford to return and take on the role of Chief Executive.

He now found himself in charge of an organisation that represented a cause which was dear to him but was in need of restructuring and redirecting. His position was strengthened by his recruiting a colleague from the National Council, Andrew McNeill, to be his deputy, and by rallying old friends from Eastwood Grange to take up vacant positions on the board.

Part of the work was administrative; the office building, which was the major capital asset, needed programmes of modernisation and more efficient management, in order to generate income. This was fundamental to the real work of the charity and Derek put part of his energies into ensuring all this came to pass. However, his real genius came in the reinvention of the UKTA to meet the changes in the public views on alcohol. Consumption rose steadily through this period, as alcohol became both more affordable and more available. Broadening off-licence provision to supermarkets was to have a long-term effect on drinking patterns in the home and amongst the young. Drinking became prevalent in a wider range of social contexts.

Derek took no delight in his Cassandra-like role, pointing out that increased consumption would lead inevitably to greater harm to public health and public order. He was particularly concerned that many churches dropped their

historic advocacy of teetotalism, in the belief that going along with the idea of moderate drinking would bring them closer to the public. The churches wished to avoid being regarded as censorious and seemed to forget why they had taken up abstinence in the first place. Derek was confirmed in the view that those who forget their history are doomed to repeat it. He was determined to avoid this negative scenario for the future and to take an evidence-based approach, with a view to changing public perceptions. He and Andrew developed the Institute of Alcohol Studies to collate and disseminate information about the harmful effects of alcohol in individuals and society. Within that broad remit the limited resources of the Institute were devoted to particular issues as opportunity arose.

The one new restriction on drinking in an era when regulations were eased was the introduction of the breathalyser for drivers. It took a brave politician, Barbara Castle, to introduce it amid a chorus of disapproval from libertarians and vested interests. The new Institute sought to work with the Campaign Against Drinking and Driving to support the new law and to push for tougher penalties for those who broke it. Along with the drink-drive legislation came the "responsible drinking" message from government. Derek was instinctively against this because it assumed drinking to be a normative activity and ignored an abstaining life-style by implication. For a while the new Institute ran a campaign for young people, in conjunction with the National Union of Students called "Stay Dry". The Achilles heel of this initiative was that, however much student welfare officers wished to limit the potentially harmful drinking of students, a large proportion of student union funds were and still are derived from bar takings.

The artwork for this campaign also

**Professor Sally Casswell, Chair of GAPA, presenting Derek Rutherford outgoing Chair with a commemorative plaque**



served to illustrate Derek's book, "A Lot of Bottle", a popular exposition of the questions alcohol raises for society. After a few years it became evident that there was no groundswell for a popular movement against alcohol consumption that might compare with those of the early twentieth century and the UKTA and the Institute began to consider new tactics under Derek's leadership.

What presented itself as a problem, the proposed harmonisation of duty on alcohol across the European Community, leading to further comparative reductions in the price of alcohol, was turned into an opportunity; the founding of Eurocare. Having once conceived this rather bold idea of taking the fight to Europe rather than accepting any adverse effects of European legislation, Derek brought to the task the same gifts that had characterised his development of the National Council on Alcoholism. This time he travelled Europe looking for possible allies and openings. The result was the first consultation at Parceval Hall, in the Yorkshire Dales, which planned the structure and programme for Eurocare.

The growth of Eurocare was not without its problems and not everyone agreed with all that Derek proposed but, by sheer dogged determination and hard work, he carried it forward. Quite early in the growth of Eurocare Derek identified the need for a presence in Brussels to facilitate contact with the Commission and persuaded the UKTA to buy premises there. At a time when the British government seemed to listen more to the industry than to the health professionals the contact with the wider European scene, including the European Region of the World Health Organization, was crucial in keeping the IAS in tune with developing trends in alcohol policy.

Europe was not enough for Derek. Alcohol production and sale

is dominated by international conglomerates, with powerful lobbies well beyond their notional host countries.

What was true in Europe was true for the world as a whole and Derek began to wonder if national non-governmental organisations around the world might be brought together to share information and promote healthier policies. Once more, having made initial enquiries and contacts, Derek masterminded a conference at Syracuse, in New York State, to consider the formation of a Global Alcohol Policy Alliance.

Historically this was an apt place to begin, for this part of New York State had seen Quakers and Methodists launch emancipation movements for women and slaves, linked with the advocacy of temperance. The meeting was timely in another sense, as it began to dawn on development agencies that changing indigenous cultures to accommodate the worst of Western drinking habits would undermine progress. GAPA became a retirement project for Derek, which he now hopes to hand on in a developed state comparable to that of Eurocare.

Meanwhile, back at base, the UKTA decided to give a measure of autonomy to the Institute of Alcohol Studies to enable it to develop as a primary source of information on alcohol issues. The skilful use of project staff in meeting particular requirements of clients was part of this. The Institute played a key role in bringing together a disparate group of opponents or critics of the legislation to change the licensing system. In the end the libertarian, drinks industry and tourist lobbies prevailed in persuading legislators to loosen up the licensing system and to all but abolish opening hours. The promised end of closing-time brawls has never materialised – we have mayhem going on into the night in some city centres. The promised leisure drink for the

**GAPA Closing Ceremony:  
The flag is handed to the  
next host, Australia.**



middle-class country walker has also gone by default, when landlords have chosen not to open when there is little trade about, not to mention the social and economic forces which are driving the cosy country pub of popular myth into extinction. The IAS did its best to prophecy the possible negative consequences of the legislation and remains in touch with its former partners against the day the legislation is revised.

The IAS has also recruited some of the country's top specialists in various aspects of the alcohol problem to act as consultants to its board. This has sharpened the focus of its activities and allowed it to follow the growing concern amongst the medical establishment concerning the rising price of alcohol-related illness to the National Health Service. Derek, as a long-time participant in the public debate around alcohol issues, has made his experience and insight available after his retirement from his executive role. He is also taking on experimental work in seeing if a new generation of abstainers can be formed.

Derek would probably regard as failure his period as International Secretary of the International Organization of

Good Templars. This is not because of any shortcomings in his administrative skills. However, over his time in office he developed a vision for the future of the organisation, which he wished to see relaunched under a new name. The critical international meeting to bring about these changes failed to reach the necessary two thirds majority in its favour. Disappointed at the time, he has since done his best to maintain contacts with his former colleagues and to draw them into the other developments in which he is now involved.

All this might suggest Derek is wholly driven by his work. This would be to underestimate his pride in his family and love for his grandchildren. It would also ignore the many years he has served as a magistrate and in his local church. However, Derek would be the first to admit that his life had been driven by his concern to open the eyes of the world to the dangers inherent in our consumption of alcohol. Some people work for the material rewards they accumulate. Derek has always counted himself fortunate to be in the paid employment which coincides with his vocation. No one, even those who disagree with him, can doubt the genuineness of his commitment.

# World Health Assembly Side Event Discusses Alcohol Marketing

Oystein Bakke, Secretary of GAPA reports



**A side event, the first specifically on alcohol, held at the recent World Health Assembly (WHA) was co-hosted by Member States from five different WHO Regions, with input from the Global Alcohol Policy Alliance. The topic of the event was “Alcohol Marketing in the Digital World”.**

The side event focused on the proliferation of digital marketing of alcohol. Despite the international public health consensus about the concerns over alcohol marketing and the effectiveness of reducing the exposure, particularly of young people, there has been a considerable expansion of marketing activity in the digital world. Alcohol is a considerable public health burden resulting in some 3.3 million deaths annually and 4.1% of the health burden measured in Disability Adjusted

Life Years (DALYs) including 6.6% for the age group 15-49 years.

In her key note presentation Professor Sally Casswell, Director SHORE & Whariki Research Centre, WHO Collaborating Centre, Massey University, New Zealand and chair of the Global Alcohol Policy Alliance (GAPA) pointed out that there are three billion internet users in the world, with two billion active social media users. Though the numbers are lower in low and middle income countries this is an area with rapid expansion. Young adults who are the heaviest users of the internet and social media in particular are also the heaviest drinkers in many countries. Alcohol marketing is widespread in many social media and entertainment channels, with both product advertisement and a blurring between company instigated

and user generated content, which often portrays a culture of intoxication and widespread alcohol use. Research has shown a link between exposure to marketing material in the digital environment and early onset of drinking and heavier use. The transnational alcohol corporations are very active marketing brands in the global youth culture and are collaborating in many real world and digital events.

### Common challenges

Following Professor Casswell's intervention, representatives of the co-hosting member states held their interventions.

H.E Margarita Guevara, Minister of Health, Ecuador pointed out that the pressure the industry is putting on is huge but that in Ecuador there is strong political will to address the problem. She presented several initiatives by the government to meet these challenges.

Triinu Täht, Alcohol Policy National Counterpart, Ministry of Social Affairs, Estonia, showed various examples

of digital alcohol marketing. She pointed out that it is not long since it was believed that tobacco advertising could not be banned and said that an international response was required.

Dr. Nguyen Minh Hang – Deputy Director, General Department of Preventive Medicine, Ministry of Health, Vietnam, referred to the International Alcohol Control Study in her country which showed that alcohol advertising is reaching all age groups including 16-17 year-olds and that Facebook is widely used by young people. She showed many examples of digital marketing including marketing of spirits on Facebook which is circumventing the law against advertising beverages above 13%.

Mr Pheny Sebonego, the National Focal person for the Alcohol and Substance Abuse programme, Botswana, showed data that indicate that the drinking age is getting lower. He said that legislation of alcohol marketing is at the draft stage and he pointed to the need for cooperation between countries. Dr. Palitha Abeykoon, Chairman, Tobacco and Alcohol Authority of Sri



**Chair of GAPA, Sally Casswell, with panel presenting at the WHA side event.**



**H.E Margarita Guevara,  
Minister of Health, Ecuador  
speaking from the side  
event**

Lanka, presented the work that has been done in Sri Lanka where there is a comprehensive act regulating both tobacco and alcohol and where there is a ban on advertising of both products. He showed some examples of industry circumvention of the legislation.

Moderator Dr. Shekhar Saxena, Director, Department of Mental Health and Substance Abuse, World Health Organization summed up the presentations with the observation that the problems in relation to digital marketing of alcohol are common in the sense of being frequent within all the countries participating and common in the sense of similarities for all the involved Member States that presented from the panel. He thanked the sponsoring member states for organising this event and all the panel members and participants for their contribution.

### **Delegates calls for stronger public health response to alcohol**

In the interventions from the audience, it was pointed out that a long time has

passed since the WHO Global strategy to reduce the harmful use of alcohol was endorsed in 2010, and that there is a need to revisit that. Several interventions referred to the experience with tobacco and would like to see something similar for tobacco. The FCTC Article 1 was mentioned in particular for definitions of advertising and sponsorship.

In the WHA debate on non-communicable diseases (NCDs) the next day several countries mentioned the need for stronger public health response to address the harmful use of alcohol. Congo, speaking on behalf of 47 countries in the African region, called on the Director General of WHO to set up a thinking group to look at harmful use of alcohol as a factor for NCDs. This was supported by Botswana speaker who called upon the Director General to study the necessity and feasibility of a legally binding instrument to strengthen the public health response to harmful use of alcohol. Also speaking on the matter, Thailand, Sri Lanka, South Africa and Senegal supported the need to address alcohol.