Analysis of changes to the World Health Organization Global Alcohol Action Plan 2022-2030

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Introduction

In 2010, the World Health Organization (WHO) reached a consensus on a *Global Strategy to Reduce the Harmful Use of Alcohol* (the Strategy). Progress towards achieving the objectives of the Strategy has been uneven across countries or Member States, leading to the WHO Executive Board calling for a detailed *Global alcohol action plan 2022–2030 to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol*[1] (the Action Plan) to accelerate progress.

During 2020 and 2021, several rounds of consultation occurred on the Action Plan. Some of this consultation has been made public, including 60 submissions from alcohol industry actors which accounted for nearly a quarter of all submissions made. Industry submissions were analysed by a team of leading Australian researchers, the results of which are published in the accompanying report: *Alcohol industry submissions to the WHO 2020 Consultation on the development of an Alcohol Action Plan: A content and thematic analysis.* This analysis identified the key arguments used by the alcohol industry in attempting to shape the content of the Action Plan.

In November 2020, the *Working Document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol*[2] (Working Document) was released and public consultation opened. This Working Document was then followed by several drafts, with a third draft of the Action Plan[3] released in January 2022, prior to discussion at the 150th session of the WHO Executive Board later in the month. Changes between the Working Document and the third draft have been compared, identifying changes that are consistent with alcohol industry recommendations.

These examples of alcohol industry arguments having an observable impact on development of health policy contribute to an existing evidence base that highlights how the alcohol industry consistently deploys strategies to undermine effective action on alcohol harm in order to protect their profits.

Key findings

In the third draft of the Action Plan there are a number of changes which are consistent with what the alcohol industry called for in their submissions. The three most concerning changes are:

1. A global target aiming for a reduction in overall alcohol consumption has been watered down, despite evidence that reducing overall consumption is an effective way to reduce alcohol-related disease and ease the burden on health systems. [4] The new target now narrowly focuses on 'harmful' alcohol use, which cannot be clearly defined, meaning measurement of progress will be difficult.
2. The emphasis on encouraging governments to adopt "SAFER" initiatives (evidence-based policies that target the price, availability and promotion of alcohol products, as well as policies to improve health services and prevention of drink driving) has been reduced. The third draft of the Action Plan waters down key targets and actions that were specifically focussed on SAFER initiatives.
3. There are more opportunities for alcohol companies to self-regulate, setting their own rules and standards around advertising and marketing, instead of governments taking responsibility for protecting public health.

Detailed analysis

Key findings from analysis of alcohol industry submissions (*see accompanying report for detail*)	Changes to the Action Plan from the Working Document to the Third Draft	Implications
Seventy-nine per cent of alcohol industry submissions focused on reduction of *"harmful"* alcohol-use, rather than the reduction of alcohol consumption per capita.	In the Working Document, Global target 1.2 aimed for a reduction in alcohol per capita consumption. In the third draft this has been changed to a reduction in the *"harmful use of alcohol".* As a result, the indicators for the Action Plan's target now include data on the prevalence of heavy episodic drinking, alcohol attributable deaths and DALYs (disability adjusted life years).[i] An indicator for long-term harm, such as the increased risk of cancer and stroke caused by alcohol is notably absent from this list.	Alcohol is a harmful drug that when used, poses risks of injury and disease. People can reduce their risk by reducing their level of drinking, but not entirely eliminate risks to their health. This is why health guidelines on alcohol, such as from the Australian Government, are based on reducing risk from drinking alcohol. Setting a target towards reducing *"harmful"*alcohol use undermines this important health guidance based on risk. It implies that if there is a harmful level of use, there is a *"non-harmful"* or safe level, which evidence shows is not correct.[5] This approach also undermines the important work of educating everyone in the community about the risks of alcohol use. The narrowing of the target shifts attention to a smaller cohort of people that are deemed to be drinking at acutely harmful levels, meaning health promotion efforts among the wider community to reduce risky drinking are not prioritised. The revised target shifts attention away from the need to take action at a population level to reduce alcohol harm. Action is required at a population level, as well as supporting people at risk, to reduce the health, social and economic impact of alcohol on the community.

i The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). See here for an explanation from the WHO: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158

Fifty-five per cent of the alcohol industry's submissions questioned a primary or sole focus on the SAFER[ii] initiatives to the exclusion of other policy options.	Global target 1.3 from the Working Document aimed for 80 per cent of the world's population to be protected from harmful alcohol use by sustained implementation and enforcement of high impact policy options and interventions. This target has been merged with Global Target 1.1 to become Global Target 1.2, and together they have been weakened by removing references to the need to sustain and enforce implementation of harm reduction measures and to strengthening of existing strategies. The level of the target has also been lowered from a high of 80 per cent down to 70 per cent. The new **Global target 1.2** now says: *"By 2030, 70 per cent of countries have introduced, enacted or maintained the implementation of high-impact policy options and interventions by 2030."* Global target 2.1 has also been weakened. The Working Document called for legislative measures to support sustained implementation of high-impact strategies and interventions in order to achieve the target. The target no longer refers to the need for legislative support for the measures, and the indicators have been adjusted accordingly: **Global target 2.1:** *"By 2030, 75 per cent of countries have developed and enacted national written alcohol policies."* Action 1 for Member States under Action Area 1 has been adjusted and provides less clarity about which measures are the priority measures to reduce harm and shifts emphasis away from the most effective SAFER initiatives. The third draft includes an addition that suggests member states can look beyond SAFER initiatives towards *"other interventions already proven to be cost-effective or subsequently proven to be cost-effective based on upcoming evidence"*. A further change to the Action Plan is found at Action 1 for the WHO Secretariat under Action Area 1. The third draft no longer requires the Secretariat to specifically lead implementation of the SAFER initiatives in collaboration with WHO partners. Instead, the action has been watered down to remove this lead role for the Secretariat and any reference to the SAFER initiatives.	Changes such as these reduce the focus of the Action Plan on the most evidence-based policies incorporated in the SAFER initiatives, that have proven effectiveness in reducing alcohol harms. These include action on price, availability and advertising which require legislative action to implement. Instead of reinforcing the message about the most effective strategies to reduce alcohol harm, as articulated in the SAFER initiatives, and providing processes to support countries to achieve these targets, these changes undermine the aims and objectives of the Global Alcohol Strategy and Action Plan reducing the effectiveness of the Plan. For example, removing the need for legislative action to support implementation of national alcohol polices in Global Target 2.1 de-emphasises the critical nature of these actions to reduce alcohol harm. This change takes the focus away from the importance of supporting action to reduce harm by legislative action.

ii SAFER Initiatives are: Strengthen restrictions on alcohol availability, Advance and enforce drink driving countermeasures, Facilitate access to screening, brief interventions, and treatment, Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion and Raise prices on alcohol through excise taxes and pricing.

Ninety per cent of industry submissions challenge a perceived exclusion of industry as a stakeholder/ partner in harm reduction and policy making.	The third draft has been changed to allow more opportunities for the alcohol industry to regulate itself on the marketing of its products, instead of calling on government-led regulation. This has been achieved through legitimisation of co-regulatory and self-regulatory approaches to alcohol policy in the Action Plan (third draft additions in bold): • Action for non-State actions in regard to marketing to minors: "[Economic operators are invited] *to take concrete steps towards eliminating the marketing and advertising of alcoholic products to minors* ***and, where relevant, towards developing and enforcing self-regulatory measures on marketing and advertising in conjunction with the development and enforcement of statutory regulations or within a co-regulatory framework****"* • Action for non-State actors regarding targeted marketing to high-risk groups:[iii] "*Economic operators in alcohol production and trade, as well as economic operators in other relevant sectors (such as retail, advertisements,* ***hospitality, tourism****, social media and communication), are encouraged to contribute to the elimination of marketing and sales of alcoholic beverages to minors and to the elimination of commercial activities targeted towards other high-risk groups,* ***as well as to implement self-regulatory measures and take other actions to contribute to the elimination of such marketing practices within regulatory and co-regulatory frameworks with a legislative basis****"*	The alcohol industry has a vested interest in selling alcohol and maximising profit. Ultimately it seeks to prevent, delay and undermine efforts to introduce effective alcohol policy that protects people's health. In Australia, the industry strives to position itself as a legitimate and important part of life. In so doing, it fails to acknowledge the health, social and economic harms that are caused by its products. These and other actions of the industry are like those used by the tobacco industry to undermine the clear evidence of harm caused by their products.[6] The Action Plan grants legitimacy to alcohol industry efforts to regulate itself through 'self-regulation', despite self-regulation being shown to be ineffective and a tactic to delay meaningful government action on alcohol harm. Self-regulation of alcohol marketing via 'codes of practice' developed by the industry have consistently failed to protect public health, young people and others who are vulnerable. Such schemes are generally voluntary, which means companies are not required to abide by them, have no power to enforce findings and have few consequences if a company is found to be in breach. Industry marketing codes of practice themselves employ vague language, which allows the industry to circumvent their own rules, and are often limited in their application.[7] Few complaints are upheld through self-regulation,[8] and where they are upheld, the damage has already been done. Due to their lack of serious penalties for breach, they ultimately lack the ability to deter future breaches. Through these changes to the Action plan, alcohol companies have now been granted further opportunities to set their own rules and standards for marketing, instead of governments.

iii In the Working Document, this statement is found under Action Area 1, in the third draft it is under Action Area 3.

References

1 For a detailed timeline of consultation, see here: https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-and-addictive-behaviours/alcohol/our-activities/towards-and-action-plan-on-alcohol

2 World Health Organization 2020 Working Document for development of an action plan to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol 14 November 2020 https://fare365.sharepoint.com/FARE_Policy/Policy%20submissions/2020/WHO%20Global%20Alcohol%20Action%20Plan/WHO_working_document_GAS_action_plan_141120.pdf

3 World Health Organization 2022 Draft Global Action Plan (2022-2030) to effectively implement the Global Strategy to Reduce the Harmful Use of Alcohol as a public health priority Appendix to Provisional agenda item 7, 150th session, WHO Executive Board https://apps.who.int/gb/ebwha/pdf_files/EB150/B150_7Add1-en.pdf

4 AIHW (2021) Burden of disease https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/overview

5 Topiwala A, Ebmeier K, Maullin-Sapey, T & Nichols T 2021 No safe level of alcohol consumption for brain health: observational cohort study of 25,378 UK Biobank participants https://www.medrxiv.org/content/10.1101/2021.05.10.21256931v1

6 Pettigrew S, Hafekost C, Jongenelis M, Pierce H, Chikritizhs T & Stafford J 2018 Behind Closed Doors: The Priorities of the Alcohol Industry as Communicated in a Trade Magazine Public Health 31 July 2018 https://doi.org/10.3389/fpubh.2018.00217

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8 Pierce H, Stafford J & Daube M 2017 Developing an alternative alcohol advertising complaint review system: Lessons from a world-first public health advocacy initiative Public Health Research & Practice 27(3) July 2017 https://www.researchgate.net/publication/318676393_Developing_an_alternative_alcohol_advertising_complaint_review_system_Lessons_from_a_world-first_public_health_advocacy_initiative/figures?lo=1

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