NAAA
National Alliance for Action on Alcohol

# Comments on the Draft action plan for the prevention and control of non-communicable diseases 2013–2020

(version released on 11 January 2013)

The National Alliance for Action on Alcohol (NAAA) has prepared comments on the *Draft action plan for the prevention and control of non-communicable diseases 2013–2020*[1]. Our comments are divided across the three most relevant aspects of the draft action plan from our perspective: (1) the proposed actions on alcohol listed under Objective 3; (2) the voluntary target and indicators on alcohol proposed for the global monitoring framework; and, (3) the involvement of the alcohol industry in the development and implementation of the draft action plan.

## 1. Comments relating to the proposed actions on alcohol under Objective 3 (pages 22-23)

The NAAA supports the broadly stated action at §38(a) of the draft plan to "advance the implementation of the global strategy to reduce the harmful use of alcohol".

However, the NAAA recommends that this section should be strengthened by **prioritising** those areas for action that are listed, according to which will have greatest effect upon reducing harmful use of alcohol and the risk of NCDs. In this regard, we recommend that the main priorities should be (in order): availability of alcohol, pricing policies, drink-driving policies and countermeasures, policies to regulate the marketing of alcohol, and health services' responses.

Further, in our view, these remain very broad alcohol policy categories and we strongly recommend the inclusion of **more detailed guidance** for each to steer countries' efforts; similar to the level of detail provided in the draft action plan pertaining to tobacco control at §35(b) and promoting a healthy diet at §36(a-i). As such, we recommend adding more detailed actions to §38(a) based around the policy options detailed in the *Global strategy to reduce harmful use of alcohol*[2], as follows:

> Actions to support the policies on the availability of alcohol include:
>
> (a) establishing, operating and enforcing an appropriate system to regulate production, wholesaling and serving of alcoholic beverages that places reasonable limitations on the distribution of alcohol and the operation of alcohol outlets in accordance with cultural norms, by the following possible measures:

[1] World Health Organisation (WHO) Draft action plan for the prevention and control of noncommunicable diseases 2013-2020. 11 January 2013. WHO. Geneva. Accessed from: http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_6-en.pdf

[2] World Health Organisation (WHO) *Global strategy to reduce harmful use of alcohol*. Geneva. 2010. Accessed from: http://www.who.int/entity/substance_abuse/alcstratenglishfinal.pdf

- introducing, where not already in place, a licensing system on retail sales, or public health oriented government monopolies;
- regulating the number and location of on-premise and off-premise alcohol outlets;
- regulating days and hours of retail sales;
- regulating modes of retail sales of alcohol;
- regulating retail sales in certain places or during special events;

(b) establishing an appropriate minimum age for purchase or consumption of alcoholic beverages and other policies in order to raise barriers against sales to, and consumption of alcoholic beverages by, adolescents;
(c) adopting policies to prevent sales to intoxicated persons and those below the legal age and considering the introduction of mechanisms for placing liability on sellers and servers in accordance with national legislations;
(d) setting policies regarding drinking in public places or at official public agencies' activities and functions;
(e) adopting policies to reduce and eliminate availability of illicit production, sale and distribution of alcoholic beverages as well as to regulate or control informal alcohol.

Actions to support alcohol pricing policies include:

(a) establishing a system for specific domestic taxation on alcohol accompanied by an effective enforcement system, which may take into account, as appropriate, the alcoholic content of the beverage;
(b) regularly reviewing prices in relation to level of inflation and income;
(c) banning or restricting the use of direct and indirect price promotions, discount sales, sales below cost and flat rates for unlimited drinking or other types of volume sales;
(d) establishing minimum prices for alcohol;
(e) providing price incentives for non-alcoholic beverages;
(f) reducing or stopping subsidies to economic operators in the area of alcohol.

Actions to support drink-driving policies and countermeasures:

(a) introducing and enforcing an upper limit of 0.05% for blood alcohol concentration, with a zero limit for professional drivers and young or novice drivers;
(b) promoting sobriety check points and random breath-testing;
(c) administrative suspension of driving licences;
(d) graduated licensing for novice drivers with zero-tolerance for drink-driving;
(e) using an ignition interlock, in specific contexts where affordable, to reduce drink-driving incidents;
(f) mandatory driver-education, counselling and, as appropriate, treatment programmes;
(g) encouraging provision of alternative transportation, including public transport until after the closing time for drinking places;
(h) conducting public awareness and information campaigns in support of policy and in order to increase the general deterrence effect;
(i) running carefully planned, high-intensity, well-executed mass media campaigns, including those targeted at specific situations, such as holiday seasons, or for audiences such as young people.

Actions to support health services' responses include:

(a) increasing capacity of health and social welfare systems to deliver prevention, treatment and care for alcohol-use and alcohol-induced disorders and co-morbid conditions, including support and treatment for affected families and support for mutual help or self-help activities and programmes;

(b) supporting initiatives for screening and brief interventions for hazardous and harmful drinking at primary health care and other settings; such initiatives should include early identification and management of harmful drinking among pregnant women and women of child-bearing age;
(c) improving capacity for prevention of, identification of, and interventions for individuals and families living with fetal alcohol syndrome and a spectrum of associated disorders;
(d) development and effective coordination of integrated and/or linked prevention, treatment and care strategies and services for alcohol-use disorders and comorbid conditions, including drug-use disorders, depression, suicides, HIV/AIDS and tuberculosis;
(e) securing universal access to health including through enhancing availability, accessibility and affordability of treatment services for groups of low socioeconomic status;
(f) establishing and maintaining a system of registration and monitoring of alcohol attributable morbidity and mortality, with regular reporting mechanisms;
(g) provision of culturally sensitive health and social services as appropriate.

Actions to support regulating the marketing of alcohol include:

(a) setting up regulatory frameworks, with a legislative basis, and avoiding self-regulatory measures, for alcohol marketing by:
- regulating the content and the volume of marketing;
- preventing the exposure of children and young people to alcohol promotion;
- regulating direct or indirect marketing in certain or all media;
- ending sponsorship of sporting and musical activities that promote alcoholic beverages, where children and young people may be exposed to these promotions;
- banning promotions that target young people;
- regulating new forms of alcohol marketing techniques, for instance social media;

(b) development by public agencies or independent bodies of effective systems of
(c) surveillance of marketing of alcohol products;
(d) setting up effective administrative and deterrence systems for infringements on marketing restrictions.

To align with the proposed actions on tobacco control at §35(c) (point 1), we recommend that the following statement is added is to §38(b) regarding the alcohol industry to ensure that **public health policies** are developed with the public interest as the primary concern:

> "In order to facilitate the implementation of measures described above, action should be taken to protect alcohol policies from commercial and other vested interests of the alcohol industry in accordance with national law. In doing so, countries should consider the 2006 WHO expert committee recommendation regarding interacting with the alcohol industry."[3]

We support the call in the draft action plan for **leadership** by health ministries on alcohol at §38(c) in the draft action plan, but we also recommend greater emphasis should be given to the role of non-traditional areas of public health in leading efforts to reduce harmful use of alcohol, such as law enforcement agencies, government treasury and finance ministries, and ministries responsible for aspects of market regulation such as pricing, advertising and product safety. This point is broadly articulated at §51(c) in the *Global strategy to reduce harmful use of alcohol*.

The WHO has previously reported that the magnitude of alcohol-attributable disease and social burden is in sharp contradiction with the resources available at all levels to reduce harmful use of alcohol. We therefore recommend that the actions in the draft plan regarding **capacity** at §38(d) be expanded to include recommended actions in the *Global strategy to reduce harmful use of alcohol* (refer to page 21-23) in relation to **technical support**, **capacity building** and **resource mobilisation**.

[3] WHO expert committee on problems related to alcohol consumption. Second Report. WHO. Geneva. 2006. Accessed from: http://www.who.int/entity/substance_abuse/expert_committee_alcohol_trs944.pdf

We believe that countries should be **monitoring** policy development, implementation and outcomes, in addition to monitoring alcohol use, and as such we recommend an expansion of §38(e) of the draft action plan to reflect this. With regards to monitoring alcohol use, we recommend that countries prioritise the collection and monitoring of alcohol sales or taxation data in order to develop robust measures of annual per capita alcohol consumption. We elaborate further below the importance of per capita alcohol consumption as an appropriate NCD risk factor indicator.

2. Comments on the voluntary target and indicators on alcohol proposed for the global monitoring framework

The NAAA accepts voluntary target #2 for alcohol described in the draft action plan of "at least 10% relative reduction in the harmful use of alcohol" by 2025 [refer to table on page 6 of the draft plan].

However, we strongly recommend that this target refer to a reduction in **adult per capita consumption of alcohol**, rather than "harmful use of alcohol", given the international scientific evidence linking overall consumption levels to the prevalence of chronic diseases caused by alcohol consumption.

Monitoring harmful patterns of alcohol use is important, but adult per capita consumption of alcohol is a more comprehensive measure of the risk of alcohol-induced chronic disease rates in the population and is more widely, consistently, and regularly collected among member countries than measures of harmful use of alcohol. As stated in the third WHO discussion paper on the NCD monitoring framework[4]:

> *The available data indicate that the overall levels of alcohol consumption, measured as per capita alcohol consumption, correlate with major alcohol-related health outcomes. Level of per capita consumption correlates with the levels of hazardous and harmful drinking and can be considered as the only reliable proxy measure for global monitoring of the "harmful use of alcohol" as defined in the WHO Global Strategy to Reduce the Harmful Use of Alcohol.*

We also remain concerned that the target for alcohol as articulated in the draft action plan is weakened by the qualifying statement attached to it: "as appropriate, within the national context". This qualifying statement does not appear in targets for any other risk factor within the draft action plan, even those where the targeted change in risk is much higher than that proposed for alcohol (e.g. 30% reduction in salt/sodium intake; 30% reduction in tobacco use).

In our view, the qualifying statement "as appropriate, within the national context" allows countries to opt out of the globally-agreed target of a 10% reduction, and determine their own, lower target for alcohol. This undermines the whole purpose of setting a global target. For example, in its submission to the first WHO discussion paper on the NCDs monitoring framework[5], the Australian government expressed opposition to the proposed target of a 10% relative reduction in per capita consumption of alcohol on the basis that in Australia the current trend in per capita consumption is "relatively stable and is not expected to significantly decline".[6] We strongly object to this statement and the logic

[4] World Health Organisation (WHO). A comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of non-communicable diseases. Third discussion paper. Version dated 25 July 2012, page 7. Accessed from: http://www.who.int/nmh/events/2012/discussion_paper3.pdf

[5] World Health Organisation (WHO). A comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of non-communicable diseases First discussion paper. Version dated 21 December 2011. Accessed from: http://www.who.int/nmh/events/2011/consultation_dec_2011/WHO_Discussion_Paper_FINAL.pdf

[6] Australian Government.Submission on WHO's first discussion paper on A comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of non-communicable diseases. 29 February 2012. Accessed from:
http://www.health.gov.au/internet/main/publishing.nsf/Content/E808AE1112F7C624CA257A6200208CAB/$File/NCD%20written%20submission%20to%20WHO29%20Feb%202012%20v5%209%20March%20FINAL.pdf

behind it, as it precludes the possibility of reducing per capita consumption of alcohol, and the risk of NCDs, before a concerted government effort to do so has been undertaken.

We are aware and concerned that most member countries are already experiencing considerable pressure exerted upon them by domestic and global alcohol companies, aiming to weaken their country's position on the proposed alcohol target and associated policy action. In this context, a single, globally-agreed target, without any caveats attached, will help to counteract such pressure from the alcohol industry and ensure that member countries can take unhindered action in support of the global action plan for the prevention and control of NCDs.

Similar to our concerns regarding the wording of the target for alcohol, discussed above, NAAA is also concerned that the specificity of indicators #3, #4, and #5 has been weakened by the inclusion of the qualifying statement "as appropriate, within the national context" [refer to table on pages 10-12 of the draft plan].

Furthermore, the inclusion of the words "among others", within footnote (1) relating to the alcohol indicators, is ambiguous and potentially further weakens the specificity of indicators. We recommend that an explanation of the meaning of these words should be included, or alternatively, these words should be removed.

With regard to the proposed indicator #3, this is supported by the NAAA and, as reflected in our comments on the alcohol target above, we believe that indicator #3 is the most appropriate and feasible indicator to monitor countries' progress towards the reducing the risk of alcohol attributable NCDs. We again recommend that the caveat "as appropriate, within the national context" be removed, as this weakens the specificity of indicator #3 and jeopardises a consistent approach to the application of this indicator among member countries.

With regard to the proposed indicators #4 and #5, these are supported by the NAAA, albeit with the qualification that these are of secondary importance to indicator #3. This is because both the prevalence of heavy episodic drinking (indicator #4) and alcohol-related morbidity and mortality (indicator #5) reflect the level of per capita consumption of alcohol in the population (indicator #3). As such, we recommend that indicator #3 be included as a minimum, mandatory requirement for all countries.

The NAAA has some concerns regarding the proposal at §39(b): "further develop a common set of indicators and data collection tools for tracking modifiable risk factors in populations, including the work on the feasibility of a composite indicator for monitoring the harmful use of alcohol at different levels". Our concern is that once work is underway to develop this composite indicator, it may be used as a justification for inaction in monitoring other important indicators.

## 3. The involvement of the alcohol industry

The NAAA is very concerned that the draft plan is ambiguous regarding the involvement of the alcohol industry in its implementation. At §23, §30, §40, §52, §60 of the draft plan, reference is made to the range of actions "proposed for international partners (including, as appropriate, the private sector when there is no conflict of interest but excluding the tobacco industry)". The NAAA strongly recommends that this section is reworded to reflect clearly the position taken by the 2006 WHO expert committee on alcohol[7] with regards to interacting with the alcohol industry:

> *The Committee recommends that WHO continue its practice of no collaboration with the various sectors of the alcohol industry. Any interaction should be confined to discussion of the contribution the alcohol industry can make to the reduction of alcohol-related harm only in the*

[7] WHO expert committee on problems related to alcohol consumption. Second Report. WHO. Geneva. 2006. Accessed from: http://www.who.int/entity/substance_abuse/expert_committee_alcohol_trs944.pdf

*context of their roles as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion.*

Given that the WHO's exclusion of the tobacco industry is clearly articulated in these sections of the draft plan, we believe that it is equally appropriate and important to articulate a similar position regarding the involvement of the alcohol industry.