Beyond exceptionalism: the global challenge of regulating alcohol in accordance with its health and social risks

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As required by the Alcohol Policy 18 Conference, I have signed a disclosure statement and note the following conflict(s) of interest:

No conflicts of interest

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Alcohol: a risk factor that is not only pervasive but also complicated
(from the 2012 Global Burden of Disease risk estimates for 2010 -- Lim et al., 2012)
The harm from alcohol is not only to the drinker, and not only to health

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<tr>
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<th>Individual</th>
<th>Family</th>
<th>Work</th>
<th>Society</th>
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<tbody>
<tr>
<td><strong>Health burden</strong></td>
<td>Morbidity from diseases caused or worsened by drinking; premature mortality.</td>
<td>Injury; stress-related problems for other family members; FASD; interpersonal violence</td>
<td>Injury and disability</td>
<td>Hospitalisation and care for alc-induced health problems, injuries; infectious dis., FASD</td>
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<td><strong>Social burden</strong></td>
<td>Decreases in functionality form intoxication, blackouts, hangovers, decrease in social roles; loss of friendships; stigma</td>
<td>Problems with parental roles, partnership roles, and roles as caregiver in general (e.g., to parents)</td>
<td>Team problems; others having to compensate for lack of productivity</td>
<td>Social costs of alcohol; vandalism</td>
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<td><strong>Economic burden</strong></td>
<td>Dependence on society of person with alcohol dependence; cost of possible job loss or absenteeism; possible social drift downwards</td>
<td>Financial problems resulting from health and social consequences of alcohol impacting on family budget and household expenses</td>
<td>Productivity costs (e.g., poor performance when working and disability, short- and long-term); replacement costs when premature mortality or long-term disability</td>
<td>Productivity losses; health care costs; welfare/child protection costs; costs in the legal sector (police, court, prisons)</td>
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Alcohol as a source of both health and social harm: the double burden

- Globally, and particularly for high- and mid-income societies, alcohol is among the most serious risk factors to the health of the drinker
- But attention to the health aspect is often weakened by a policy emphasis on the social harms
  - This points to a moralised response often focusing on punishing the drinker
- One result: acceptance of a higher health risk for alcohol than for other consumption behaviours
What levels of risk to health do our societies usually accept?

In terms of lifetime chances of death from the risk:

• For involuntary risks:
  – e.g., cancer risk from contaminants in water supply: 1 in 1 million, or maybe 1 in 100,000

• For voluntary risks: a thousandfold more
  – e.g., canoeing, rock-climbing: ~1 in 1000


• Risks from alcohol consumption a mixture of voluntary and involuntary
  – Another common behaviour mixing risks is automobile driving
    – for it, Australia aims for a lower lifetime risk (i.e. higher ratio) than 1 in 200 (Room & Rehm, Clear criteria based on absolute risk. *Drug & Alcohol Review* 31(2): 135-140, 2012.)
But higher risks are deemed acceptable for alcohol: “Low-risk” drinking guidelines (lifetime absolute risk basis)

• current Australian official guidelines (2009):
  – No more than 20 gm. alcohol per day average: lifetime risk of death from alcohol-induced disease < 1 in 100
  – No more than 40 gm on an occasion: if twice a week or less, lifetime risk of death from alcohol-related injury < 1 in 100 (combining the two, maybe < 1 in 70)

• In Europe: drinking 20 gm a day is above a risk threshold of 1 in 100 on a lifetime basis
  – Acceptable Daily Intake (ADI) would be 2.6 gm/day by the standards of the WHO Programme on Chemical Safety (Rehm et al., 2014)
Alcohol as the great exception

• Even in a public health frame, greater risks are seen as acceptable for alcohol than for other risky behaviours

• Societal responses to alcohol-related problems are dispersed, not well coordinated, and often inadequate
Factors involved in alcohol’s unique status in European and related societies

• Not regulated as an addictive substance under the international drug control system
  – Strong cultural acceptance and influence of alcohol industries
• Not treated as other food products
  – exempt from mandated list of ingredients & nutrition labelling in EU, Australia, etc., not controlled as carcinogen
• Public health community has often been ambivalent
  – reflecting generational reactions against Temperance era
• Public perceptions underestimate risk (Rehm et al., 2014)
Thus internationally: a curious history

- Alcohol was the first psychoactive substance under international control
  - 1890 treaty between colonial powers controlling “trade spirits” in Africa
  - Defunct by 1960s
- Since: no international control from a public health perspective
- Alcohol would clearly qualify for control under drug treaties -- issue has been avoided
- Meanwhile: Trade treaties limit national & subnational controls, push toward greater availability
  - EU common market
  - Other regional & bilateral treaties
  - WTO: Technical Barriers to Trade, etc.
Alcohol harm concerns in UN organisations

• Almost only the World Health Organization
  – Jellinek at WHO, late 1940s – reflecting 1\textsuperscript{st} leader of Mental Health’s interest – ended abruptly with advent of 2\textsuperscript{nd} leader
    • Until late ‘60s, mostly promoting alcoholism treatment
  – Periods of interest, 1960s onward – mostly supported by extrabudgetary funds (US, Sweden, Norway, Thailand ...)
    • Greater concern with population patterns, control policies
    • But periodic de-emphases (e.g., early ‘80s) under alcohol industry pressure through member states
  – Greater interest in 2000s → Global Strategy 2010
    • But starved for resources
Within WHO: shifting links & framing

• In terms of **mental disorder**:  
  – alcoholism → alcohol dependence → alcohol use disorders  
  – but alcohol never a central concern in psychiatry

• Linked with **tobacco** early in Brundtland era – but left behind in the push for the Framework Tobacco Convention

• With **drugs** as “Substance Abuse” in ‘80s – but as a public health agency, WHO inevitably favoured harm reduction  
  – a phrase forbidden in official international discourse by the US for over a decade; WHO’s role in drugs was then de-emphasised

• With **NCDs** (a major risk factor): but chronic diseases < half alcohol’s health harm (not injury, not infectious diseases)

• Any one framing (what kind of disorder? risk factor for what? health/social/welfare problem? ) tends to obscure other aspects
WHO global strategy to reduce the harmful use of alcohol endorsed by the 63rd World Health Assembly resolution, 2010

“...the global strategy for reducing the harmful use of alcohol is a true breakthrough. This strategy gives you a large and flexible menu of evidence-based policy options for addressing a problem that damages health in rich and poor countries alike. The strategy sends a powerful message: countries are willing to work together to take a tough stand against the harmful use of alcohol.”

Dr Margaret Chan
Then the Director-General
World Health Organization
Closing speech at WHA63, 2010
Since 2010: Further symbolic recognition -- but the alcohol program remains starved of resources

- 2011+: the push on NonCommunicable Diseases (NCDs)
  - alcohol is recognised as one of the leading risk factors
  - but faces the most pressure to weaken indicators and goals:
    Target 2: “At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context” (vs. Target 5: at least 30% reduction in tobacco use)

- 2015: UN Sustainable Development Goals for 2030 include strengthening prevention & treatment for “harmful use of alcohol”
- But resources are lacking, if anything shrinking --
  - Professional staff in international agencies working on:
    drugs: in the 100s; tobacco: in the dozens; alcohol: less than 5
What is to be done internationally?
International law and psychoactive substances: a stark divide

- **Heroin, cocaine, amphetamines, diazepides....**
  - Internat’l treaties (1961, 1971, 1988), backed up by national laws:
    - Prescription requirement for most medical use
    - Otherwise growing, selling, possession prohibited, punished as crime
    - Treaties have provided de-facto protection against trade disputes

- **Tobacco**
  - Framework Convention on Tobacco Control (in effect since 2005)
    - Fairly new, relatively “soft law”: encouraging but not requiring national actions
    - Legal markets, increasingly strong national controls

- **Alcohol: the great exception**
  - No international public health law
  - Legal markets, weakened controls at national or subnational levels
A counterforce: the world of trade treaties

• In trade agreements and disputes, both tobacco and alcohol are treated as ordinary commodities; national market restrictions are subject to overturn in trade dispute decisions
  - e.g., for 14 Asian countries 1994-2013, 4 decisions against them on alcohol and 1 on tobacco. (Baker P et al., Globalization & Health 10:66, 2014)
  - Threats of suits and their costs are used to deter actions
    - Philip Morris’s suit against Australian cigarette plain packaging was used to deter Uruguay & others;
    - complaints by Australia, the EU and others successfully deterred Thailand from graphic warnings on alcohol containers
  - The public health exceptions in trade treaties have proved useless, since they only apply in exacting conditions.
• New treaties -- TPP, TTIP, TISA will make things worse for alcohol
An example in a pending trade treaty: marginalisation of warning labels on wine & spirits

• The Trans-Pacific Partnership (TPP) treaty
  – Annex 8-A: technical regulations on labelling of wine and spirits
  – A health warning, listing of ingredients, etc. cannot be required to be on the main label of the container, only on a supplementary label
  – There a routine possible exception for measures “necessary to protect ... health”, but this is interpreted narrowly in trade dispute decisions
  – TPP provisions as a template for future agreements
    • e.g., already the Singapore-Australia bilateral agreement
An example of what is at stake – proposed rotating warning messages for Australia

Option 1: bring alcohol into drug treaties

- “There was a brief discussion as to whether ethanol (ethyl alcohol) should be considered for pre-review.... The Expert Committee referred the matter for consideration at a future Expert Committee meeting.”

- Deferred to future meeting by 2014 Expert Committee

- If considered, would clearly qualify. If recommended, probably under Schedule II of 1971 treaty.

- If scheduled, would require amendment of treaty on limitations to medical use, etc.

- Strong resistance from those in the international drug control system to jolting the applecart

- Alcohol industries already fighting hard against per-capita alcohol consumption as an indicator of reduced NCD risk

- Putting alcohol into the frame of controlled substances would be an important step forward in public health, but presently unlikely
Option 2. A new Single Convention on drugs, including tobacco & alcohol as well?

- Internal market up to each country: regulate or prohibit
  - soft-law recommendations on regulation of domestic markets (as in Tobacco Convention)
- Comity required: nations must respect other nations’ regimes
  - forbidding commercial export to where prohibited
  - requiring national advertising & promotion bans/restrictions to be respected
- International oversight agency
  - to monitor production and trade & patterns of use
  - to coordinate international action to reduce social & health harms
- Public health and order considerations to take precedence over trade and free market agreements/dispute resolution
- Would be resisted strenuously, not likely in the near future
Option 3: a Framework Convention on Alcohol Control

• Modelled on the Framework Convention on Tobacco Control, but modified for alcohol’s special characteristics
• Providing for limitations on marketing and promotion
• Countering coverage of alcohol under trade treaties and disputes (informally or formally)
• Establishing comity between nations – not acting to undercut another nation’s controls
• A structure for international coordination – e.g., regular Conferences of Parties, international control board – coordinating action on alcohol as a main risk factor to health (including NCDs) and welfare
Why coverage by a treaty matters

• Symbolic (longer-term) as well as pragmatic (more immediate) importance

• Institutional commitment and staffing at the international level
  – Stimulating and coordinating national efforts

• Expectation of comity – one nation doesn’t undercut another’s control measures

• Coordination to counter the power of the multinationals

• Countering pressures to increase availability through the trade treaties
Some conclusions

• Compared to other psychoactive substances, and to other major risks to health, alcohol is an exception in terms of its status and in terms of societal and international responses.

• At the international level, a clear way forward would be a new Framework Convention on Alcohol, negotiated under WHO auspices.

• This will only be accomplished with major and coordinated efforts by “civil society” constituents such as those at AP18.