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COMMENTARY

Dealing Responsibly with the Alcohol Industry in London

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Abstract — The 2012 UK Government's Alcohol Strategy for England and Wales has been welcomed broadly and resulted only in muted criticism within the UK public health community. This is despite strong continuities with previous alcohol industry constructions of the nature of the problem and preferred policy responses. This is probably because the strategy shows progress on the public health lobby's key issue of pricing of alcohol beverages. There are, however, many problems with the wider content of the strategy, showing little interest in much needed industry regulation other than on price, and an absence of commitment to investment in research. Some dilemmas posed for the research community are discussed.

The UK Government Alcohol Strategy for England and Wales (Secretary of State for the Home Department, 2012) has broadly been welcomed as a step in the right direction that needs to go further. The *Lancet* (2012) suggested that the 'government should be commended for taking strong, effective steps to reduce alcohol consumption that will save lives'. *Alcohol Research U.K.* (2012) 'broadly supports the approach adopted'. Witnesses giving evidence to the first session of the parliamentary health select committee in April gave similar praise (BMJ, 2012a). Ian Gilmore, Chair of the Alcohol Health Alliance and former President of the Royal College of Physicians, saw this as an important milestone in the first acceptance of evidence that price, availability and marketing cause alcohol problems, albeit with weaker responses in the latter areas than called for (U.K. Parliament Health Select Committee Inquiry into the Government's Alcohol Strategy, 2012a).

The commitment to introduce minimum unit pricing (MUP) of alcohol had been particularly championed by public health advocates as very likely to help reduce the current UK population levels of alcohol problems. The principle of MUP has been conceded, with the exact price per unit to be consulted upon. While the Scottish Government have decided upon a 50 pence per unit rate, the UK Prime Minister offers the example of 40 pence in his foreword, though it is important to note that low price is defined there as 'the root cause of this problem'. The definition of the problem therein is particularly interesting. It begins:

'Binge drinking isn't some fringe issue, it accounts for half of all alcohol consumed in this country. The crime and violence it causes drains resources in our hospitals, generates mayhem on our streets and spreads fear in our communities. My message is simple. We can't go on like this. We have to tackle the scourge of violence caused by binge drinking.' (Secretary of State for the Home Department, 2012, P. 2).

This framing of the problem relegates the importance of mortality and morbidity due to long-term heavy drinking, and invites a multi-sectoral approach led by criminal justice rather than health agencies. The strategy document emphasizes the construct of 'irresponsible' drinking. This belongs to a wider industry narrative that locates the problems caused by alcohol in the behaviour of their customers rather than in the nature of the drug or in the industry's corporate practices (see for example, SAB Miller, 2012). Throughout the strategy document this rather nebulous construction of

'responsibility/irresponsibility' is applied both to the behaviour of individuals and to that of businesses. What it actually means is, of course, open to interpretation. The industry is happy to accept injunctions on responsibility, with the Portman Group having already previously rebranded itself as 'the responsibility body for alcoholic drinks producers in the U.K.' (Portman Group, 2011).

After short chapters having been devoted to statements of the problem and price and advertising, the remaining chapters are concerned with local community actions, supporting individuals to change and 'shared responsibility with industry'. The content of this latter chapter eschews any enhanced regulatory stance; concrete recommendations are absent. Lauding the progress of the Responsibility Deal (Bonner and Gilmore, 2012) forms the substance of this material, wrapped up in corporate friendly content on the importance of alcohol to the economy, and the need to cut red tape, i.e. deregulation. Encouragement of further industry involvement in education, messaging in advertising, prevention and other interventions is to be facilitated by the expansion of Drinkaware, originally established by the Portman Group and hitherto entirely industry funded.

The new announcement choreographed on the same day as the publication of the strategy but strangely not contained within it, was the Responsibility Deal pledge to reduce the alcohol content of drinks in response to market research indicating consumer demand (BMJ, 2012b). This could yield public health benefits if it does successfully reverse increases in the potency of standard beers and wines over the last 10–20 years available in the UK, and the growth of superlagers, high strength ciders and similar products particularly likely to be affected by an MUP for alcohol. We do not, and cannot, know whether this would have happened anyway without the Responsibility Deal. It could be taken, however, as achievement of the tough-sounding action to 'Challenge the industry to meet a new set of commitments to drive down alcohol misuse', a call that lacked any more specific content. The Strategy seems to ignore the fact that the approach to public health through the Responsibility Deal was widely criticized by bodies such as the British Medical Association, the Royal College of Physicians and Alcohol Concern and lacked much support beyond government and industry (BMJ, 2011).

The role of the current Health Secretary and indeed the Department of Health in the production of the Strategy is

unclear. It is not surprising therefore that the terms of reference of the UK Parliamentary Health Select Committee Inquiry into the Alcohol Strategy are prominently concerned with establishing who is responsible within Government for alcohol policy and the role of the industry (U.K. Parliament Health Select Committee Inquiry into the Government's Alcohol Strategy, 2012b). The Committee is also considering the evidence; and Alcohol Research UK for one has voiced some disappointment that the Strategy lacks 'explicit reference to the need for high quality research to evaluate these measures' (Alcohol Research U.K., 2012).

Across the Irish sea, there is a strong commitment to evidence-based policy involving research as one of the five main pillars of the emerging national substance misuse strategy (along with supply, prevention, treatment and rehabilitation; Department of Health, 2012). This points policies in a very different direction, following a period of industry self-regulation and partnership work that failed. For example, in relation to advertising and sponsorship sweeping mandatory changes are now in the process of being introduced which will prohibit all outdoor advertising of alcohol; employ a 9.00 p.m. watershed for alcohol advertising on television and radio; subject advertising in the print media to stringent codes, enshrined in legislation and independently monitored; and end industry sponsorship of sport and other large public events in Ireland by 2016 (Department of Health, 2012).

In France, a blanket ban on advertising prevents alcohol manufacturers from associating themselves with sporting events such as the Olympic Games. These restrictions on alcohol advertising have been tested at the EU level (European Court of Justice, 2004). In the UK, however, the lack of similar controls has allowed Heineken UK to be one of the principal sponsors of the London 2012 Olympics. The new strategy simply makes non-specific proposals lacking clear targets or concrete actions, beyond working with the Portman Group and other bodies, as has been done previously (Secretary of State for the Home Department, 2012).

Public health activists in England and Wales will be participating in the consultation to achieve as high a MUP as possible, commensurate with the anticipated benefits, notwithstanding uncertainties about the precise magnitude of effects (McCambridge and Kypri, 2009). Making plain the Strategy's limitations with respect to advertising and availability should help develop the case for a more genuinely strategic and evidence-based response. There are also less obvious and more difficult questions to consider, such as concerning the relationship of the research community to bodies such as Drinkaware that are funded by the industry, and participation in governmental initiatives heavily influenced by industry (Adams *et al.*, 2010). Some activities may be well considered realpolitik and others misguided follies, and both may perpetuate fundamental problems associated with industry involvement in alcohol policy making (Babor, 2000, 2009; Jernigan, 2012). Such problems certainly do not only afflict the current UK Government (Room, 2004; Anderson, 2007).

We should not be reticent about making the case for greater public funding of UK alcohol research. While the UK Medical Research Council (2010) has recognized the need for capacity building, its own Addiction Research Strategy devoted only small sums to this aim and failed to gain more than paltry sums from the Economic and Social Research Council and other important funders. In contrast, the multi-national alcohol

beverage manufacturer SAB-Miller, to take one example, has separate departments devoted to Alcohol Policy, UK Government Relations and Reputation and Corporate Communications all engaged with policy makers in the UK. Better understanding of the alcohol policy environment itself (Hawkins *et al.*, 2012) and what social scientists describe as its corporate capture (Miller and Harkins, 2010) is surely a necessary precursor to enhancing capacity for the design of effective policies that really will reduce alcohol harms. Now that would be a truly responsible approach to take.

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